ST. JOSEPH HEALTH – PETALUMA VALLEY HOSPITAL

2017 Community Health Needs Assessment Report

To provide feedback about this Community Health Needs Assessment, email Daniel.Schurman@stjoe.org

St. Joseph Health
Petaluma Valley

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[1] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

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

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

[2] To be reported as a community benefit initiative or program, **community need must be demonstrated**. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

APPENDICES:

EXECUTIVE SUMMARY

St. Joseph Health-Petaluma Valley Hospital is a community hospital founded in 1980 by the Petaluma Health Care District. Located in Petaluma, California, St. Joseph Health has managed operations of the facility since 1997. The facility has 80 licensed beds, all 80 of which are currently available, and a campus that is 14.63 acres in size. Petaluma Valley Hospital (PVH) has a staff of more than 275 full time employees and professional relationships with more than 260 local physicians. Major programs and services include emergency care, outpatient surgery, a birthing center, and pulmonary rehabilitation.

Part of a larger healthcare system known as St. Joseph Health (SJH), PVH is part of a countywide ministry, St. Joseph Health-Sonoma County (SJH-SC) that includes two hospitals, urgent care facilities, hospice, home health services, and other facilities for treating the healthcare needs of the community in Sonoma County and the region. The ministry's core facilities are PVH, an 80-bed acute care hospital, and Santa Rosa Memorial Hospital (SRMH), a full service, state of the art 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.

In response to identified unmet health-related needs in the community needs assessment, during FY18-FY20 PVH will focus on mental health and substance use disorders, homelessness and housing concerns, and access to resources for the broader and underserved members of the surrounding community.

OVERVIEW OF COMMUNITY HEALTH NEEDS ASSESSMENT

Since 1994, not-for-profit hospitals in California have been required by state law to assess community health needs every three years and to use that assessment as the basis for community benefit planning and coordination. Beginning with tax year 2013, under the requirements of the Federal Affordable Care Act (ACA), not-for-profit hospitals throughout the United States are also required to file a community health needs assessment with the Internal Revenue Service. ACA regulations include additional requirements to prioritize community health needs through a comprehensive review of local health data and the gathering of local community input. Beginning in 2014, each not-for-profit hospital is required to prepare an implementation plan that shows how the hospital will use its community benefit resources and the assets of local communities to address the prioritized health needs.

This Community Health Needs Assessment (CHNA) process was guided by the fundamental understanding that much of a person and community's health is determined by the conditions in which they live, work, play, and pray. In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at

socioeconomic factors, the physical environment, health behaviors, and the availability of clinical care. This framework focuses attention on the social determinants of health to learn more about opportunities for intervention that will help people become and stay healthy within their community.

Within this framework, publicly available data was sought that would provide information about the communities in our service area. Examples of the types of information that were gathered are socioeconomic factors, physical environment, health behaviors, and availability of clinical care. In addition to these determinants of health, we also looked at the health outcomes of the people living in the service area, including overall health condition as well as rates of asthma, diabetes, heart disease, cancer, and mental health. Finally, a qualitative data collection process was conducted to solicit direct input from residents and institutional stakeholders about their perceptions and experiences of health needs in the communities where they live and work.

COMMUNITY INPUT

The process of collecting qualitative community input took three main forms: Community Resident Focus Groups, a Nonprofit and Government Stakeholder Focus Group, and a Community Forum. Each group was designed to capture the collected knowledge and opinions of people who live and work in the communities served by PVH. In addition, the findings from the recent Sonoma County Collaborative CHNA conducted in 2016 and from the ongoing Community Building Initiative in the Roseland neighborhood of Southwest Santa Rosa were considered as additional sources.

COLLABORATING ORGANIZATIONS

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

- Sonoma County Department of Health Services
- Community Child Care Council (4Cs) of Sonoma County
- First 5 Sonoma County
- Burbank Housing
- Community Foundation Sonoma County
- Sonoma County Sheriff's Office
- City of Santa Rosa Violence Prevention Partnership
- Community Action Partnership of Sonoma
- Sonoma County ACEs Connection
- Sonoma County Economic Development Board
- Sonoma County Permit & Resource Management Department
- Sonoma County Environmental Health & Safety
- Buckelew Programs
- Sonoma County Office of Education
- Sonoma County Community Development Commission
- La Luz Community Center
- Petaluma People Services Center
- Sutter Health
- Kaiser Permanente

- Santa Rosa Community Health Centers
- West County Health Centers
- Petaluma Health Care District
- Petaluma Health Center
- Alliance Medical Center
- Sonoma West Medical Center
- Palm Drive Health Care District
- North Sonoma County Health Care District
- Sonoma Valley Health Care District
- Russian River Area Resources and Advocates
- Community Health Initiative of the Petaluma Area
- Latino Service Providers
- Sonoma County Human Services Department
- Sonoma County Task Force on the Homeless
- Sonoma County Health Care for the Homeless Coalition
- Mendocino County Department of Health & Human Services
- Healthy Mendocino

SIGNIFICANT HEALTH NEEDS

In compiling and analyzing both the quantitative and qualitative data collected in the CHNA process, the following were identified as the most significant health needs in our community:

- Mental Health
- Substance Use
- Obesity
- Heart Disease
- Oral Health
- Access to Resources
- Housing Concerns
- Diabetes
- Food and Nutrition
- Early Childhood Development
- Insurance and Cost of Care
- Homelessness
- Economic Insecurity
- Asthma
- Cancer
- Crime and Safety
- Immigration Status

PRIORITY HEALTH NEEDS

The Community Benefit Committee of SRMH and PVH considered the above health needs in conjunction with our capacities and resources and identified the following as the priority areas that our ministry will address in our FY18-FY20 Community Benefit Plan/Implementation Strategy Report.

- Access to Resources
- Homelessness and Housing Concerns
- Mental Health/Substance Use

INTRODUCTION

WHO WE ARE AND WHY WE EXIST

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

PVH is a community hospital founded in 1980 by the Petaluma Health Care District. Located in Petaluma, California, St. Joseph Health has managed operations of the facility since 1997. The facility has 80 licensed beds, all 80 of which are currently available, and a campus that is 14.63 acres in size. PVH has a staff of more than 275 full time employees and professional relationships with more than 260 local physicians. Major programs and services include emergency care, outpatient surgery, a birthing center, and pulmonary rehabilitation.

Since joining St. Joseph Health, PVH has established itself as an anchor institution in leading multiple and various community health improvement programs, initiatives, and partnerships aimed at increasing access to care and improving the health and quality of life of the communities we serve. Prominent among these efforts are the provision of free medical care for all who seek it at our Mobile Health Clinic, and the provision of free dental care to children at our St. Joseph Health Community Dental Clinic. During Fiscal Year 2016 (FY16), PVH invested a total of $9,997,108 in community benefit, providing service to 1,300 persons. In addition, PVH invested an additional $7,730,200 in unpaid cost to Medicare.

MISSION, VISION, 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.

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 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, PVH 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 the next five years (FY2022) St. Joseph Health and PVH are strategically focused on two key areas with which the Community Benefit strategy strongly aligns: population health management and network of care.

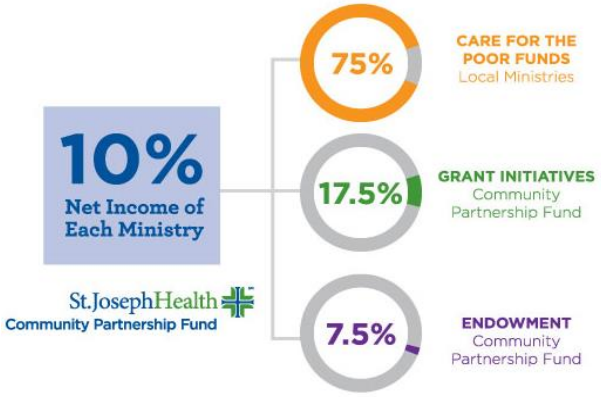
OUR COMMITMENT TO COMMUNITY

Organizational Commitment

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

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

Figure 1. Fund distribution



SJH hospitals.

Each year, PVH allocates 10% of its net income (net unrealized gains and losses) to the St. Joseph Health Community Partnership Fund (See Figure 1). 75% of the contributions are used to support local hospital Care for the Poor programs. 17.5% is used to support SJH Community Partnership Fund grant initiatives. The remaining 7.5% is designated toward reserves, which helps ensure the Fund's ability to sustain programs into the future that assist low-income and underserved populations.

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

Community Benefit Governance

PVH further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The Vice President of Mission Integration and the Community Partnership Manager are responsible for coordinating implementation of California Senate Bill 697 provisions and Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Benefit Plan.

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

A charter approved in 2007 establishes the formation of the Santa Rosa Memorial Hospital and Petaluma Valley Hospital Community Benefit Committee. The role of the CB Committee is to support the Board of Trustees in overseeing community benefit issues. The Committee acts in accordance with a Board-approved charter. The CB Committee 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 Community Health Needs Assessment and Community Benefit Plan/Implementation Strategy Reports, and overseeing and directing the Community Benefit activities.

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

Roles and Responsibilities

Senior Leadership

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

Community Benefit Committee (CBC)

- CBC serves as an extension of trustees to provide direct oversight for all charitable program activities and ensure program alignment with *Advancing the State of the Art of Community Benefit* (ASACB) Five Core Principles. It includes diverse community stakeholders. Trustee members on CBC serve as 'board level champions'.
- The committee provides recommendations to the Board of Trustees regarding budget, program targeting and program continuation or revision.

Community Benefit (CB) Department

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

Local Community Representatives on the CBC

- 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.

OUR COMMUNITY

Community

Description of Community Served

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

Hospital Total Service Area

The community served by the Hospital is defined based on the geographic origins of the Hospital's inpatients. The Hospital Total Service Area is the comprised of both the Primary

Service Area (PSA) as well as the Secondary Service Area (SSA) and is established based on the following criteria:

- PSA: 70% of discharges (excluding normal newborns)
- SSA: 71%-85% of discharges (draw rates per ZIP code are considered and PSA/SSA are modified accordingly)
- Includes ZIP codes for continuity
- Natural boundaries are considered (i.e., freeways, mountain ranges, etc.)
- Cities are placed in PSA or SSA, but not both

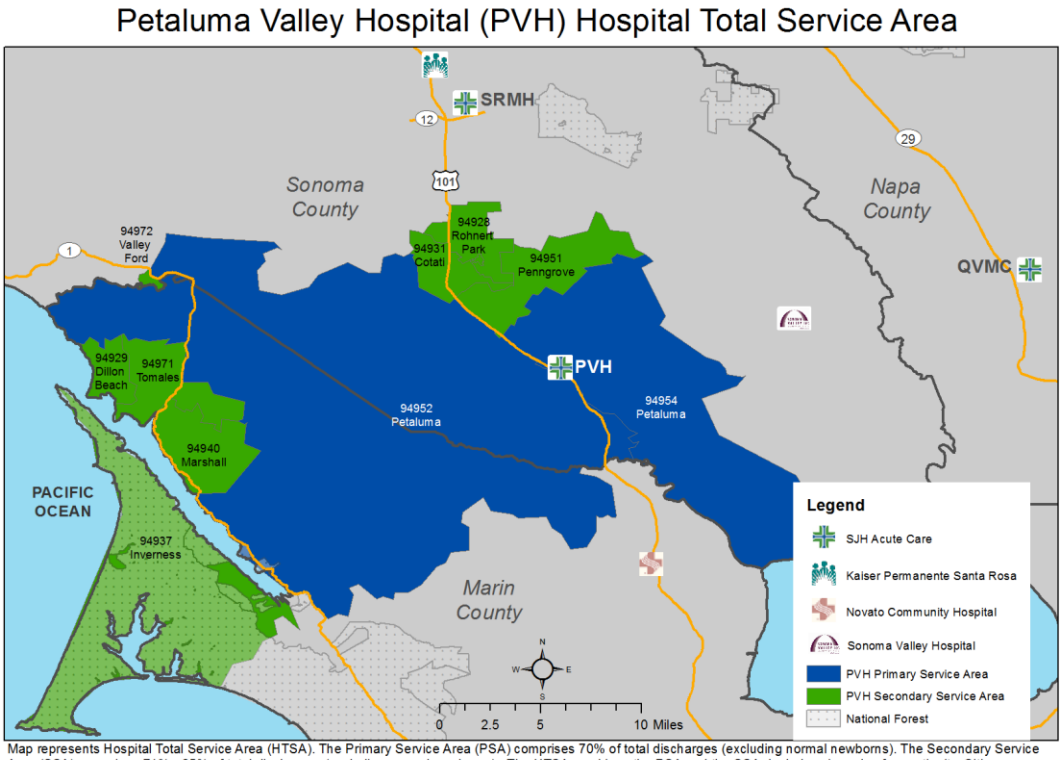
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients reside. The PSA is comprised of the city of Petaluma. The SSA is comprised of the Sonoma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

Table 1. Cities and ZIP codes

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

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

Figure 1. PVH Total Service Area



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

Community Profile

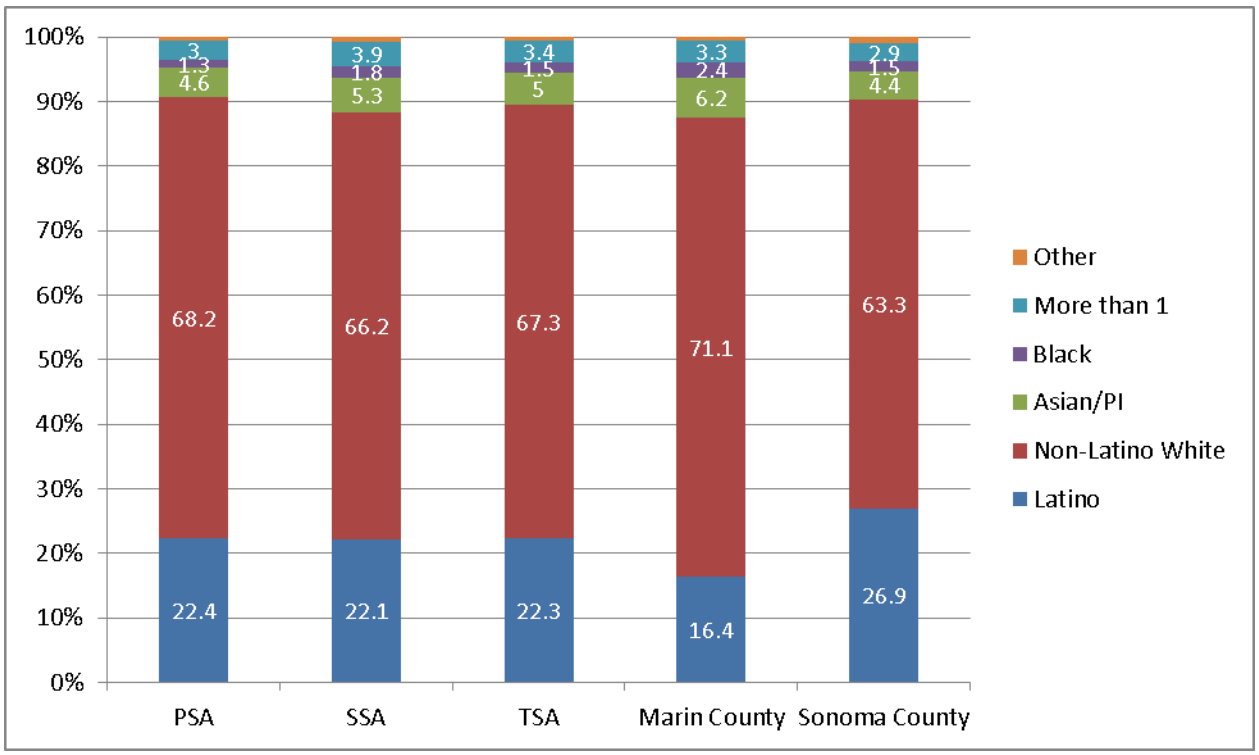
The table and graph below provide basic demographic and socioeconomic information about the Petaluma Valley Hospital Service Area and how it compares to Sonoma and Marin Counties and the state of California. The Total Service Area (TSA) of Petaluma Valley Hospital includes approximately 133,000 people.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

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

Service Area Demographic Overview

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

Race/Ethnicity



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

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

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

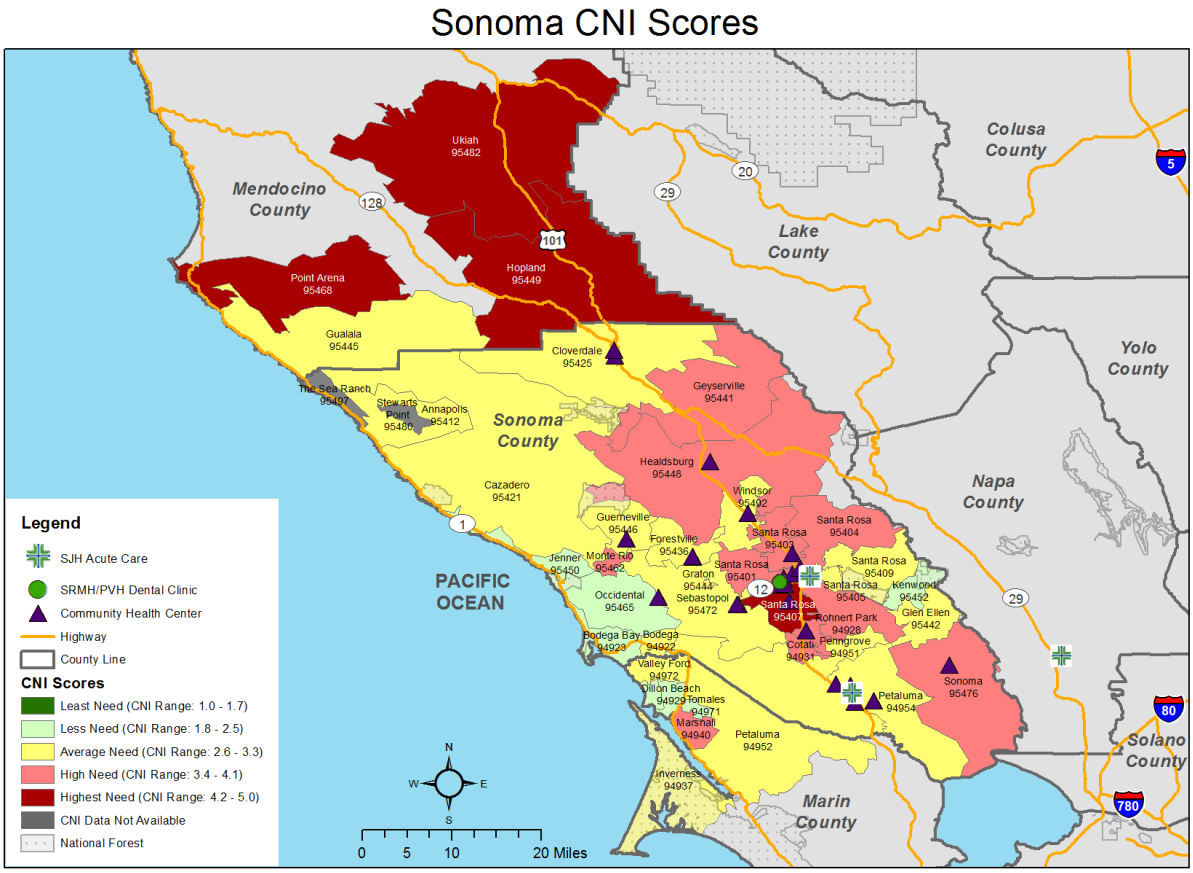
- Income Barriers (Elder poverty, child poverty and single parent poverty)
- Culture Barriers (non-Caucasian limited English);
- Educational Barriers (% population without HS diploma);
- Insurance Barriers (Insurance, unemployed and uninsured);
- Housing Barriers (Housing, renting percentage).

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

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

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

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



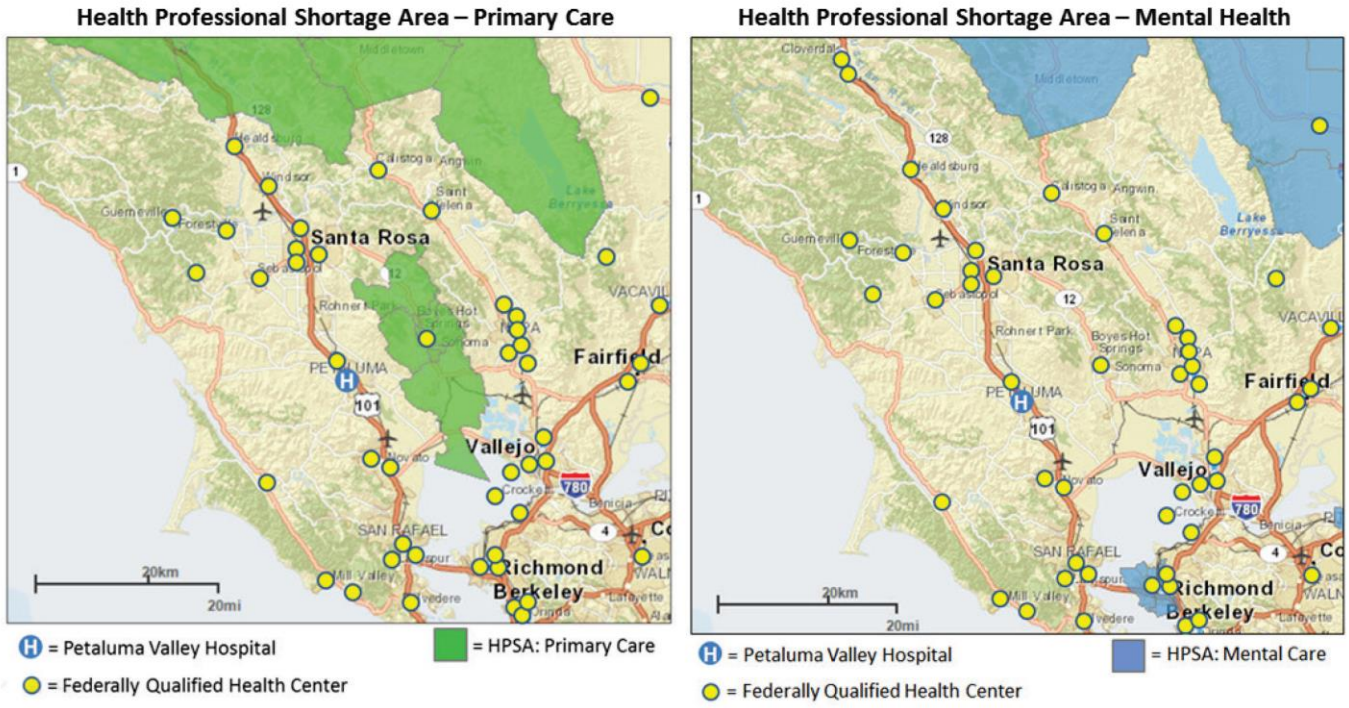
Source: Dignity Health Community Need Index (cni.chw-interactive.org), 2015 (accessed March 2016); Redwood Community Health Coalition (rchc.net) (accessed Oct. 2016).
Prepared by the St. Joseph Health Strategic Services Department, April 2016.

See Appendix 1: Community Needs Index data

Health Professions Shortage Area – Mental, Dental, Other

The Federal Health Resources and Services Administration designates Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). The map below depicts these shortage areas relative to PVH's location.

Figure 3. Petaluma Valley Hospital Health Professions Shortage Area

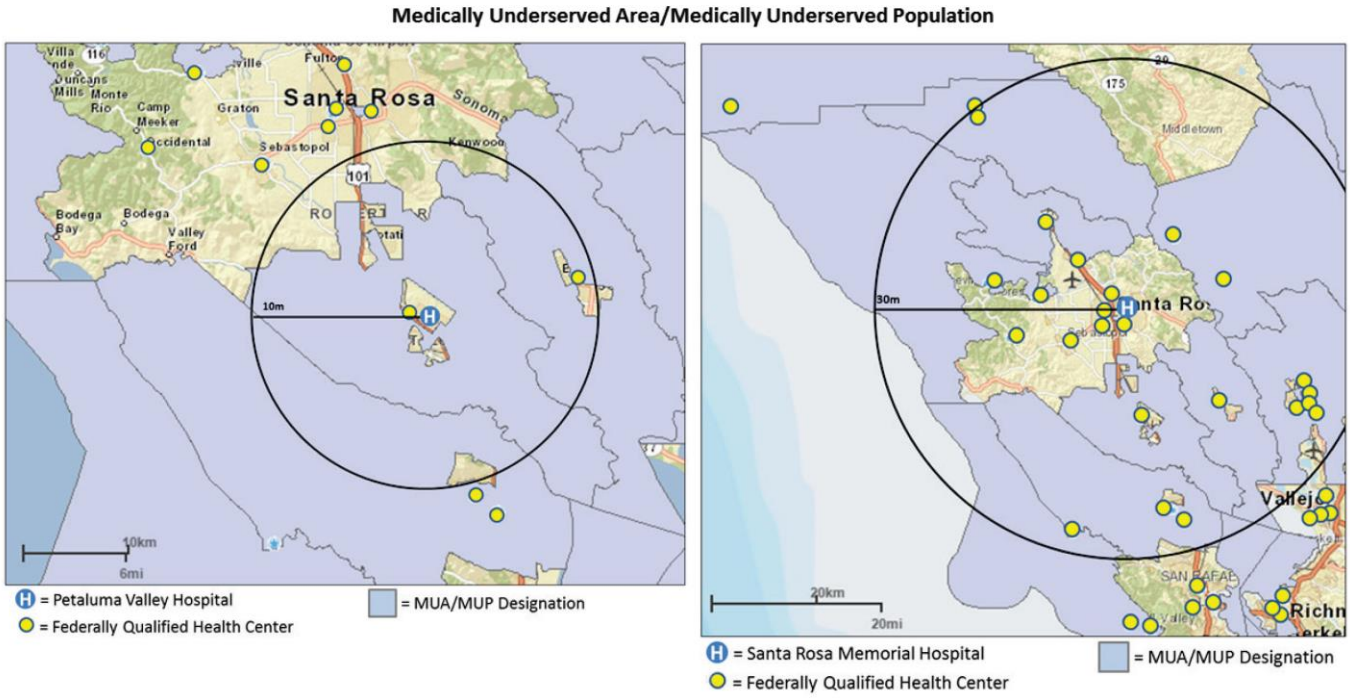


• Neither Petaluma Valley Hospital nor its service area is located in a Health Professional Shortage Area.

Medical Underserved Area/Medical Professional Shortage Area

Medically Underserved Areas and Medically Underserved Populations are defined by the Federal Government to include areas or population groups that demonstrate a shortage of healthcare services. This designation process was originally established to assist the government in allocating community health center grant funds to the areas of greatest need. Medically Underserved Areas are identified by calculating a composite index of need indicators compiled and compared with national averages to determine an area's level of medical "under service." Medically Underserved Populations are identified based on documentation of unusual local conditions that result in access barriers to medical services. Medically Underserved Areas and Medically Underserved Populations are permanently set, and no renewal process is necessary. The map below depicts the Medically Underserved Areas/Medically Underserved within a 30 mile radius from PVH.

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



• Petaluma Valley Hospital, along with the almost all of the service area, is located in a Medically Underserved Area/Medically Underserved Populations area, signifying the importance of Petaluma Valley Hospital to the community it serves.

• There are two Federally Qualified Health Centers within a ten mile radius of Petaluma Valley Hospital.

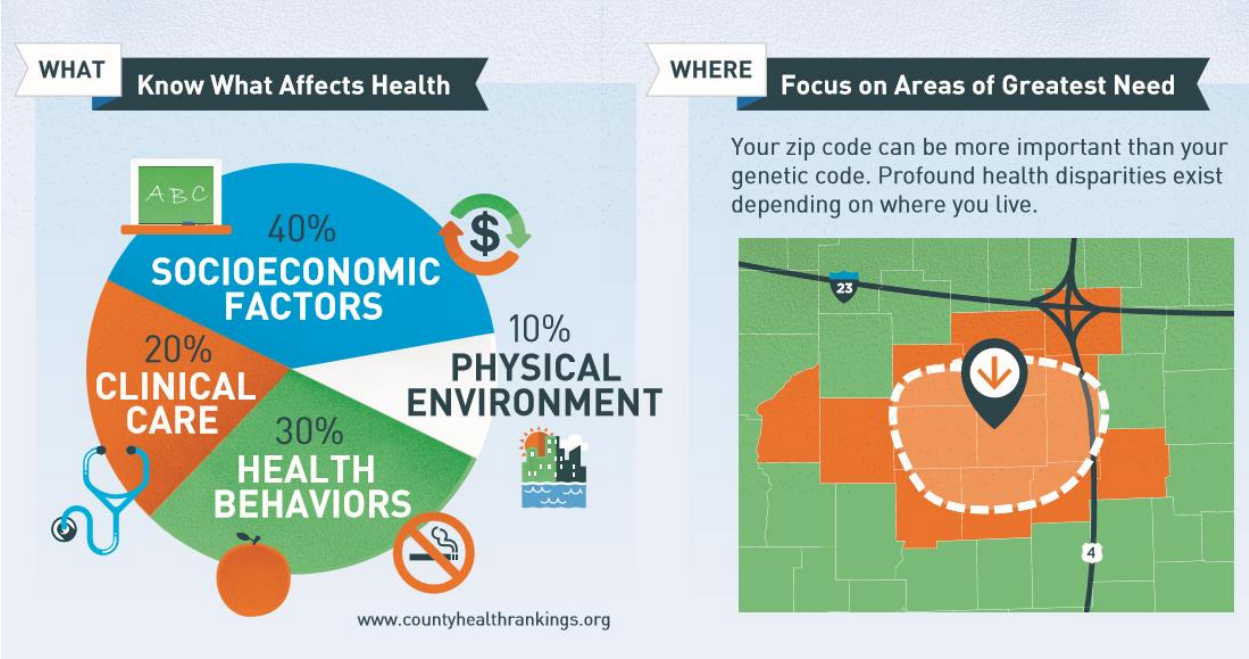
OVERVIEW OF THE CHNA PROCESS

Overview and Summary of the Health Framework Guiding the CHNA

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

In addition, we recognized that where people live tells us a lot about their health and health needs, and that there can be pockets within counties and cities where the conditions for

supporting health are substantially worse than nearby areas. When data was publicly available, it was collected at the zip code level to show the disparities in health and the social determinants of health that occur within the hospital service area.



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

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

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

Health Behaviors – obesity[3], sugary drink consumption, physical exercise, smoking, and substance abuse

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

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

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

[3] Per County Health Rankings obesity is listed under the health behavior category of diet and exercise. http://www.countyhealthrankings.org/our-approach/health-factors/diet-and-exercise

METHODOLOGY

Collaborative Partners

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

- Sonoma County Department of Health Services
- Community Child Care Council (4Cs) of Sonoma County
- First 5 Sonoma County
- Burbank Housing
- Community Foundation Sonoma County
- Sonoma County Sheriff's Office
- City of Santa Rosa Violence Prevention Partnership
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- Sonoma County Task Force on the Homeless
- Sonoma County Health Care for the Homeless Coalition
- Mendocino County Department of Health & Human Services
- Healthy Mendocino

The Olin Group is a socially conscious consulting firm working across nonprofit, public, private, and philanthropic sectors to bring about community transformation. Based in Santa Ana, California, The Olin Group has 15 years of experience working on evaluation, planning, assessment, fundraising, communication, and other services for nonprofit organizations, and had previously supported the CHNA process of multiple hospitals in the St. Joseph Health system. The Olin Group served as the lead consultant in the CHNA process, coordinating the quantitative and qualitative data collection processes and assisting in the prioritization and selection of health needs.

Community Partners:

Petaluma Valley Hospital, in collaboration with Santa Rosa Memorial Hospital, partnered with the following community groups to recruit for and host the Focus Groups and Forum:

The Community Child Care Council of Sonoma County – known as 4Cs – is a nonprofit agency dedicated to supporting and providing quality, accessible and affordable preschool and child care services for children, families and child care professionals through education, resources, and direct services. 4Cs also operates eleven State-funded preschools throughout Sonoma County. The mission of the Community Child Care Council is to inspire our community to support the well-being of every child and to improve the quality and availability of child care in Sonoma County.

Petaluma People Services Center (PPSC) is a multi-service nonprofit social services agency serving the communities of Petaluma and southern Sonoma County with more than 53 human services programs based on best practice research with measurable outcomes. PPSC has five significant core service areas:

- Senior Services – Meals-On-Wheels, Adult Day Care, Case Management, Nutrition Site-Senior Cafe, Transportation
- Homeless Prevention, SHARE of Sonoma and Fair Housing Sonoma County
- Employment & Training – Adult and Youth
- Counseling – Individual, Couples & Family, Drug & Alcohol Prevention, Gang Prevention
- Petaluma Bounty – Healthy Food For All

La Luz is the primary social service agency in the Sonoma Valley region which includes one of Sonoma County's prominent areas of need with one of the highest concentrations of working poor Latino families. La Luz provides English language training and financial support services, teaches computer skills, distributes food, hosts medical and legal services, offers crisis counseling, and supports events that celebrate the multicultural richness of the community. La Luz services ensure that Sonoma Valley residents facing all types of challenges have the opportunity to improve their lives.

Community Action Partnership of Sonoma County (CAP Sonoma) has been partnering with low-income families and individuals to help them achieve economic and social stability; to build community, and to advocate for social and economic justice since 1967. As the surviving community action agency for Sonoma County from the War on Poverty in the '60s, CAP Sonoma is the largest nonprofit social services agency in Sonoma County.

Secondary Data/Publicly available data

Within the guiding health framework for the CHNA, publicly available data was sought that would provide information about the communities (at the city and zip code level when available) and people within our service area. In addition, comparison data was gathered to show how the service area communities are faring compared to the county or state. Indicators were chosen if they were widely accepted as valid and appropriate measures[4] and would readily communicate the health needs of the service area. Preference was given to data that was obtained in the last 5 years and was available at the zip code level. The data sources used are highly regarded as reliable sources of data (e.g., ESRI Business Analyst Online, US Census Bureau American FactFinder, and California Health Interview Survey Neighborhood Edition). In total, 81 indicators were selected to describe the health needs in the hospital's service area. Appendix 2 includes a complete list of the indicators chosen, their sources, the year the data was collected, and details about how the information was gathered.

If an indicator had zip code level data available, data was pooled to develop indicator values for the Total Service Area (TSA), Primary Service Area (PSA), and Secondary Service Area (SSA) of the hospital. This enabled comparisons of zip code level data to the hospital service area and comparisons of the hospital service area to county and state measures.

After the data was gathered, the zip code level data was compared to the Total Service area values and color coded light pink to dark red depending on how much worse a zip code area was compared to the TSA value. This made it easier to visualize the geographic areas with greater health needs. The criteria for color-coding the zip code level data are explained in the spreadsheets in Appendix 2.

Community Input

The process of collecting qualitative community input took three main forms: Community Resident Focus Groups, a Nonprofit and Government Stakeholder Focus Group, and a Community Forum. Each group was designed to capture the collected knowledge and opinions of people who live and work in the communities served by Santa Rosa Memorial Hospital. We developed a protocol (noted in Appendix 3b) for each group to ensure consistency across individual focus groups, although the facilitators had some discretion on asking follow-up questions or probes as they saw fit. Invitation and recruitment procedures varied for each type

[4] https://wwwn.cdc.gov/CommunityHealth/PDF/Final_CHAforPHI_508.pdf

of group. Appendix 3 includes a full report of the community input process and findings along with descriptions of the participants. In addition, the findings from the recent Community Building Initiative in Roseland were considered as an additional source.

Resident Focus Groups

For Community Resident Groups, Hospital Community Benefit staff, in collaboration with their Community Benefit Committees and the St. Joseph Health Community Partnerships Department, identified geographic areas where data suggested there were significant health, physical environment, and socioeconomic concerns. This process also identified the language needs of the community, which determined the language in which each focus group was conducted. Community Benefit staff then partnered with community-based organizations that serve those areas to recruit for and host the focus groups. The community-based organization developed an invitation list using their contacts and knowledge of the area, and participants were promised a small incentive for their time. Two consultants staffed each focus group, serving as facilitators and note takers. These consultants were not directly affiliated with the ministry to ensure candor from the participants.

Nonprofit and Government Stakeholder Focus Group

For the Nonprofit and Government Stakeholder Focus Group, Community Benefit staff developed a list of leaders from organizations that serve diverse constituencies within the hospital's service area. Ministry staff sought to invite organizations with which they had existing relationships, but also used the focus group as an opportunity to build new relationships with stakeholders. Participants were not given a monetary incentive for attendance. As with the resident focus groups, this group was facilitated by outside consultants without a direct link to St. Joseph Health.

Resident Community Forum

Recruitment for the Community Resident Forum was much broader to encourage as many people as possible to attend the session. Community Benefit staff publicized the event through flyers and emails using their existing outreach networks, and also asked their partner organizations to invite and recruit participants. No formal invitation list was used for the forum and anyone who wished to attend was welcomed. The forum was conducted by an outside consultant in English, with simultaneous Spanish language translation for anyone who requested it.

While the focus groups followed a similar protocol to each other in which five to six questions were asked of the group, the forum followed a different process. The lead facilitator shared the health needs that had emerged from the CHNA process so far and asked the participants to comment on them and add any other concerns. Once the discussion was complete, the participants engaged in a cumulative voting process using dots to indicate their greatest

concerns. Through this process, the forum served as something of a "capstone" to the community input process.

Shared Process with Santa Rosa Memorial Hospital

Petaluma Valley Hospital shared their community process with Santa Rosa Memorial Hospital. As a result, two of the focus groups and the forum were held outside of Petaluma's service area, although efforts were made to ensure that stakeholders and forum participants represented Petaluma's needs as well. In preparing this report, data and responses that were specific to Petaluma were given extra weight.

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur.

- Not all desired health-related data was available. As a result proxy measures were used when available. For example, there is limited community or zip code level data on the incidence of mental health, or many health behaviors such as substance abuse.
- Data that is gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as rates of uninsured) and the most recent data available is not a good reflection of the current state.
- Zip code areas are the smallest geographic regions for which many health outcomes and health behavior indicators are publicly available. It is recognized that even within zip codes, there can be populations that are disproportionately worse off. For example, within smaller geographic areas, such as census tracts, socio-economic data provides a more granular understanding of disparity at the neighborhood level. As previously mentioned, census tract health outcome and health behavior data was not publicly available to paint a complete picture of community level need.
- Data for zip codes with small populations (below 2000) is often unreliable, especially when the data is estimated from a small sample of the population. In the total service area, Dillon Beach, Inverness, Marshall, Tomales, and Valley Ford each had fewer than 2,000 people.
- Information gathered during focus groups and community forums is dependent on who was invited and who showed up for the event. Efforts were made to include people who

could represent the broad interests of the community and/or were members of communities of greatest need.

- Fears about deportation kept many undocumented immigrants from participating in the focus groups and community forum and made it more difficult for their voice to be heard.

SELECTED HEALTH INDICATORS: SECONDARY DATA

Selected Health Indicators

For each set of indicators shown below, there are two types of tables. The first table shows the values for the Primary Service Area (PSA), the Secondary Service Area (SSA), the Total Service Area (TSA), the counties that have communities in the service area, and California. The second table(s) shows the areas of greatest need by zip code. For the second table type, the cells are colored red, orange, yellow, or white based on how much worse the indicator value is for that zip code compared to the TSA. The specific definitions for the color coding are shown in the table below.

Indicator	Much Worse	Moderately Worse	Slightly Worse	Not Worse
Household Income	80% or more below the TSA median household income	80.1% - 90% below the TSA median household income	90.1%-95% below the TSA median household income	No color means the value is about the same as, or better than, the TSA
Any indicator shown as a percent	4.0 or more percentage points worse than the TSA value	2-3.9 percentage points worse than the TSA value	1-1.9 percentage points worse than the TSA value	
Pollution Burden	4 or more higher than the TSA value	2-3.999 higher than the TSA value	1-1.999 higher than the TSA value	
Violent Crime	40% or more above the value for the county in which the city is located	20%-39% above the value for the county in which the city is located	10%-19% above the value for the county in which the city is located	

While TSA and Sonoma County data compare favorably to California averages, zip code level data shows there are more socioeconomic challenges in Cotati and Rohnert Park, and there are more children living in poverty in western Petaluma.

Indicator	PSA	SSA	TSA	Marin County	Sonoma County	California
Socioeconomic Indicators						
Median Household Income	$77,319	$60,202	$68,661	$95,860	$63,910	$62,554
Households below 100% of FPL	6.3%	7.1%	6.6%	5.3%	7.6%	12.3%
Households below 200% FPL	17.3%	19.8%	18.3%	13.6%	21.6%	29.8%
Children living below 100% FPL	12.9%	9.3%	11.4%	10.8%	15.1%	22.7%

Indicator	PSA	SSA	TSA	Marin County	Sonoma County	California
Older adults living below 100% FPL	6.6%	7.9%	7.1%	5.3%	6.8%	10.2%
Age 25+ and no HS diploma	11.0%	11.7%	11.3%	7.5%	13.2%	18.5%
Enrolled in Medi-Cal	12.3%	13.9%	13.0%	10.6%	15.8%	20.3%
Low-income food insecurity	3.8%	5.0%	4.3%	2.3%	5.3%	8.1%

Areas of Greatest Concern – Cities/communities with a population below 2000 that are moderately worse than the Total Service Area average on at least one of the eight socioeconomic indicators shown above.

Indicator	Petaluma	Rohnert Park	Cotati
	94952	94928	94931
Median Household Income			
Households below 100% of FPL			
Households below 200% FPL			
Children living below 100% FPL			
Older adults living below 100% FPL			
Age 25+ and no HS diploma			
Enrolled in Medi-Cal			
Low-income food insecurity			

Physical Environment

Across the service area, housing costs and overcrowding are comparable or better than California and county averages, and pollution is much better than the state. Cotati and Rohnert Park have more challenges in some of these areas, especially the cost of housing relative to income.

Indicator	PSA	SSA	TSA	Marin County	Sonoma County	California
Physical Environment Indicators						
More than 1 occupant per room	3.7%	4.1%	3.8%	3.3%	4.9%	8.2%
Renters pay more than 30% of household income for rent	52.4%	61.5%	57.2%	55.9%	57.8%	57.2%
Pollution Burden	15.192	15.497	15.436	10.434	15.274	25.312
Violent crimes (rate per 100,000 inhabitants)	NA	NA	NA	176.8	370.3	397.8

Areas of Greatest Concern - Cities/communities with a population below 2000 that are moderately worse than the Total Service Area average on at least one of the physical environment indicators shown.

Indicator	Rohnert Park	Cotati
	94928	94931
More than 1 occupant per room		
Renters pay more than 30% of household income for rent		
Pollution Burden		
Violent Crime (city level data)		

Health Outcomes

Health outcomes in the TSA are comparable to or better than California and Sonoma County for many metrics, although heart disease and asthma are more prevalent in the TSA than California. The difference in heart disease may be influenced by the older demographic. Penngrove and Rohnert Park are worse than the TSA for some conditions, most notably the number of disabled individuals in Penngrove. This may also be influenced by the relative age of that city.

Indicator	PSA	SSA	TSA	Marin County	Sonoma County	California
Health Outcome Indicators						
Fair or poor health (ages 0-17)	3.9%	3.6%	3.8%	NA	4.3%	5.2%
Fair or poor health (ages 18-64)	17.3%	16.2%	16.8%	9.2%	18.1%	19.2%
Fair or poor health (ages 65+)	20.4%	21.4%	20.8%	17.2%	20.4%	27.8%
Disabled population (all ages)	9.3%	10.5%	9.8%	9.0%	11.2%	10.3%
Asthma in children (ages 1-17)	16.5%	16.5%	16.5%	12.4%	16.4%	14.6%
Asthma in adults (ages 18+)	14.7%	15.1%	14.9%	16.9%	14.6%	13.9%
Diabetes in adults (ages 18+)	8.5%	6.7%	7.7%	4.6%	8.7%	8.8%
Heart disease (Ages 18+)	7.0%	5.9%	6.5%	7.5%	7.0%	5.9%
Serious psychological distress (ages 18+)	7.4%	8.4%	7.9%	4.1%	7.8%	8.1%

Areas of Greatest Concern - Cities/communities with a population below 2000 that are moderately worse than the Total Service Area average on at least one of the health outcome indicators shown.

Indicator	Rohnert Park	Penngrove
	94928	94951
Fair or poor health (ages 0-17)		NA
Fair or poor health (ages 18-64)		

Fair or poor health (ages 65+)		NA
Disabled population (all ages)		
Asthma in children (ages 1-17)		NA
Asthma in adults (ages 18+)		
Diabetes in adults (ages 18+)		
Heart disease (Ages 18+)		
Serious psychological distress (ages 18+)		

Health Behaviors

Obesity and its root behaviors are generally better in the TSA compared to the county and state, although the metrics are not as good in eastern Petaluma. However, the rate of teen alcohol and drug use in Sonoma County is much higher than California averages.

Indicator	PSA	SSA	TSA	Marin County	Sonoma County	California
Health Behavior Indicators						
Overweight (ages 2-11)	11.2%	10.9%	11.1%	8.7%	12.5%	13.3%
Overweight or obese (ages 12-17)	30.2%	28.5%	29.5%	7.9%	32.2%	33.1%
Obese (ages 18+)	24.3%	23.4%	23.9%	13.5%	25.5%	25.8%
Sugary drink consumption (ages 18+)	11.5%	12.1%	11.8%	11.8%	12.6%	17.4%
Regular physical activity (ages 5-17)	25.1%	24.9%	25.0%	24.8%	23.9%	20.7%
Youth alcohol/ drug use in the past month (grades 7, 9, and 11)	NA	NA	NA	30.0%	34.7%	27.8%
Births per 1,000 teens (ages 15-19)	NA	NA	NA	5.9	13.6	23.2

Areas of Greatest Concern - City/community with a population above 2000 that is moderately worse than the Total Service Area average on at least one of the health behavior indicators shown.

Indicator	Petaluma
	94954
Overweight (ages 2-11)	
Overweight or obese (ages 12-17)	
Obese (ages 18+)	
Sugary drink consumption (ages 18+)	
Regular physical activity (ages 5-17)	
Current smoker (ages 18+)	

Clinical Care

County level clinical care data demonstrates that the ratio of population per provider is similar to or better than the State. However, there is no specific data for the service area. Prenatal care

rates are higher in the TSA than the county and state. The rate of prenatal care in Rohnert Park is below the rate for the TSA, but still better than the county and state rates.

Indicator	PSA	SSA	TSA	Marin County	Sonoma County	California
Clinical Care Indicators						
Uninsured (ages 0-17)	NA	1.8%	1.7%	NA	NA	3.2%
Uninsured (ages 18-64)	12.7%	14.0%	13.3%	8.9%	14.3%	19.3%
First trimester prenatal care	89.3%	86.4%	88.1%	93.5%	84.6%	83.8%
# of people per primary care physician	NA	NA	NA	693:1	1,012:1	1,274:1
# of people per non-physician primary care provider	NA	NA	NA	2,248:1	2,120:1	2,192:1
# of people per dentist	NA	NA	NA	928:1	1,153:1	1,264:1
# of people per mental health provider	NA	NA	NA	152:1	268:1	356:1

Areas of Greatest Concern - City/community with a population above 2000 that is moderately worse than the Total Service Area average on at least one of the clinical care indicators shown.

Indicator	Rohnert Park
	94928
Uninsured (ages 0-17)	
Uninsured (ages 18-64)	
First trimester prenatal care	

See Appendix 2: Secondary Data /Publicly available data

SUMMARY OF COMMUNITY INPUT

Summary of Community Input

To better understand the community's perspective, opinions, experiences, and knowledge, Petaluma Valley Hospital, in partnership with Santa Rosa Memorial Hospital, held four sessions in which community members and nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions; full details on the protocols, findings, and attendees are available in Appendix 3. These sessions were scheduled as follows:

Session	City	Date	Language
Community Resident Focus Group	Sonoma	3/16/17	Spanish
Community Resident Focus Group	Petaluma	3/23/17	English
Nonprofit/Government Stakeholder	Santa Rosa	3/24/17	English

Focus Group			
Community Resident Forum	Santa Rosa	3/28/17	English with simultaneous interpretation in Spanish

Review of Findings

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

Mental Health: Discussions about mental health connected it to homelessness, poverty, and Adverse Childhood Experiences (ACEs). Stress in the immigrant community was tied to fears about deportation and disruption of their families. The elderly, with co-occurring dementia and mental illness were another concern. The lack of mental health providers and services, especially for people with moderate to severe mental illness and for the elderly, was discussed as a real deficit in the region.

Substance Abuse: High rates of alcohol use among teen-agers, over-prescription of opioids, including to the elderly, and babies born with neonatal abstinence syndrome were all described at the focus groups. Participants also recognized that substance abuse often occurs in tandem with mental illness. They noted the lack of intensive residential treatment facilities and sober living environments.

Housing: There is too little affordable, available housing and long wait lists for affordable housing. Negligent landlords do not maintain properties and people end up living in leaky, moldy domiciles. The high cost of housing makes it difficult to recruit professionals to the area.

Economic Insecurity: The high cost of living, especially housing, contributes to economic insecurity for many people. Stakeholders noted that the poverty in the region is often masked in the data because poor families share neighborhoods with wealthy families and the averages do not show the disparities.

Access to Resources: Shortages of medical providers and challenges attracting doctors, nurses, and other health care professionals were discussed. It manifests itself in long wait times for appointments and at the emergency room, and increased stress among health care workers.

Immigration Status: Undocumented immigrants are afraid to access public services, even if they or family members are eligible, due to fears of deportation. They also are reluctant to report substandard housing. Without health insurance, they wait until their health condition is dire before seeking help in the emergency room. Concerns of racial discrimination also were raised at the Spanish-language focus group.

Oral Health: About half of kindergartners start school with cavities or other dental disease experience. Schools lose funds and parents lose time at work when they have to take children out of the classroom for dental treatment. The lack of dental coverage and the cost of care was a big concern for community members.

Obesity: The prevalence of obesity, especially among Latino children, was noted. Among contributing factors were the lack of affordable, healthy food in poorer neighborhoods, schools not providing healthy lunches, and parents/grandparents being too busy to cook.

Diabetes: Participants linked diabetes to obesity, with many of the same causes. Residents noted its impact on all age groups, from infants to adults.

Crime and Safety: Public Safety was discussed in terms of domestic violence, bullying, aggressive drivers, distracted drivers, and people driving under the influence. Domestic violence, which is often exacerbated by substance abuse and is widely under-reported, was discussed as a cause of homelessness and childhood trauma.

The following concerns were identified as concerns for the community by the community resident focus groups but were not discussed at the nonprofit/government stakeholder focus group.

Insurance and Cost of Care: While the Affordable Care Act has reduced the number of uninsured individuals, there are still concerns about the cost of prescription drugs and high prices charged by private physicians. In addition, people who do not have insurance, like undocumented immigrants, cannot afford health care.

Food and Nutrition: Residents of Sonoma said they cannot find affordable, healthy food in their town and have to drive elsewhere for it. In Petaluma, residents talked about the easy access to fast food restaurants and regulations to limit any new fast food franchises in the town.

Health Conditions: Participants described a number of health conditions of concern to them, including allergies, asthma, heart disease, diabetes, and cancer.

Transportation: Transportation was cited as a problem, especially for the elderly and people without a driver's license. Public transportation can require multiple transfers and take a long time to get somewhere.

The following concerns were identified by the nonprofit/government stakeholder focus group but were not discussed at the community resident focus groups.

Homelessness: The homeless have become more visible in some parts of the service area even though the homeless count has been going down. The connections between homelessness, mental health, substance abuse, and domestic violence were described.

Early Childhood Development: Participants recognized the value of high quality child care and preschool, but described how families do not meet eligibility requirements for subsidized programs and then cannot afford quality care on their own. Preschools have difficulty recruiting qualified providers due to the high cost of living in the area.

The following concerns received the most support at the Community Forum:

Mental Health

Homelessness

Economic Insecurity

Housing

Early Childhood Development

Drug and Alcohol Abuse

See Appendix 3: Community Input

SIGNIFICANT HEALTH NEEDS

The graphic below depicts both how the compiled quantitative community level data and community input (focus group and community forum data) were analyzed to generate the list of significant health needs, as well as the prioritization process that allowed the selection of three significant health needs around which Petaluma Valley Hospital will build its FY18-FY20 Community Benefit/Implementation Report plan. Details of the selection and prioritization process are provided in the sections that follow and in Appendix 5.

	Generating List of Significant Health Needs	Prioritization Step 1	Prioritization Step 2	Prioritization Step 3	Prioritization Step 4
Who	**2 external raters**	**2 external raters**	**Community Benefit Lead and internal Work group**	**Community Benefit Lead**	**Community Benefit Committee**
What	A comprehensive review of data & community input	Apply the following criteria per significant health need	Apply the following criteria per significant health need	Review through two filters	Review List of issues and narrow to 1-3 priority areas for FY18-FY20 CB Plan/ Implementation Strategy Report
Criteria	All sources were analyzed for severity of the problem and level of community concern.	1. Seriousness of the problem 2. Scope of the problem – # of people affected 3. Scope of the problem –compared to other areas 4. Health disparities among population groups 5. Importance to the community 6. Potential to affect multiple health issues (root cause) 7. Implications for not proceeding	1. Sustainability of impact 2. Opportunities for coordination/ partnership 3. Focus on prevention 4. Existing efforts on the problem 5. Organizational competencies	1. Is it aligned with the Mission of St. Joseph Health? 2. Does it adhere to the Catholic Ethical and Religious Directives?	1. Is the health need relevant to the ministry? 2. Is there potential to make meaningful progress on the issue? 3. Is there a meaningful role for the ministry on this issue? 4. Where do we want to invest our time and resources over the next three years?
Scale	**Multiple**	**1-5 scale**	**1-5 scale**	**Yes or No**	**CB Committee Dialogue**

Selection Criteria and Process

Evaluators from The Olin Group performed a rigorous review of the publicly-available data and community input to identify 17 significant health needs for Santa Rosa Memorial Hospital.

The selection process began with the development of a general list of potential health needs, derived from a broad review of the indicator data, focus group findings, and literature around health concerns and social determinants of health. The goal of the selection process was to analyze the wide variety and large quantity of information obtained through the quantitative and qualitative processes in a consistent manner. Each source of input was considered as follows:

- Quantitative Data: Weighting was based on how the service area compared to California and county averages and how individual cities and zip codes compared to the service area averages. Note that for some health needs, data was not readily available.
- Resident Focus Groups: Focus Group transcripts and notes were reviewed and considered both at the individual focus group level and collectively across focus groups. The findings from the Roseland Community Building Initiative were also considered in this step. Weighting was related to how often and how extensively an issue was discussed by the participants.
- Stakeholder Focus Group: Weighting for the stakeholder group was based on how strongly the problem was discussed by the participants and the extent of agreement among the participants about the problem.
- Community Resident Forum: The Community Forum was designed to measure the importance of an issue to attendees. The forum ended with "dot voting" on significant health issues allowing all participants to have a voice in indicating which issues were most important to them. Issues that received more votes were considered to be more important to the community.

In developing the list of significant health needs, the quantitative data was given equal weight to the community input. After reviewing and rating all the available information, the list of potential health needs was ranked from greatest to lowest need for the ministry and the top 17 were recommended by The Olin Group for further consideration.

Before the final selection of significant health needs, two reviews took place. First, The Olin Group reviewed the list to determine if there were needs that were identified as priorities through the community process but not highlighted by the data, or for which no data was available. In some cases, a significant health need may have been added to the list due to this review. In the second review, the Community Benefit Lead examined the list, using his ministry-specific knowledge to determine if the significant health needs should be consolidated or added. Once the review was completed, the list was finalized for prioritization.

PRIORITY HEALTH NEEDS

Prioritization Process and Criteria

To rank order the list of significant health needs and ultimately select the three health needs to be addressed by Petaluma Valley Hospital, a four-step process was followed that incorporated the experience, expertise, and perspective of both internal and external stakeholders of the ministry. The criteria and rating scales can be found in Appendix 5.

Step 1: Using criteria that were developed in collaboration with the St. Joseph Health Community Partnerships Department and the Community Benefit Lead, The Olin Group Evaluation Team scored each health need on seven criteria.

- Seriousness of the Problem: The degree to which the problem leads to death, disability, and impairs one's quality of life
- Scope of the Problem 1: The number of people affected, as a percentage of the service area population
- Scope of the Problem 2: The difference between the percentage of people affected in the service area compared to regional and statewide percentages
- Health Disparities: The degree to which specific socioeconomic or demographic groups are affected by the problem, compared to the general population
- Importance to the Community: The extent to which participants in the community engagement process recognized and identified this as a problem
- Potential to Affect Multiple Health Issues: Whether or not this issue is a root cause, and the extent to which addressing it would affect multiple health issues
- Implications for Not Proceeding: The risks associated with exacerbation of the problem if it is not addressed at the earliest opportunity

Step 2: The Community Benefit Lead for Santa Rosa Memorial and Petaluma Valley Hospitals convened a working group of internal stakeholders to complete the second stage of prioritization. This working group applied 4 criteria to each need.

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

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

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

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

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

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

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

Rank-ordered significant health needs

The matrix below shows the 17 health needs identified through the selection process, and the prioritization scores through Step 3. The check marks indicate each source of input and whether this issue was identified as a need by that input process.

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

Definitions:

Mental Health: Covers all areas of emotional, behavioral, and social well-being for all ages. It includes issues of stress, depression, coping skills, as well as more serious health conditions such as mental illness.

Substance Abuse: Pertains to the misuse of all drugs, including alcohol, marijuana, methamphetamines, opiates, prescription medication, and other legal or illegal substances. It does not encompass cigarette smoking, which was considered separately and not identified as a significant health need.

Obesity: Primarily defined as the health condition in which individuals are sufficiently overweight as to have detrimental effects on their overall health. This does not include issues of exercise or food choices, which were considered as separate issues.

Heart Disease: Encompasses the prevention of heart disease as well as its incidence and treatment.

Oral Health: Includes knowledge of dental health and the availability of providers and dental insurance, as well as the cost of services.

Access to Resources: Includes most barriers to accessing health care services and other necessary resources, such as transportation, a shortage of providers, particularly specialists, language barriers, and resources being unavailable outside of working hours.

Housing Concerns: Includes affordability, availability, overcrowding, and quality of housing.

Diabetes: Specifically focused on the health condition of diabetes, and awareness and prevention of it.

Food and Nutrition: Concerns about healthy eating habits, nutrition knowledge, and challenges of cost and availability of healthy options.

Early Childhood Development: Includes early childhood education, the consequences of Adverse Childhood Experiences, and education around typical developmental milestones and intervention opportunities.

Insurance and Cost of Care: Refers to those without insurance and those who have insurance, but for whom costs of premiums, co-pays, prescriptions, and other needs are excessively burdensome. It also encompasses issues around the complexities of the system and its navigation.

Homelessness: Primarily focused on the condition of homelessness, including helping homeless individuals, prevention of homelessness, and mitigating its impact on communities.

Economic Insecurity: Identified as a root cause of other health issues, this issue covers the effects of poverty and economic challenges as well as difficulties around finding jobs that pay livable salaries.

Asthma: Includes the treatment of and management of asthma.

Cancer: Covers the prevention, early detection, and treatment of cancer.

Crime and Safety: Encompasses the incidence of crime and violence as well as the fear of it, which prevents people from feeling safe or enjoying their community.

Immigration Status: Individuals who are, or are connected to, undocumented immigrants feel afraid and stressed, which affects their health.

PRIORITY HEALTH NEEDS

Petaluma Valley Hospital will address the following priority areas as part of its FY18-FY20 CB Plan/Implementation Strategy Report:

Access to Resources was a major concern for the community focus groups, was raised at the stakeholder group, and received two votes at the community forum. Although the data shows that the ratio of population to health care providers (doctors, non-physician primary care providers, dentists, and mental health providers) is similar to or better than statewide ratios,

there is concern that the high cost and limited availability of housing, in particular, is making it difficult to recruit health care professionals to the area. This concern was projected to intensify as physicians retire. Participants also noted shortages of specialists that cause residents to travel out of the area for specialty care. Residents talked about long wait times for appointments and at the emergency room. It is also possible that the large geographic spread of the service area leads to situations where people in smaller towns such as Sonoma or Petaluma may have long distances to travel for some services. Access to Resources was ranked sixth after the first 3 steps of the prioritization process.

The SRMH and PVH Community Benefit Committee (CBC), recognizing that while many adults in Sonoma County are able to obtain insurance coverage and access regular healthcare in the wake of the implementation of the Affordable Care Act (ACA), disparities persist. Specifically, lower income residents have difficulty accessing care, as many remain uninsured due to high premium costs and those with public insurance face barriers to finding providers who accept MediCal. Foreign-born residents who are not U.S. citizens also face stark barriers in obtaining insurance coverage and accessing care. While only 10.0% of Sonoma County residents are uninsured, 18.7% of residents earning below 138% of the Federal Poverty Level and 34.2% of foreign-born residents who are not U.S. citizens do not have insurance coverage.5 Among those who do have insurance coverage, primary data identified other barriers to accessing care including that there are not enough primary healthcare providers in Sonoma County to meet the high demand. The CBC recognizes this as an ongoing, high-priority need, and one which, given the existing SRMH Community Benefit programs (mobile health and dental clinics, fixed-site dental clinic, and in-home care), we are uniquely qualified with appropriate capacity to address.

Mental Health/Substance Abuse were combined by the CBC in recognition of the fact that mental health and substance use disorders often go hand-in-hand and for many patients are co-occurring conditions. In fact, we prefer the term behavioral health to refer to these conditions collectively. In addition, the CBC noted that at the conclusion of Step 3 of the prioritization process, these were the first and second highest ranked concerns. Both concerns were raised throughout the community input process and received a high number of votes at the community forum. Data on mental health and substance abuse is difficult to obtain, but the California Health Interview Survey shows suicidal ideation rates among adults that are higher in Sonoma County (10.1%) and Mendocino County (11.7%), than across the state (7.8%). Youth suicidal ideation rates in Sonoma County (19.4%) are only slightly higher than the state rate (18.5%). Self-reported use of alcohol and drugs in the last month by youth is higher in Sonoma County (34.7%) and Mendocino County (38.3%) than across the state (27.8%). The differences are even higher among 11th graders: 45.6% in Sonoma County; 55.3% in Mendocino County; 38.3% in California. Although the data shows a better ratio of population to mental health providers in Sonoma and Mendocino Counties than the state, focus group participants spoke of

[5] US Census Bureau, American Community Survey, 2014.

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

Housing Concerns and Homelessness were combined by the CBC in recognition of the fact that the two issues, while identified separately in the data collection process, are inextricably linked and cannot be effectively addressed separately, and that while homelessness is the more visible problem, the stress of housing insecurity and the threat of homelessness are equally injurious to community and individual health.

At the conclusion of Step 3 of the prioritization process, these were ranked 7th and 12th. Housing was a major topic of discussion at all of the focus groups, with concerns raised about its high cost and the lack of availability of any housing, but especially housing that is affordable to people with lower incomes. The cost of housing was frequently cited as making it difficult to recruit professionals to the area. Well over half of renters pay 30% or more of household income on rent, and the rate is over 60% in some zip codes, including one Santa Rosa zip code, Rohnert Park, and Healdsburg. Residents also spoke about the poor conditions of some rental properties. The Roseland Community Building Initiative also identified housing as one of the five greatest community concerns. Although the resident focus groups did not discuss homelessness, it tied for the higher number of votes at the community forum. Stakeholders noted that homelessness has become more visible because construction in the areas the homeless used to frequent has pushed them into greater public view. The number of homeless children in Sonoma schools increased by 90% between 2011 and 2014. 2,835 homeless persons were found during the January 26, 2017 Sonoma County Homeless Count. 988 people were found in shelters or transitional housing. Almost two-thirds were living outside (1,847 people). 326 people were in families with children. They made up 11% of all people counted. 598 chronically homeless people were found. These are people with disabilities who have experienced homelessness for a year or more. The number of homeless veterans was 211. The number of homeless youth was 532. While these numbers reflect a declining trend in homelessness in Sonoma County over the past five years, the number is still very large: on any given night, 5.6 people out of every 1,000 residents is homeless, and many of them in much more visible locations than in previous years' counts.

For these reasons, the CBC believes it is imperative that we join in our community's efforts to combat these trends as we see this as the most prominent social determinant of health that we must address.

See Appendix 4: Prioritization protocol and criteria / worksheets

Significant Health Need and Assets Summary

Communities with Disproportionate Unmet Health Needs (DUHN) are communities defined by zip codes where there is a higher prevalence or severity for a particular health concern than the general population within the Petaluma Valley Hospital 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 significant health needs and community resources/assets.

Significant Health Need	Target Population	Geographic Area (City, Zip Code, County)	Community Resources (Name of Organization(s)
• Access to health care • Access to affordable prescription drugs • Information about health insurance • Oral health care for children and low income adults • Food security and access to healthy food • Childhood obesity prevention and awareness programs • Secure neighborhoods and access to safe recreation activities	Low income families	Throughout entire TSA	• Community Action Partnership of Sonoma County • Petaluma People Services Center • La Luz • West County Community Services • Santa Rosa Community Health Centers • Petaluma Health Center • West County Health Centers • Northern California Center for Well Being
• Information about health insurance access • Access to culturally and linguistically sensitive	Latino community	Throughout entire TSA	• SJH – Mobile Health Clinic • SJH – Neighborhood Care Staff • SJH – Agents of Change • Promotores de Salud

Significant Health Need	Target Population	Geographic Area (City, Zip Code, County)	Community Resources (Name of Organization(s)
health services, e.g., patient centered medical home • Substance use prevention • Gang prevention measures • Family violence prevention • Informational immigration forums • Nutrition education about healthy eating and foods • Access to healthy food			• DAAC (Drug Abuse Alternative Center): substance use resources • Local law enforcement agencies
• Health education and awareness • Injury prevention education • Obesity prevention education and programs, including nutrition education, and access to healthy foods • Fitness training • Sports Teams and Resources • Substance Use prevention • Civic engagement opportunities • Organized youth activities • Gang prevention measures • Higher education mentorship programs • Student retention • STD education and awareness • After school programs • Libraries	Children and Youth	Throughout entire TSA	• Free or Low Cost Children's Health Insurance • Healthy for Life • SJH- Clinic and Mobile Clinic • SJH – Mighty Mouth Dental Health Education Program • SJH – Circle of Sisters • Schools ESL classes for parents • After school programs for youth • DAAC (Drug Abuse Alternative Center): substance use resources • Local sports clubs recreation opportunities for youth • City Parks & Recreation Depts. • City libraries • Head Start

Significant Health Need	Target Population	Geographic Area (City, Zip Code, County)	Community Resources (Name of Organization(s)
• Access to health services • Health screenings • Balance training to prevent falls • Obesity prevention: access to healthy foods and fitness training • Transportation • Affordable housing • Informational forums • Home care • Senior center resources • Food security • Recreational activities	Seniors	Throughout entire TSA	• SJH – House Calls • SJH –Home Sweet Home – home care visits • SJH – Neighborhood Care Staff • Community Health Centers • Senior Centers • Council on Aging • Petaluma People Services • Jewish Family and Children's Services • Episcopal Senior Communities: Senior Resources at Home • Senior Advocacy Services • County of Sonoma Human Services: Adult and Aging Division
• Information about health insurance • Assistance accessing Immigration resources • Processes that facilitate access to medical care • Wider outreach & access to healthy food through more food pantries • Affordable housing for single	Undocumented immigrants who do not speak English	Throughout entire TSA	• SJH – Mobile Health Clinic • Promotores de Salud • Redwood Empire Food Bank Food • Latino Servive Providers • La Luz • Redwood Empire Food Bank • Community agencies • Employment, education, and family support programs • Housing assistance addressing needs of undocumented and low income residents

Existing Health Care Facilities in the Community

See Appendix 5: Existing Health care Facilities in the Community

EVALUATION OF IMPACT ON FY15-FY17 CB PLAN/IMPLEMENTATION STRATEGY REPORT: FY16 ACCOMPLISHMENTS

Planning for the Uninsured and Underinsured
Patient Financial Assistance Program

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why we have a **Patient Financial Assistance Program**[6] that provides free or discounted services to eligible patients.

One way Santa Rosa Memorial Hospital informs the public of the Patient Financial Assistance Program is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. In FY16, Petaluma Valley Hospital ministry provided $900,019 free (charity care) and discounted care and 864 encounters.

For information on our Financial Assistance Program click here.

Medicaid (Medi-Cal) and Other Local Means-Tested Government Programs

Petaluma Valley Hospital provided access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California, and other local means-tested government programs. In FY16, Petaluma Valley Hospital ministry provided $7,730,200 in Medicaid (Medi-Cal) shortfall.

[6] *Information about* Santa Rosa Memorial Hospital's *Financial Assistance Program is available at* *http://www.stjosephhealth.org/documents/Sonoma_FABrochure_2016.pdf*

Addressing the Needs of the Community: FY15 –17 Key Community Benefit Plan
FY16 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

Outcome Measure	Baseline (FY15)	FY16 Target	FY16 Result
Percent of patients served who are of the remaining uninsured population[7]	85% of patients served by *Mobile Medical Clinic* in FY14 were of the remaining uninsured population	90% or more of the patient population should be of the remaining uninsured population	90% of the patient population were of the remaining uninsured population

Strategy(ies)	Strategy Measure	Baseline	FY16 Target	FY16 Result
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*: 139 Referrals *Mommy and Me*: 53 warm handoffs, 26 confirmed to be seen	10% increase over baseline	*Mobile Medical Clinic* made 441 referrals to community health centers, specialists, other services / programs, an increase of 217% over baseline. Dental program *Mommy and Me* made 101 warm handoffs to Santa Rosa Community Health Centers for pregnant woman; of those 48 were

[7] 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.

				confirmed to be seen. These represent increases of 91% and 85%, respectively, over baseline.
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	Dental Clinics: 317 uninsured patients *Mobile Medical Clinic* : 2 new sites	Provide treatment to 400 uninsured patients in Dental Clinics; Add 2 new sites for *Mobile Medical Clinic* to visit.	The dental programs provided treatment to 543 uninsured patients. 5 new sites added for the *Mobile Medical Clinic*
Serve patients in their communities and provide medical care to the underserved	Number of patients and encounters in the *Mobile Medical Clinic*	971 patients, 2,519 encounters: *Mobile Medical Clinic*	10% increase in number of patients and encounters	838 patients served by the *Mobile Medical Clinic* over 2,372 encounters, decreases of 14% and 6%, respectively, from baseline.

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.

FY16 Accomplishments:

Our *Mobile Medical 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 FY16 in the SRMH service area, the clinic saw 834 patients over 2,367 encounters at numerous locations, including the addition of 5 new sites. After conducting a survey of vulnerable populations in Sonoma County and consulting *A Portrait of Sonoma County*, the clinic identified Guerneville, Roseland, and Cloverdale as communities in need. The clinic, through our partnership with Burbank Housing, maintains a twice-monthly site at their Paulin Creek apartments and in conjunction with The Redwood Empire Food Bank, conducts monthly screenings at the REFB's facility. After a devastating fire heavily damaged the West County Health Center's Russian River clinic in December, 2015, the *Mobile Medical Clinic* provided interim facilities to continue the much-needed healthcare services in that area. For two weeks, the Russian River clinic provided care to their regular customers while the *Mobile Medical Clinic*, utilizing the Mobile Dental Clinic's van, continued to provide care to Sonoma County's most vulnerable patients. All sites from St. Rose in Santa Rosa, Windsor Presbyterian Church in Windsor, The Filipino Center in Fulton and Sonoma Springs Village in Sonoma were visited by *Mobile Medical Clinic* and our patients received uninterrupted care.

FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY16 Accomplishments (Continued)

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.

Outcome Measure	Baseline (FY15)	FY16 Target	FY16 Result
Percent of participants who report improvement in behavioral changes related to healthier eating and increased physical activity	80% of *Your Heart, Your Life* participants and 44% of *Healthy for Life* participants demonstrated improved knowledge of healthy living principles	10% positive behavior change	86% of *Your Heart, Your Life* participants and 40% of *Healthy for Life* participants demonstrated improved knowledge of healthy living principles

Strategy(ies)	Strategy Measure	Baseline	FY16 Target	FY16 Result
Provide evidence-based education and programming that promotes healthy eating and active living	Number of persons served in the *Healthy for Life, Promotores de Salud,* and *Your Heart, Your Life* programs	*Healthy for Life* : 1,053 persons, 11,712 encounters *Promotores de Salud* : 1,404 persons, 3,925 encounters *Your Heart, Your Life* : 85 persons	10% increase over baseline	2,178 persons served by *Healthy for Life* over 19,570 encounters, increases of 107% and 67%, respectively, over baseline. 506 persons served by the *Promotores de Salud* over 2,090 encounters, decreases of 64% and 47%, respectively, over baseline. 74 persons served by the *Your Heart, Your Life* program, a decrease of 13% over baseline.
Improve data collection processes and methodologies to better track impacts of healthy eating active living programs	Restructure *Healthy for Life* survey collection system for K-2 parent-responder surveys	36% -50% return rate of parent-responder surveys	10% increase over baseline	Two Rock Elementary school increased its return rate from 36% to 71% (an increase of 97%). Sonoma Charter increased its return rate from 50% to 82% (an increase of 64%).

Expand *Healthy for Life* program in partnership with collaborative agencies and supporters	New partnerships formed and new sites added	3 new sites	3 new sites	Old Adobe Union School District in Petaluma added one new site (Old Adobe); Jefferson Elementary (Cloverdale) & Cesar Chavez Elementary (Santa Rosa) joined as self-funded "lite" H4L sites.
Demonstrate improved knowledge of healthy living principles *in Your Heart, Your Life* and *Circle of Sisters* programs	Percent of *Circle of Sisters* participants reporting increased self-esteem and improved health habits	58% of *Circle of Sisters* participants reported increased self-esteem and improved health habits	10% increase over baseline	44% of *Circle of Sisters* participants reported increased self-esteem and improved health habits

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.

FY16 Accomplishments:

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. During the past two years, 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. The parent group, with support from our staff, has organized regular 5-days-a-week donation-only 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. The community leadership capacity that has been built through our work engaging residents in Roseland has been an active voice on behalf of the community's interests in establishing a new playground and additional water stations for families and pets in the trail, playground, and community center areas. In addition, these new community advocates testified before the County Board of Supervisors in support of a proposed tax initiative to fund additional parks and recreational resources in their community.

In FY16 in the SRMH service area, 543 persons were served by the *Promotores de Salud* over 1,732 encounters, despite a staff reduction from FY15 of 50% to 1.5 FTEs. 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. 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 1,204 persons were served in over 11,527 encounters throughout the SRMH service area. Two new sites were added, one in Cloverdale 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.* Recertification of *Healthy for Life* as a Tier 3 program with the Sonoma Upstream Investments Initiative was achieved.

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 result in residents identifying issues of concern and need for them in their neighborhoods and developing strategies for creating and advocating for solutions. Often these efforts are in line with the efforts of the *Promotores de Salud* program, as in the example cited above in the Roseland neighborhood. Similarly, in Cloverdale the *Neighborhood Care Staff* organized a group of residents that led to the addition of Cloverdale sites in the health promotion programs. The Cloverdale group also began to form a Sonoma County Health Action chapter, one of 9 such groups throughout the county. Additionally, in Guerneville the *Neighborhood Care Staff* worked extensively with local government and community organizations to develop responses to a growing homelessness problem in the area, as well as direct involvement in their Health Action chapter, the Russian River Area Resources and Advocates.

FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY16 Accomplishments (Continued)

Initiative 3 (community need being addressed): Access to Mental Health and Substance Use Services
Goal (anticipated impact): Improve coordination of behavioral health and substance use disorder care for high-risk populations in the SJH-SC Service area.

Outcome Measure	Baseline (FY15)	FY16 Target	FY16 Result
Percentage of client population receiving mental health screening	17% of *Mobile Medical Clinic* patients screened for depression principles	Sustain screening rates at or above at least 70% of patients in the *Mobile Medical Clinic*	90% of *Mobile Medical Clinic* patients were screened for depression; of those who were screened, 17% tested positive for depression and were referred to other medical/social service providers.
Successful continuation of pilot program serving homeless population	Project Nightingale serves patients of high- and low-level of acuity in 13-bed facility	Increase capacity through doubling of beds	$205,000 grant to partner Catholic Charities enabled the targeted expansion and doubling of capacity

Strategy(ies)	Strategy Measure	Baseline	FY16 Target	FY16 Result
Improve awareness and understanding of behavioral health and substance use issues faced by our client population through regular screening	Percentage of client population receiving mental health screening	17% of *Mobile Medical Clinic* patients screened for depression principles	Sustain screening rates at or above at least 70% of patients in the *Mobile Medical Clinic*	90% of *Mobile Medical Clinic* patients were screened for depression; of those who were screened, 17% tested positive for depression and were referred to other medical/social service providers.
Partner with community based organizations	Successful community partnership resulting	Project Nightingale serves patients of	Increase capacity through doubling of	Expansion to 26-bed facility through the opening of annex

working to address mental health and substance use needs among vulnerable populations	in services to vulnerable populations	high- and low-level of acuity in 13 bed facility	beds	for low-acuity 13-bed facility and dedication of all original 13 beds to high-acuity patients

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.

FY16 Accomplishments*:*

As part of our effort to better understand the scale of the needs related to mental and behavioral health, the *Mobile Medical Clinic* routinely screens for depression or mental illness using a validated tool known as the Patient Health Questionnaire (PHQ-9 & PHQ-2). We have improved screening rates from 60% to over 90% each month and are providing regular feedback on screening performance to our provider team. *Circle of Sisters* has also been working to help address mental and behavioral health issues that present in the program. This year, the program increased attention to the mixed and hidden messages girls receive from the many forms of media they face every day. By deconstructing these messages through guided discussions, the girls how to preserve their self-esteem despite the presence of negative influences. In FY16, in the SRMH service area, *Circle of Sisters* served 194 young women in 5,554 encounters.

In partnership with a countywide collaborative led by Catholic Charities of the Diocese of Santa Rosa, our Community Benefit Committee of the Board granted $250,000 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, accommodate a higher level of acuity and the expansion added wraparound case management services.

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 FY16, 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.

FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY16 Accomplishments (Continued)

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.

Outcome Measure	Baseline (FY15)	FY16 Target	FY16 Result
Number of seniors receiving advance health care planning education	Reached 80 clients and partnered with several key community organizations regarding the importance of advance care planning	100 clients reached and 20% completed AHCDs	Reached 174 clients; 59 completed AHCDs (34%)
Number of frail elderly patients served	118 unduplicated patients served and completed over 5,760 encounters	10% increase over baseline	142 unduplicated patients served during the course of 6,674 encounters.

Strategy(ies)	Strategy Measure	Baseline	FY16 Target	FY16 Result
Through the *House Calls* program, serve the frail elderly in their homes with medical care and case management	Number of clients served in the *House Calls* program	118 unduplicated patients served and completed over 5,760 encounters	10% increase over baseline	142 unduplicated patients served during the course of 6,674 encounters, increases of 22% and 16%, respectively, over baseline.
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 health care planning education	Provided advanced health care education to 80 individuals	100 clients reached and 20% completed AHCDs	Reached 174 clients; 59 completed AHCDs (34%)

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.

FY16 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 135 unduplicated patients and completed over 6,340 service encounters countywide, helping to prevent unnecessary emergency department visits and to more effectively manage chronic disease.

FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY16 Accomplishments (Continued)

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.

Outcome Measure	Baseline (FY14)	FY16 Target	FY16 Result
Continue to serve as an access clinic, bringing new patients into care and completing treatment plans.	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)	Sustain 20% new patient rate and complete treatment on 40% of patients	Dental programs treated 9847 patients with a decay rate of 24% (n=2342) Completed treatment on 53% (n=1240) 22% of patients were new (n=2201)

Strategy(ies)	Strategy Measure	Baseline	FY16 Target	FY16 Result
Serve patients in the fixed site dental clinic	Number of patients served	3,748 patients served and completed over 8,058 encounters	10% increase over baseline	5,729 patients served and completed 8,535 encounters, increases of 53% and 6%, respectively, over baseline.
Serve patients in the *Mobile Dental Clinic* and *Mighty Mouth* school-based program	Number of patients served	4,697 patients served; 9,724 encounters	10% increase over baseline	*Mobile Dental Clinic* and *Mighty Mouth:* 5,729 patients served and completed 11,702

				encounters including 5,578 education only visits, increases of 22% and 20%, respectively, over baseline.
Educate pregnant women and intervene early to encourage prevention-oriented behaviors	Number of pregnant women educated	124 Pregnant women were educated; 91 returned for treatment at dental clinic *Mommy and Me* program participants demonstrated a 1% decay rate among one-year-olds, compared to compared to non-participating children in the same age group with 15% decay rate Returning 2-5 year-olds in *Mommy and Me* program demonstrated a 15% decay rate compared to non-participating children in the same age group with 35% decay rate	10% increase over baseline	101 Pregnant women were provided education, a decrease of 19% from baseline. *Mommy and Me* program participants demonstrated a 1% decay rate among one-year-olds, compared to compared to non-participating children in the same age group with a 5% decay rate Returning 2-5 year-olds in *Mommy and Me* program demonstrated a 13% decay rate compared to non-participating children in the same age group with 22% decay rate

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.

FY16 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 FY16, 5,729 patients were served over 8,535 encounters at the *SJH Dental Clinic*. Our *Mobile Dental Clinic* and *Mighty Mouth* school-based prevention program saw 5,729 patients and completed over 11,702 encounters countywide. FY16, there was a 1% decay rate among one-year-olds, compared to 5% decay rate among patients in the clinic who did not participate in the program. We saw a 13% decay rate among returning 2-5 year-olds in *Mommy and Me* program, compared to non-participating children in the same age group with 22% decay rate.

FY16 Other Community Benefit Program Accomplishments

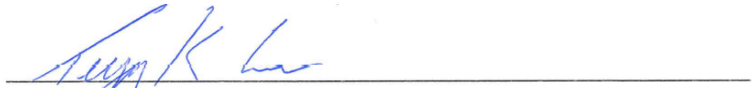
Initiative (community need being addressed):	Community Benefit Category	Program	Description	FY16 Accomplishments
Mental Health/Substance Use	Cash and In-Kind Contributions	Community Grant Making Program	Increase level of services provided to community by partner organizations	Awarded 7 separate grants to community partners totaling $85,000
Healthy Aging	Cash and In-Kind Contributions			Awarded 2 separate grants to community partners totaling $25,000
Healthy Eating and Physical Fitness	Cash and In-Kind Contributions			Awarded 4 separate grants to community partners totaling $90,000
Access to Care	Cash and In-Kind Contributions			Awarded one grant to community partner totaling $10,000
Education	Cash and In-Kind Contributions			Awarded 2 separate grants to community partners totaling $37,500

FY16 Other Community Benefit Program Accomplishments

Initiative (community need being addressed):	Program	Description (insert Target for)	FY16 Accomplishments
Mental Health/Substance Use	Community Grant Making Program	Increase level of services provided to community by partner organizations	Awarded 7 separate grants to community partners totaling $85,000
Healthy Aging			Awarded 2 separate grants to community partners totaling $25,000
Healthy Eating and Physical Fitness			Awarded 4 separate grants to community partners totaling $90,000
Access to Care			Awarded one grant to community partner totaling $10,000
Education			Awarded 2 separate grants to community partners totaling $37,500

GOVERNANCE APPROVAL

This FY17 Community Health Needs Assessment Report was approved at the June 27, 2017 meeting of the Santa Rosa Memorial Hospital and Petaluma Valley Hospital Community Benefit Committee a sub-Committee of the Board of Trustees.



Community Benefit Committee Chair's Signature confirming approval of Petaluma Valley Hospital FY17 Community Health Needs Assessment Report

6-27-2017

Date

See Appendix 6: Ministry Community Benefit Committee

Appendix 1: Community Needs Index data

Community Need Index (CNI) Scores
St. Joseph Health-Sonoma County Total Service Area (HTSA)

ZIP Code[1]	Service Area	CNI Score[2]	Population	City	County
95468	HTSA	4.6	1,182	Point Arena	Mendocino
95407	HTSA	4.2	41,541	Santa Rosa	Sonoma
95482	HTSA	4.2	31,880	Ukiah	Mendocino
95449	HTSA	4.2	1,707	Hopland	Mendocino
95403	HTSA	3.8	47,237	Santa Rosa	Sonoma
95401	HTSA	3.8	37,658	Santa Rosa	Sonoma
95448	HTSA	3.8	17,465	Healdsburg	Sonoma
95439	HTSA	3.6	735	Fulton	Sonoma
95476	HTSA	3.6	36,167	Sonoma	Sonoma
94931	HTSA	3.6	9,149	Cotati	Sonoma
95404	HTSA	3.4	42,439	Santa Rosa	Sonoma
94928	HTSA	3.4	43,786	Rohnert Park	Sonoma
95441	HTSA	3.4	1,915	Geyserville	Sonoma
95462	HTSA	3.4	1,456	Monte Rio	Sonoma
94940	HTSA	3.4	142	Marshall	Marin
95492	HTSA	3.2	29,026	Windsor	Sonoma
95436	HTSA	3.2	5,364	Forestville	Sonoma
95446	HTSA	3.2	5,445	Guerneville	Sonoma
95442	HTSA	3.2	3,916	Glen Ellen	Sonoma
95409	HTSA	3.0	27,894	Santa Rosa	Sonoma
95472	HTSA	3.0	28,219	Sebastopol	Sonoma
95425	HTSA	3.0	11,785	Cloverdale	Sonoma
95445	HTSA	3.0	2,304	Gualala	Mendocino
95412	HTSA	3.0	369	Annapolis	Sonoma
95405	HTSA	2.8	21,581	Santa Rosa	Sonoma
95444	HTSA	2.8	701	Graton	Sonoma
94954	HTSA	2.8	39,591	Petaluma	Sonoma
94952	HTSA	2.8	33,839	Petaluma	Sonoma
94951	HTSA	2.8	4,057	Penngrove	Sonoma
95421	HTSA	2.8	1,969	Cazadero	Sonoma
94922	HTSA	2.6	79	Bodega	Sonoma
94937	HTSA	2.6	1,094	Inverness	Marin
94923	HTSA	2.4	1,191	Bodega Bay	Sonoma
95465	HTSA	2.4	2,255	Occidental	Sonoma
95450	HTSA	2.4	349	Jenner	Sonoma
94971	HTSA	2.4	217	Tomales	Marin
95452	HTSA	2.2	1,282	Kenwood	Sonoma
94929	HTSA	2.2	308	Dillon Beach	Marin
94972	HTSA	2.2	84	Valley Ford	Sonoma
95402	HTSA	PO Box	N/A	Santa Rosa	Sonoma
95406	HTSA	PO Box	N/A	Santa Rosa	Sonoma
94927	HTSA	PO Box	N/A	Rohnert Park	Sonoma
95473	HTSA	PO Box	N/A	Sebastopol	Sonoma

94975	HTSA	PO Box	N/A	Petaluma	Sonoma
94953	HTSA	PO Box	N/A	Petaluma	Sonoma
94955	HTSA	PO Box	N/A	Petaluma	Sonoma
95497	HTSA	Data Not Available	N/A	The Sea Ranch	Sonoma
95480	HTSA	Data Not Available	N/A	Stewarts Point	Sonoma

1. CNI scores are not calculated for non-populated ZIP codes, including such areas as PO boxes, national parks, public spaces, state prisons, and large unoccupied buildings.
2. CNI scores are sorted from highest to lowest. A CNI score of 1 represents the lowest need nationally, while a score of 5 indicates the highest need nationally.
Source: Dignity Health Community Need Index (cni.chw-interactive.org), 2015; Accessed March 2016.

Appendix 2: Secondary Data /Publicly available data

For information about CHNA FY17 Secondary Data click below

Appendix 2A: Secondary Data/Publicly Available Data
https://www.stjoesonoma.org/community-outreach/community-benefit-reports/

Appendix 2B: Secondary Data/Publicly Available Data Appendix
https://www.stjoesonoma.org/documents/Appendix-2B.pdf

Appendix 3: Community Input

Appendix 3a: Focus Group and Community Forum Participants

Residents who participated in focus groups and community forums completed an anonymous survey to allow reporting on demographics of the participants. In the table below, the number and percentages are shown for the focus groups, community forums, and then for all participants in both the focus groups and community forums. Percentages were calculated using the number of respondents for each question, which may be less than the total number of respondents because people could choose to leave a question unanswered.

Santa Rosa Memorial and Petaluma Valley Hospitals	Resident Focus Groups	Community Forum Participants	ALL Community Members	Resident Focus Groups	Community Forum Participants	ALL Community Members
Number of Respondents	22	12	34	22	12	34
Gender						
Female	19	10	29	86%	83%	85%
Male	3	2	5	14%	17%	15%
Race/Ethnicity*						
Hispanic/Latino	17	2	19	77%	18%	58%
Non-Latino White	5	8	13	23%	73%	39%
Black/African American	0	1	1	0%	9%	3%
Chronic Conditions						
Person with chronic conditions or a leader or representative of individuals with chronic conditions	1	2	3	6%	18%	11%
Age						
0-17 years	0	0	0	0%	0%	0%
18-44 years	12	5	17	57%	42%	52%
45-64 years	5	6	11	24%	50%	33%
65-74 years	3	1	4	14%	8%	12%
75 years or older	1	0	1	5%	0%	3%
Total Household Income before Taxes						
Less than $20,000	5	1	6	33%	10%	24%
$20,000 to $34,999	5	0	5	33%	0%	20%
$35,000 to $49,999	3	1	4	20%	10%	16%
$50,000 to $74,999	1	3	4	7%	30%	16%
$75,000 to $99,999	0	3	3	0%	30%	12%
$100,000 or more	1	2	3	7%	20%	12%
Decline to answer	4	1	5	Decline to Answer responses were not included in the calculation of percentages		
Number of People in Household						
Average	3.7	2.4	3.2	NA	NA	NA
Median	4	2	4	NA	NA	NA
Range	1-5	1-4	1-5	NA	NA	NA

*The percentages for race/ethnicity may add up to more than 100% because people could select more than one race/ethnicity.

Appendix 3b. List of Stakeholder Focus Group Participants and Organizations

The Nonprofit/Government Stakeholder Focus Group was held on **March 24, 2017 in Santa Rosa**. The list of participants is presented in the table below, along with information about their organizations and the population they serve.

Name	Title	Organization	Public Health Dept.	The population served by the organization includes people who have or represent:			
				Chronic Condition	Diverse Community	Medically Underserved	Low Income
Erika Klohe	Family Service Coordination, Team Leander	Buckelew Programs		✓	✓	✓	✓
Larry Florin	Executive Director	Burbank Housing			✓		✓
Arcelia Moreno	Community Services Coordinator	Burbank Housing			✓		✓
Susan Cooper	Deputy Director	Community Action Partnership of Sonoma		✓	✓	✓	✓
Karin Demarest	VP Programs	Community Foundation Sonoma County			✓		✓
Mike Kennedy	Director of Mental Health	County of Sonoma	✓	✓	✓	✓	✓
Ellen Bauer		Department of Health Services Public Health Division	✓	✓	✓	✓	✓
Tracy Greenwald-Brown	Director Maternal Child Adolescent Health Services	Family Health Section, Public Health Division, Sonoma County Department of Health Services	✓	✓	✓	✓	✓
Angie Dillon-Shore	Executive Director	First 5 Sonoma County			✓	✓	✓
Patrice Mascolo		Healthy Mendocino			✓	✓	✓
Anne Molgaard		Mendocino County Department of Health & Human Services	✓	✓	✓	✓	✓
John Savage	Program Manager	MidPen Housing			✓		✓
Leslie Choate	Program Manager	SoCo Environmental Health			✓		✓
Melanie Dodson	Executive Director	Sonoma County Community Child Care Council		✓	✓	✓	✓
Jim Leddy	Special Projects Director	Sonoma County Community Development Commission		✓	✓		✓
Tim Ricard	Business Retention Manager	Sonoma County Economic Development Board			✓		
Misti Harris	Community Relations	Sonoma County Sheriff's Office		✓	✓		✓

Appendix 3c. Focus Group and Community Forum Report

Community Focus Groups

Santa Rosa Memorial Hospital, in collaboration with Petaluma Valley Hospital, held two Community Resident Focus Groups, one in Sonoma in Spanish, and one in Petaluma in English. In total, 27 individuals participated in the Community Resident Focus Groups.

Location	Date and Time	Language	Attendees
Sonoma	3/16/17, 9:00 AM	Spanish	20
Petaluma	3/23/17, 6:00 PM	English	7

The Community Resident Focus Group attendees were 86% female and 14% male. 77% of attendees identified as Hispanic/Latino and 23% identified as non-Latino White. The Petaluma group was largely comprised of individuals over the age of 60. Of those participants who responded, 66% said they earned less than $35,000 annually. More detailed demographic information is listed in Appendix 3a.

Resident participants were engaged and appreciated the opportunity to share their thoughts, as well as learn from others in the room. Attendees seemed to understand the purpose of the sessions, with most open to sharing their experiences and networking with one another to learn about available programs and services.

Identified Health Challenges

Both focus groups discussed challenges in the community with **Housing**. They were concerned about the high cost of housing and lack of access to low-income housing. There also were concerns about negligent landlords who do not repair leaking roofs and allow mold to develop, or who raise rents and give notices to vacate with little notice. The high cost of housing was cited as a contributor to the challenges of recruiting health care professionals to the area.

Access to Resources was a concern at both focus groups, where shortages of medical providers, long wait times for appointments and at the emergency room, and quality of care were top issues. Participants in Petaluma noted that 60% of the population is insured by Kaiser, but Kaiser does not have a hospital in the area; emergency care is available only at Petaluma Valley Hospital. As more physicians retire, residents anticipate more shortages of physicians because the high cost of living makes it difficult to recruit physicians. The shortage of specialists causes people to travel out of the area for specialty care.

Economic Issues emerged in the focus group discussions in terms of the high costs of housing, health care, and food.

The lack of **Dental** coverage and cost of care was discussed extensively in the Sonoma focus group and was considered a major challenge to staying healthy in the community.

The challenges faced by the **Undocumented Immigrant Community** were discussed at both focus groups. They noted that undocumented immigrants do not have insurance. They wait until their health concern is very serious before seeking help because of the cost of care and fear of being reported. They also noted that undocumented immigrants are afraid to report substandard housing conditions because they fear being evicted. At the Sonoma focus group, some participants said they felt that clinic and hospital staff discriminated against them because of their race.

While the Affordable Care Act has reduced the number of uninsured individuals, it has not eliminated all problems around **Insurance and Cost of Care**. People who do not have insurance, such as undocumented immigrants, cannot afford health care. The cost of prescription drugs and high prices charged by private physicians were raised as specific concerns.

Participants at both focus groups noted the prevalence of **Obesity** among children, especially Latino children. They attributed this, in part, to parents and grandparents who do not want to or do not have the time to cook, and schools not providing healthy lunches.

Diabetes was recognized as a problem affecting people of all ages, from infants to adults.

While there are opportunities for healthy eating in the area, **Food and Nutrition** was also a concern at the focus groups. In Sonoma, participants said they had to leave town to find affordable food in nearby towns such as Santa Rosa, Rohnert Park, and Petaluma. In Petaluma they talked about the easy access to fast food restaurants and regulations to limit any new fast food franchises in the town.

Mental Health was raised as an issue at both focus groups. There were specific concerns about a lack of mental health providers, especially those trained to serve the elderly. Petaluma does not have a place for psychiatric holds on the weekend. In Sonoma, participants noted the stress in the immigrant community associated with fears of deportation and disruption of their families.

Substance Abuse was discussed in Petaluma, where participants expressed concerns about the high rate of alcohol use among teenagers and over-prescription of opioids, including to the elderly. They noted that the teen curfew is not enforced and teens who are drunk on the streets are given a card and told to turn themselves in next morning (this was followed by laughter).

Public Safety was discussed in terms of domestic violence, bullying, aggressive drivers, distracted drivers, and people driving under the influence. Budget cuts have reduced the visibility of police in the community.

In addition to the issues described above, the following topics were mentioned, but not discussed in depth at the focus groups: asthma, allergies, heart disease, cancer, and diabetes.

Community Assets and Advantages

In addition to asking about issues facing the community, the facilitators explored what helps people stay healthy in the community. Participants at both focus groups had a number of positive things to say about their community. They spoke about the availability of parks, even in low-income areas, and paths for walking and how being active helped them stay healthy. With the nearby farmland, there is an

abundance of fresh produce at the markets and restaurants. There are community services to support families and seniors, such as the Family Resource Center (El Verano), the Food Bank, Meals on Wheels, Senior Café, the library, gyms, community gardens, and police stations.

They talked about the importance of being connected to their neighbors and having a sense of community. Churches provide places for people to engage with their community and care for each other. Volunteering is another avenue that provides a sense of purpose and builds connections within the community.

Stakeholder Focus Group

The Stakeholder Focus Group was held on March 24, 2017 in Santa Rosa at the Community Child Care Council of Sonoma County. There were 17 participants representing community and government organizations (a complete list of participants is available in Appendix 3b). Many of the participants knew one another prior to participation in the focus group. There was valuable networking that took place among participants.

Identified Health Challenges

The stakeholders were savvy about the various health concerns in the community. They were primarily focused on the root causes of health conditions, such as homelessness and socioeconomic issues. They were not just concerned with the individual health issues, but also the compounding effect of one or more of these diseases for individuals.

Homelessness – Participants pointed out the lack of data on homelessness. They noted that homelessness is most visible in certain zip codes in Sonoma County. Construction in areas where the homeless used to hide (along the railroad and downtown) has pushed them into more visible areas. The homeless count has been trending down as the economy has improved. There was a sense that homelessness is going up in Mendocino County, even if you don't count the seasonal workers, such as the trimmigrants who work in the marijuana industry.

There were many concerns about **Housing** in Sonoma and Mendocino Counties. People are living in substandard housing conditions. There are long wait lists for affordable housing. Average wages compared to home prices are well outside state and national ratios. There is very little housing stock – for example, there are no houses to buy in Mendocino, even if you have money. People come to the area and buy up houses as vacation rentals or second homes. The owners don't live here and aren't part of the community.

Childcare and Early Education can be an issue for a broad section of the population. With the high cost of living, some people do not meet income eligibility requirements for subsidized childcare because their incomes are too high to qualify for subsidized childcare or preschool but they cannot afford it on their own. In addition, it is difficult to recruit childcare providers to the area given the high cost of living – one person noted the Head Start program had 12 openings.

Diabetes and Obesity are prevalent issues, due to a lack of affordable, quality, nutritious food. Some poorer neighborhoods are "food deserts," where it is not possible to purchase nutritious food.

Much of the focus group discussion was about **Mental Health.** Participants connected it to homelessness, poverty, and Adverse Childhood Experiences (ACEs). One person pointed out that the county has higher rates of ACEs than California and they are at the root of many other issues, such as obesity, mental health, and depression. Perinatal mental health and its effect on the next generation is another big concern. Seniors with dementia and co-occurring mental illness are not getting the services they need. There is a big gap in services for people with moderate to severe mental health problems. It can be a challenge to get consistent, quality mental health care. There is a lack of psychiatric beds, long-term care programs, and housing. In Mendocino County, there is nowhere for people to get help. Participants also expressed concern about the potential loss of coverage if ACA goes away or MediCal services are cut.

Substance Abuse was discussed as co-occurring with mental health. There are high rates of opioid use in the area and babies born with neonatal abstinence syndrome. There are not enough places to help people recover from substance abuse, such as intensive residential treatment facilities and sober living environments.

Oral Health issues were raised and one participant noted that half the kindergartners start school with cavities or other dental disease experience. Dental treatment interrupts both the child's learning and a parent's workday, which can be a particular concern for those without flexible schedules.

Immigration Status was acknowledged as a cause of fear of deportation and families being separated. These fears have led families to dis-enroll from CalFresh, MediCal, and WIC. As a result, families have to choose between buying food and paying rent, which leads to housing instability.

One participant noted that health care workers in the hospitals are overwhelmed now that more people have health insurance, which complicates problems around **Access to Resources**. There have been challenges attracting doctors, nurses, and other professionals (including teachers) due to the high cost of living and housing.

Economic Insecurity was recognized both as an issue and for being under-reported. There are places where very poor people live next to very wealthy people, but they are hidden by averages. It is especially difficult for poor children in these areas who can see the difference between themselves and their wealthy neighbors. There also are low income people in isolated communities who may lack transportation and cannot get to the health services they need for themselves and their children, complicating access issues.

Domestic Violence was discussed as a **Safety** issue and a cause of homelessness and childhood trauma. Domestic Violence is often exacerbated by substance abuse and is widely under-reported.

The participants recognized that nonprofit and county leadership does not reflect the racial/ethnic makeup of the people they serve. This can make it difficult for these decision makers to truly understand the needs of the community. They also talked about how policy making does not proactively

address some of the historical equity challenges. Job growth is celebrated without recognizing that low-paying jobs will not help families make ends meet in the high-cost region. They also suggested that when approving new development, cities and the county need to take into account proximity to supermarkets, walking paths, jobs, etc.

Community Assets and Advantages

The focus group participants pointed out the strong connection to the community that people make through neighborhoods, faith, or other means.

They also noted that people who obtain stable, supported housing in the community are less likely to be hospitalized and less likely to need higher levels of care. In particular, they talked about the benefits of free services being offered at low-income housing properties, including the Redwood Empire Food Bank, a free mobile clinic, and a free dental clinic.

The participants were very proud of their history of collaboration. Service providers work together on upstream issues. They have a collective, long-term vision of investing early to help people be and stay healthy. Their work is data-informed. They also noted good collaborations among county departments, law enforcement, and community-based providers. The large number of grassroots organizations in the community provides an opportunity to develop new partnerships

Community Forum

One community forum was held in Santa Rosa at the Finley Community Center. There were 12 participants, most of whom represented community-based organizations in and around Santa Rosa. The forum was conducted in English with interpretation services available for participants in Spanish; however, no one required interpretation.

At the beginning of the forum, the participants viewed a short PowerPoint presentation with an overview of the CHNA framework, the hospital service area, and the health needs that had emerged from the data and preceding focus groups. The health needs also were written on poster paper taped to the walls of the room. Both the PowerPoint and the health needs were in English and Spanish. After the presentation, participants were invited to share their perspectives on the health needs in the community – to confirm, clarify, or add to items on the list. New items and clarifications were written on the poster paper. After the discussion, each person was given four adhesive dots and asked to place their dots on the health needs of greatest concern to them, applying only one dot per health need.

The discussion at the forum raised many of the same issues as had been described at the focus groups. Access to care, mental health, poverty, and housing and homelessness were all frequent discussion points. There was also extensive discussion about young children and their families, and the special challenges they face. Early childhood education and development were both discussion points, and the unique obstacles for parents of young children (such as access to quality child care and preschool and the need to take time off from work). The group also wanted to consolidate several ideas before voting. After some discussion, they opted not to combine homelessness and housing, but they did combine

cancer, diabetes, and asthma into “Chronic Diseases” and to include “Domestic Violence” with “Violent Crime.” Both combined categories only received one vote each.

Below are the categories that received multiple votes in the forum. The labels provided are the English language headings that were listed on flip chart paper. Spanish language translations were provided next to the English language labels, but were not necessary as all participants were fluent in English.

Health Need	# of Votes
Mental Health	6
Homelessness	6
Economic Insecurity	6
Housing	5
Early Childhood Development	5
Drug and Alcohol Abuse	4
Immigration Status	3
Access to Health Care	2

Appendix 3d: Focus Group and Community Forum Protocols and Demographic Survey

Community Resident Focus Group Protocol

Introduction:

Hello everyone and thank you for agreeing to be part of this focus group. We appreciate your time and willingness to participate.

We are doing this focus group as part of Santa Rosa Memorial Hospital Community Health Needs Assessment. This is an every three years process in which non-profit hospitals such as Santa Rosa Memorial explore community needs with input from the local community to better respond to the unmet needs. My name is _____ and I'll be running the focus group along with my colleague _____. We do not work for the Hospital as they wanted to have an outside partner to help run the process. This focus group is one of many that Santa Rosa Memorial Hospital is holding to hear directly from its communities' residents.

A focus group is a great way to get information and to capture people's ideas, opinions, and experiences. It's a structured conversation where we have some scripted questions and look to you to respond and take the discussion where it needs to go.

We need your input and want you to share your honest and open thoughts with us. Your responses will be anonymous. While we will be reporting in broad terms what is said during this focus group, we will not be attributing it to any person or organization. And we ask the same of you—that if you discuss this focus group outside of this room, you do not connect anyone to anything specific that was said.

Ground Rules:

1. There are no right or wrong answers. It's ok to respectfully disagree with someone else's opinion as that leads to dialogue and a better understanding of everyone's position and thoughts. Every opinion counts, and it is perfectly fine to have a different opinion than others in the group, and you are encouraged to share your opinion even if it is different.

2. We have a list of questions to ask, but we want YOU to do the talking. We would like everyone to participate, so we may call on people who have been particularly quiet.
3. We would like to record our conversation. Our note taker will be taking notes so that we remember what people have to say, but we'd also like to record the conversation to ensure we have the most accurate information possible. Is that okay?

This session should take 90 minutes. If you need to get up to use the restroom or grab refreshments, feel free to do so.

Any questions before we begin?

OK, then a couple other things before we get into the questions. First of all, can we please go around the room and introduce ourselves and say where we live and say something you like about your community.

Focus Group Questions

1. What are the biggest health issues affecting you, your family and friends in the community?
    a. Prompt – health issues refers to specific health conditions like heart problems, diabetes, obesity, cancer, asthma, or depression, and health behaviors refers to exercising, smoking, unhealthy eating, and drug use

Now, I'd like to ask you to look at the graphic that we're handing out right now. This was made by the United States Center for Disease Control and Prevention, a federal agency whose mission it is to help our country be healthy. The visual shows the many things that contribute to community health. Note that this graphic, and your own introductions, show that there is a lot more to "health" than just medical concerns. Let's keep that in mind as we go to our next questions.

2. What are the things in your community that help you stay healthy?
    a. Prompt – if you were to tell a friend about some of the good things in this community that help people live a good life here, what would you tell them?
    b. Prompt – This could include safe places to walk, clean air, enough doctors, easy access to health care, caring community, affordable housing, good-paying jobs, etc.
3. What are some of the challenges to staying healthy in this community?
    a. Prompt – if you were to tell a friend about some of the things that make it difficult to live a good life here, what would you tell them?
    b. Prompt – This could include no nearby grocery stores with fresh produce, no place to get exercise, overcrowded housing, low incomes, no doctors that take your insurance, poor air quality, gangs, etc.
4. Thinking about all the concerns discussed today, which do you think are the biggest concerns needing the most immediate attention?
5. What would you like to see in the communities to address these top concerns? How can some of the positive aspects of your community help?

Closing:

I wanted to thank you on behalf of the Santa Rosa Memorial Hospital for spending your time with us and sharing your wisdom and experiences. I wanted to stress that this meeting has been one very important part of the Needs Assessment process for Santa Rosa Memorial. I also wanted to be clear that everything that was said today will be recorded, reported, and considered. But some of what was said may not find its way into the final plan, because the Hospital has to pull together everything they've learned in the process and make decisions about priorities. What I can say is that the final plan will be publicly available, and if you read it, you should see the key themes from today's meeting in there. Thank you again, and have a good evening.

Government/Non-Profit Stakeholders Focus Group

Hello everyone and thank you for agreeing to be part of this focus group. We appreciate your willingness to participate.

We are doing this focus group as part of Santa Rosa Memorial Hospital Community Health Needs Assessment. This is an every three years process in which non-profit hospitals such as Santa Rosa Memorial study their communities' needs in order to become even better at serving those needs. My name is _____ and I'll be running the focus group along with my colleague _____. We do not work for the Hospital as they wanted to have an outside partner to help run the process. This focus group is one of other focus groups that are being conducted with community residents.

A focus group is a great way to get information and to capture people's ideas, opinions, and experiences. It's a structured conversation where we have some scripted questions and look to you to respond and inform the discussion to where it needs to go.

We need your input and want you to share your honest and open thoughts with us. Your responses will be anonymous. While we will be reporting in broad terms what is said here today, we will not be attributing it to any person or organization. And we ask the same of you—that if you discuss this focus group outside of this room, you do not connect anyone to anything specific that was said.

Ground Rules:

1. We have a list of questions to ask, but we want YOU to do the talking. We would like everyone to participate, so we may call on people who have been particularly quiet. But answering any question is optional.
2. There are no right or wrong answers. It's ok to respectfully disagree with someone else's opinion. In fact, we encourage it because it leads to dialogue and a better understanding of everyone's position and thoughts.
3. _____ will be taking notes, but we also will be recording the group in order to capture everything you have to say. We are doing this for our own notes and reporting, but again, we won't share the recording or identify anyone by name in our report. You will remain anonymous.

Facilitator shows presentation focusing on high level findings from quantitative data. During the presentation, use the BARHII visual as an icebreaker to get people to talk about what factors influence a community's health, while answering the question "Please tell us your name, organization, and referring to the visual (provided in the PowerPoint), which area does your organization focus on or address in the upstream or downstream factors that influence community health?

After concluding the presentation, ask the following questions:

1. What are the biggest health issues facing our community?

a. Prompt – health issues refers to specific health conditions like heart problems, diabetes, obesity, cancer, asthma, or depression, and health behaviors refers to exercising, smoking, unhealthy eating, and drug use

2. What helps our community stay healthy?
    a. Prompt – if you were to tell a friend or colleague about some of the good things in this community that help people live a good life here, what would you tell them?
    b. Prompt – This could include safe places to walk, clean air, enough doctors, easy access to health care, caring community, affordable housing, good-paying jobs, etc.

3. What are the challenges to staying healthy in our community?
    a. Prompt – if you were to tell a friend or colleague about some of the things that make it difficult for people to live a good life here, what would you tell them?
    b. Prompt – This could include no nearby grocery stores with fresh produce, no place to get exercise, overcrowded housing, low incomes, no doctors that take residents' insurance, poor air quality, gangs, etc.

4. What are the opportunities in our community to improve and maintain health?

5. What are the biggest health concerns needing immediate attention?

Closing: Thank the participants and talk about next steps.

Community Resident Forum Process/Protocol:

Hello everyone and thank you for agreeing to be part of this forum. We appreciate your willingness to participate.

We are doing this forum as part of Santa Rosa Memorial Hospital Community Health Needs Assessment. This is an every three years process in which hospitals such as Santa Rosa Memorial study their communities' needs in order to become even better at serving those needs. My name is _____ and I'll be running the focus group along with my colleague _____. We do not work for the Hospital as they wanted to have an outside partner to help run the process. This forum is one of many that Santa Rosa Memorial Hospital is holding to hear directly from its community residents.

The purpose of this forum is to get a sense of what you think are the needs, issues, and opportunities in your communities. We need your input and want you to share your honest and open thoughts with us. Your responses will be anonymous. While we will be reporting in broad terms what is said to the Hospital, we will not be attributing comments made to any person or organization.

Ground Rules:

1. We have a process in mind today, but it will only be as successful as you all make it; this session is for you. So please, feel free to be candid. Answering any question is optional; we won't be calling on anyone.
2. There are no right or wrong answers. It's ok to respectfully disagree with someone else's opinion.

3. _____ will be taking notes, but we also will be recording the group in order to capture everything you have to say. We are doing this for our own notes and reporting, but again, we won't share the recording or identify anyone by name in our report. You will remain anonymous

Provide context: Facilitator: Be sure to provide context and how the information will be used up front

1. There will be two 5-10 minute presentations of findings from the community-based data and focus groups with questions in between. One presentation will focus on socioeconomic factors and physical environment; the other on health outcomes, health behaviors, and clinical care.
2. Point out the poster paper headings around the room, on which we list the areas of concern we have already seen on socioeconomic and physical environment and health needs that were identified through the quantitative data and qualitative process
3. After the first presentation on context and socioeconomic factors and physical environment, ask the following questions:
    a. Do you have any questions about the information you just saw or the poster paper headings?
    b. What did you see that matches with what you know about your community?
    c. What surprised you?
    d. What's missing? What's happening in your community that was not mentioned in the presentations?

4. After the second presentation on health outcomes, health behaviors and clinical care:

    a. Do you have any questions about the information you just saw or the poster paper headings?
    b. What did you see that matches with what you know about your community?
    c. What surprised you?
    d. What's missing? What's happening in your community that was not mentioned in the presentations?
5. Write down issues that are new or not already represented on the poster paper
6. Add explanation to the poster paper issues as provided from participants
7. Keep a parking lot for issues that are important but not necessarily related to the task at hand
8. Explain the process that participants will use to identify the most pressing areas of concern. Each participant will receive 4 dots to specify what they view as the most significant health issues; no more than one dot may be assigned to a health issue. Allow 10-15 minutes to complete this process
9. Review the results and facilitate discussion about the results – ask for more input on why some issues received more dots than others
10. Explain what will happen next with this information
11. Thank everyone for their time.

Demographic Survey

Thank you for taking time to participate in our focus group today. Please take a few moments to complete the demographic survey below. Your identity will be kept confidential and anonymous. We'd like to gather some demographic data to reflect the individuals who participated in the focus groups or community forums. Please complete the survey and submit to the facilitator. Thank you for your time.

1. Please check the box next to the description that best describes you:

☐ Community Member who does not work for a local health or social services provider (skip to question 3)
☐ Community Member employed by:
☐ Community-based Org/Nonprofit
☐ County/Government Agency
☐ Foundation/Funder
☐ Health Care/Hospital/Clinic
☐ University
☐ Other (please provide): _____

2. If applicable, please check the box next to the role that most closely matches your position/role within the organization:

☐ Administrative Staff
☐ Board Member
☐ Executive Director
☐ Medical Professional
☐ Program Manager/Staff
☐ University/Faculty/Researcher
☐ Volunteer
☐ Other (please provide): _____

3. Please check the box next to your current gender identity:

☐ Female
☐ Male
☐ Other (please provide): _____
☐ Decline to answer

4. What race/ethnicity do you identify as (Please select all that apply)

☐ Black/African American
☐ Non-Latino White
☐ Asian or Pacific Islander:
☐ Vietnamese
☐ Filipino
☐ Chinese
☐ Hispanic/Latino
☐ Native American
☐ Japanese
☐ Korean
☐ Indian
☐ Native Hawaiian or Pacific Islander
☐ Other: _____

5. Do you identify as a person with chronic conditions, or a leader or representative of individuals with chronic conditions (such as diabetes, arthritis, or cancer)?

☐ Yes
☐ No
☐ Decline to answer

6. What is your age group?

☐ 0 - 17 years
☐ 18 - 44 years
☐ 45 – 64 years
☐ 65 - 74 years
☐ 75 years or older

7. How much total combined money did all members of your HOUSEHOLD earn last year before taxes?

☐ Less than $20,000
☐ $20,000 to $34,999
☐ $35,000 to $49,999
☐ $50,000 to $74,999
☐ $75,000 to $99,999
☐ $100,000 or more
☐ Decline to answer

8. How many people live in your household, including you? Please enter a number _____

Appendix 4: Prioritization protocol and criteria / worksheets

Step 1 Criteria and Score Definitions

#	Criteria	Criteria Definition	Score Definitions				
Step 1			1	2	3	4	5
1	**Seriousness of the problem**	Degree to which the problem leads to death, disability, and impairs one's quality of life.	For most people with the problem, the consequences are mild and not life threatening		Most people with the problem have some impairment of their quality of life; only some people die from the problem		For most people with the problem, the consequences are lethal or extremely debilitating
2	**Scope of the problem - Part 1**	Number of persons affected	Affects very few people		Affects about half the population		Affects much of the population
3	**Scope of the problem - Part 2**	Take into account the variance between regional benchmark data and targets and/or statewide averages. (for example, the prevalence of the problem in the primary service area compared to Target 2020 goals and/or prevalence in the county or state.)	The region is doing much better than targets or county/statewide averages		The region is on par with targets or county/statewide averages		The region is doing much worse than targets or county/statewide averages
4	**Health disparities**	Degree to which specific groups are affected by the problem	There are no differences in prevalence or severity of the problem across demographic or socioeconomic groups		One or more demographic or socioeconomic groups are doing moderately worse than the average in the service area		One or more demographic or socioeconomic groups are doing much worse on the health problem than the average in the service area
5	**Importance to the community**	Community members recognize this as a problem; it is important to diverse community stakeholders	Community input did not identify this area as a problem		Community input showed a moderate amount of concern about this problem		Community input showed a high level of concern about this problem
6	**Potential to affect multiple health issues**	Affects residents' overall health status; addressing this issue would impact multiple health issues.	Addressing this issue would not affect any other health issue		Addressing this issue would affect a few other health issues		Addressing this issue would impact many health issues - it is a root problem

#	Criteria	Criteria Definition	Score Definitions				
7	**Implications for not proceeding**	Risks associated with exacerbation of problem if not addressed at the earliest opportunity	There is no risk that this problem will get worse if we don't address it now		There is a moderate risk that the problem will get worse if we don't address it now		This problem will definitely get worse if we don't address it now

These criteria were applied by raters from The Olin Group Evaluation Team to all identified health needs.

Step 2 Criteria and Score Definitions

#	Criteria	Criteria Definition	Score Definitions				
Step 2			1	2	3	4	5
8	**Sustainability of impact**	The ministry's involvement over next 3 years would add significant momentum or impact that would remain even if funding or ministry emphasis were to cease	Ministry involvement would likely yield little to no momentum or impact that would remain after 3 years of funding		Ministry involvement would likely yield moderate momentum or impact that would remain after 3 years of funding		Ministry involvement would likely yield significant momentum or impact that would remain after 3 years of funding
9	**Opportunities for coordination/ partnership**	Ability to be part of collaborative efforts	There is not much opportunity for the ministry to be part of collaborative efforts		There is some opportunity for the ministry to be part of collaborative efforts		There are many opportunities for the ministry to be part of collaborative efforts
10	**Focus on prevention**	Effective and feasible primary and/or secondary prevention is possible	There are no or few effective and feasible prevention strategies with which the ministry could be involved		There are a moderate number of effective and feasible prevention strategies with which the ministry could be involved		There are many effective and feasible prevention strategies with which the ministry could be involved
11	**Existing efforts on the problem**	Ability to enhance existing efforts in the community	There is so much work being done on this problem that our contribution would be meaningless		The problem is already being addressed by others and our contribution would be only moderately meaningful		We could make a very meaningful contribution to enhance the work of others in addressing this problem
12	**Organizational competencies (only CB Staff complete)**	Ministry has or could develop the functional/technical, behavioral (relationship building) and leadership competency skills to address significant health need	The ministry does not have and could not develop the competencies to address the issue		The ministry has some of the competencies or could develop them to address the issue		The ministry has or could easily develop strong organizational competencies to address the issue

These criteria were applied by raters from the Santa Rosa Memorial and Petaluma Valley Hospitals Health Needs Assessment Prioritization Working Group to all identified health needs.

Step 3 Criteria

Criteria	Criteria Definition	Responses		
Step 3		**Yes**		**No**
Relevance to Mission of St. Joseph Health	Is this area relevant or aligned with the Mission of St. Joseph Health?	Proceed to the next set of criteria		No further consideration of this health problem is necessary
Adheres to ERD's	Does this area adhere to the Catholic Ethical and Religious Directives?	Proceed to the next set of criteria		No further consideration of this health problem is necessary

These criteria were applied by the Santa Rosa Memorial and Petaluma Valley Hospitals Community Benefit Lead to all identified health needs.

Appendix 5: Existing Health care Facilities in the Community

Site	Address	City	State	ZIP	SERVICES
Petaluma Health Center	1179 North McDowell Blvd	Petaluma	CA	94954	Health Care
Petaluma Health Center - Rohnert Park Clinic	5900 State Farm Drive, 2nd Floor	Rohnert Park	CA	94928	Health Care
Petaluma Health Center - San Antonio Clinic	500 Vallejo Street	Petaluma	CA	94952	Young Adult Health Care
Petaluma Health Center - Casa Grande Clinic	333 Casa Grande Road	Petaluma	CA	94954	Young Adult Health Care
Petaluma Health Center - SRJC Student Health Services Clinic	680 Sonoma Mtn. Pkway	Petaluma	CA	94954	Young Adult Health Care
Allexander Valley Healthcare- Medical Offices	6 Tarman Drive	Cloverdale	CA	95425	Health Care
Allexander Valley Healthcare- Dental Offices	100 W 3rd Street	Cloverdale	CA	95425	Dental Care
Alliance Medical Center- Healdsburg Clinic & Dental	1381 University Avenue	Healdsburg	CA	95448	Health and Dental
Alliance Medical Center- Windsor Clinic	8465 Old Redwood	Windsor	CA	95492	Health Care
Alliance Medical - Teen Health Center	1381 University Avenue	Healdsburg	CA	95448	Young Adult Health Care
Sonoma County Indian Health Project	144 Stony Point Road	Santa Rosa	CA	95401	American Indian Health Care
Sonoma Valley Community Health Center	19270 Sonoma Highway	Sonoma	CA	95476	Health Care
Santa Rosa Community Dental Center	1110 N. Dutton Ave	Santa Rosa	CA	95401	Dental Care
Vista Family Health Center	3569 Round Barn Circle	Santa Rosa	CA	95403	Health Care
Southwest Community Health Center	751 Lombardi Court	Santa Rosa	CA	95407	Health Care
Roseland Pediatrics	711 Stony Point Road, Suite 17	Santa Rosa	CA	95407	Children's Health Care
Elsie Allen Health Center	599 Bellevue Avenue, G17	Santa Rosa	CA	95407	Young Adult Health Care
Brookwood Health Center	983 Sonoma Avenue	Santa Rosa	CA	95405	Health Care
Santa Rosa Junior College Clinic	1501 Mendocino Avenue	Santa Rosa	CA	95401	Young Adult

Site	Address	City	State	ZIP	SERVICES
					Health Care
West County Health Centers - Occidental Area Health Center	3802 Main Street	Occidental	CA	95465	Health Care
West County Health Centers - Russian River Health Center	16319 3rd Street	Guerneville	CA	95446	Health Care
West County Health Centers - Sebastopol Community	6800 Palm Avenue, Ste. C	Sebastopol	CA	95472	Health Care
West County Health Centers - Gravenstein Community	652 Petaluma Avenue, Suite H	Sebastopol	CA	95472	Health Care
West County Health Centers - Forestville Wellness Center	6550 Front Street	Forestville	CA	95436	Health Care
Forestville Teen Clinic	6570 1st Street	Forestville	CA	95436	Young Adult Health Care
Jewish Community Free Clinic	50 Montgomery Drive	Santa Rosa	CA	95404	Health Care
Planned Parenthood - Santa Rosa Health Center	1140 Sonoma Ave., Bldg. 3	Santa Rosa	CA	95405	Reproductive Health Care
Kaiser Permanente	401 Bicentennial Way	Santa Rosa	CA	95403	Hospital/Health Care
Sutter Santa Rosa Regional Hospital/Sutter Health	30 Mark West Springs Road	Santa Rosa	CA	95403	Hospital/Health Care

Appendix 6: Ministry Community Benefit Committee ***(or Board of Trustee Roster, if ministry does not have CB Committee)***

Name	Title	Affiliation or Organization
Robert Agrella	Retired President	Santa Rosa Junior College
James Carr		Community Member
Lisa Carreño	Regional Director	10,000 Degrees
Susan Castillo	Community Mental Health Section Manager	Behavioral Health Division, Sonoma County Department of Health Services
Pam Chanter	Vice President	Vantreo Insurance Brokerage
Oscar Chavez	Assistant Director	Sonoma County Human Services Department
Robert Curry	Project Director	Marin County Tobacco Control Project
Karin Demarest	Vice President of Programs	Community Foundation Sonoma County
Sister Patrica Haley	Sister	Sisters of St. Joseph of Orange
Jennielynn Holmes	Director of Shelter and Housing	Catholic Charities of the Diocese of Santa Rosa
Jeff Kolin	Retired City Manager	City of Santa Rosa
Teejay Lowe	Former CEO	G&G Super Markets

Name	Title	Affiliation or Organization
Marrianne McBride	President & CEO	Council on Aging
Tim Reese	Executive Director	Community Action Partnership of Sonoma County
Todd Salnas	President	St. Joseph Health – Sonoma County
Rita Scardaci	Retired Director	Sonoma County Department of Health Services
Suzie Shupe	Executive Director	Redwood Community Health Coalition
Josephine Thornton		Community Member
Catherine Wittenberg	Retired CNO	UCSF