



*St. Joseph Health- Petaluma Valley*

**Fiscal Year 2012 COMMUNITY BENEFIT REPORT  
PROGRESS ON FY 12-FY 14 CB PLAN/IMPLEMENTATION STRATEGY**

**St. Joseph Health**   
Petaluma Valley

## EXECUTIVE SUMMARY

### **Our Mission**

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

### **Our Vision**

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

### **Our Values**

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

## **Who We Are and What We Do**

St. Joseph Health- Petaluma Valley, located approximately 40 miles north of San Francisco just off the Highway 101 corridor in southern Sonoma County in the town of Petaluma, is an 80-bed acute care hospital. Its services include a 24-hour emergency department, intensive/coronary care unit, family birth center, inpatient medical/surgical unit, day surgery, imaging, laboratory, and respiratory, physical and occupational therapies. PVH forms part of St. Joseph Health's ministry in Sonoma County, which will be referred to in this document as SJH-SC, founded by the Sisters of St. Joseph of Orange, has been serving the healthcare needs of families in the community for more than 50 years. During this time, its mission has remained the same: to continually improve the health and quality of life of people in the communities served. Part of a 14-hospital health system serving California, west Texas and eastern New Mexico known as St. Joseph Health (SJH), SJH-SC operates two hospitals, St. Joseph Health-Petaluma Valley and St. Joseph Health-Santa Rosa Memorial, urgent care and community clinics, hospice, home health services, and other facilities for treating the healthcare needs of the community in Sonoma County and the region.

As a values based organization, St. Joseph Health has a long-standing commitment to the community it serves. SJH works under the premise of "Value Standards." SJH's Value Standard Seven: Community Benefit states, "We commit resources to improving the quality of life in the communities we serve, with special emphasis on the needs of the poor and underserved." Ten percent of the net income is dedicated to community benefit. SJH-SC has formed one countywide Community Benefit Department, which serves the service areas of both Petaluma Valley Hospital and Santa Rosa Memorial Hospital, where it is administratively housed. In Sonoma County, the Community Benefit Department integrates actions through Strategic Elements that address the political, social, behavioral and physiological determinants of health: Healthy Communities, Community Health and Advocacy. The primary strategies employed to

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address community needs are community capacity building, improving health outcomes for vulnerable populations and reducing social isolation of special populations.

Community Benefit programs and clinics include: Neighborhood Care Staff community organizing program, Agents of Change Training in Our Neighborhoods leadership training, Circle of Sisters after-school program, St. Joseph Mobile Health Clinic, House Calls multi-disciplinary in-home care for seniors, *Promotores de Salud* health promotion program, Healthy for Life obesity prevention program, the continuum of oral health clinics and programs that include the St. Joseph Dental Clinic, *Cultivando la Salud* Mobile Dental Clinic and Mighty Mouth dental disease prevention program.

In FY 12 St. Joseph Health, Petaluma Valley provided **\$5,961,351** in community benefit and an additional **\$7,419,484** for the unpaid cost of Medicare.

### ***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 St. Joseph Health- Petaluma Valley has a **Patient Financial Assistance Program** that provides free or discounted services to eligible patients. In FY 12, St. Joseph Health- Petaluma Valley provided **\$1,374,108** in charity care with 1,212 persons served.

St. Joseph Health- Petaluma Valley enhanced its process for determining charity care by adding an assessment for presumptive charity care. This assessment uses a predictive model and public records to identify and qualify patients for charity care, without a traditional charity care application.

### ***Community Plan Priorities***

Petaluma Valley Hospital's major Community Benefit accomplishments addressed in this plan during Fiscal Year 12 (FY 12) include:

- ***Youth Alcohol Abuse Prevention:***

Families play a critical role in preventing **youth alcohol** (American Academy of Pediatrics, 2010), making the strengthening of trusting relationships between young people and the adults in their lives essential in supporting healthy choices. In FY 12, SJH-SC's Circle of Sisters found that 93% of the program's participants reported having trusting relationships with adults; exceeding the year's target of 75%. A remarkable 100% of the participants' parents who received support and responded to the survey reported a high degree of self efficacy. These achievements are an important part of the foundation of internal and external assets that support a young person's decision to not use alcohol.

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- **Children's Healthy Weight:**

SJH-SC's Community Benefit team continues its strong focus on helping communities and families achieve a **healthy weight** of their children. Over 300 children, youth, and adults received ongoing mentoring on healthy eating and physical activity, and nearly 10,000 participated in community education sessions. The Neighborhood Care Staff provided leadership training to 11 residents from low-income communities, and nearly 500 were engaged in environmental and policy change efforts in their communities that support healthy living. Over 1,800 individuals were referred to food assistance programs, and over 200 were identified as at-risk for developing diabetes; over half of whom participated in nutrition counseling.

- **Senior Care Management:**

SJH-SC's Healthy Communities programs increased their engagement with the long-standing efforts of the House Calls program to improve the health and well-being of **frail, low-income seniors**. The Circle of Sisters and Neighborhood Care Staff teams engaged a total of 339 seniors residing in low-income neighborhoods in the Area Agency on Aging's 5-year needs assessment and planning process through focus groups and individual surveys. House Calls provided integral in-home care and intensive care management to over 100 frail and homebound seniors.

## INTRODUCTION

### *Who We Are and What We Do*

St. Joseph Health-Petaluma Valley, located approximately 40 miles north of San Francisco in the town of Petaluma, is an 80-bed acute care hospital. Owned by the Petaluma Health Care District, PVH is administered by and forms part of St. Joseph Health - Sonoma (SJH-SC), founded by the Sisters of St. Joseph of Orange; and which has been serving the healthcare needs of families in the community for more than 50 years. During this time, its mission has remained the same: to continually improve the health and quality of life of people in the communities served. SJH-SC is part of a 14-hospital health system serving California, west Texas and eastern New Mexico known as St. Joseph Health (SJH), the central offices of which are in Orange County. SJH-SC operates two hospitals, St. Joseph Health-Petaluma Valley and St. Joseph Health-Santa Rosa Memorial, urgent care and community clinics, hospice, home health services, and other facilities for treating the healthcare needs of the community in Sonoma County and the region.

In FY 12 St. Joseph Health, Petaluma Valley provided **\$5,961,351** in community benefit and an additional **\$7,419,484** for the unpaid cost of Medicare.

SJH-SC has formed one countywide Community Benefit Department, which serves the service areas of both Petaluma Valley Hospital and Santa Rosa Memorial Hospital, where it is administratively housed. The Community Benefit Department integrates actions through these Strategic Elements that address the political, social, behavioral and physiological determinants of health: Healthy Communities, Community Health and Advocacy. The primary strategies employed to address community needs are community capacity building, improving health outcomes for vulnerable populations and reducing social isolation of special populations. Its key programs and clinics include:

Healthy Communities: Building community capacity and empowerment to address quality of life concerns.

The Neighborhood Care Staff (NCS) mentor grassroots leadership to address local community health and quality of life issues. NCS models and mentors community representatives in these key functions: the identification of local assets, providing forums for dialogue, surfacing and supporting local leaders, facilitating the development of self-sustaining community groups, facilitating community-based strategic planning, helping to build linkages to and between community resources, and advocating for community participation in the issues that most affect it. In FY 12, NCS mentored 128 grassroots community leaders in low-income neighborhoods in the Petaluma area. These resident leaders developed local action plans addressing two key Social Determinants of Health that resulted in nearly 2,000 (1,977) actions of advocacy, education, and organizing to reduce obstacles to healthy food and physical activity; and to increase neighborhood safety.

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Agents of Change Training in our Neighborhoods (ACTION) is a companion program to NCS that provides leadership and advocacy training. In FY 12 provided follow-up mentoring to ACTION graduates who serve as leaders of the Sunrise Community Garden, and provided leadership training and mentoring to 35 children and youth.

Community Health: Promoting health improvement and increasing access to healthcare services for low-income and under-served vulnerable persons, while fostering collaboration and incorporating healthy community strategies.

House Calls tend 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. House Calls served 18 patients in the Petaluma area with 316 visits.

The Mobile Health Clinic serves primarily low-income Latino persons of all ages who are without a regular physician or have difficulty accessing healthcare services; traveling to sites throughout the county that include churches, schools, migrant camps and homeless shelters. The Clinic offers health screenings, well child exams, immunizations, treatment of minor medical problems, health and nutritional education, information and referrals. During fiscal year 12, the Mobile Health Clinic provided 1,115 visits to 335 homeless persons at the Committee on the Shelterless' Mary Isaak Center.

The *Promotores de Salud* bridge language and culture, providing health information and referrals, enrolling uninsured families into publicly funded health plans, conducting cooking and nutrition classes, and enrolling patients in the MiVIA Electronic Personal Health Record. In FY 12, the *Promotores de Salud* served a total of 178 low-income children, youth, and adults from Petaluma. These services included enrollment in publicly funded insurance programs and provided outreach at health fairs and other community events. The Promotores de Salud (Health Promoters) conducted two 10 week courses for Your Heart, Your Health in which a total of 24 people graduated. The courses were led by two volunteers who graduated from the training the year before. The Promotores de Salud also partnered with the Boys & Girls Club of Petaluma to provide the Healthy for Life obesity prevention program, with participation of an additional 30 children.

St. Joseph Health – Sonoma County's continuum of oral health services include a children's dental clinic located in Santa Rosa that serves children from all over the county, as well as a mobile dental clinic and Mighty Mouth dental disease prevention program. These clinics and program were founded to address the number one unmet need of children in the community: access to dental care. 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 FY 12, 643 individuals were served by the oral health team through a total of 1,281 visits.

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Advocacy: Advocating for vulnerable populations and working to affect social and public policy change through grassroots advocacy and engaging persons of influence.

Circle of Sisters is a free violence prevention after-school program for girls ages 10 to 14. The program participants attend schools with high rates of free and reduced lunches. In FY 2012, Circle of Sisters partnered with the Boys & Girls Club of Petaluma and Marin to serve 22 girls in Petaluma.

Together with their community partners, coalitions, agencies and residents, SJHS-SC's Community Benefit team addressed its current strategic community health priorities: children's oral health, youth and peri-natal substance abuse, and childhood obesity. Its actions have been planned and implemented within the framework of the Spectrum of Prevention developed by The Prevention Institute. This framework, also used in the Sonoma County Community Health Needs Assessment that informed the development of this Community Benefit plan, serves to ensure a comprehensive, multi-disciplinary and multi-layered approach to addressing these concerns; and in this way, creates potential for achieving deeper, more sustainable change.

An integrated approach to community health mandates the development and monitoring of both process and outcomes measures, as is reflected in the highlights of SJHS-SC's FY 12 achievements.

- Families play a critical role in preventing **youth alcohol** (American Academy of Pediatrics, 2010), making the strengthening of trusting relationships between young people and the adults in their lives essential in supporting healthy choices. In FY 12, SJH-SC's Circle of Sisters found that 93% of the program's participants reported having trusting relationships with adults; exceeding the year's target of 75%. A remarkable 100% of the participants' parents who received support and responded to the survey reported a high degree of self efficacy. These achievements are an important part of the foundation of internal and external assets that support a young person's decision to not use alcohol.
- SJH-SC's Healthy Communities programs increased their engagement with the long-standing efforts of the House Calls program to improve the health and well-being of **frail, low-income seniors**. The Circle of Sisters and Neighborhood Care Staff teams reduced the social isolation of 343 seniors residing in low-income neighborhoods through participation in inter-generational community activities and in the Area Agency on Aging's 5-year needs assessment and planning process through focus groups and individual surveys. House Calls provided integral in-home care and intensive care management to over 100 frail and homebound seniors.
- SJH-SC's Community Benefit team continues its strong focus on helping communities and families achieve a **healthy weight** of their children. Over 300 children, youth, and adults received ongoing mentoring on healthy eating and physical activity, and nearly

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10,000 participated in community education sessions. The Neighborhood Care Staff provided leadership training to 11 residents from low-income residents, and nearly 500 were engaged in environmental and policy change efforts in their communities that support healthy living. Over 1,800 individuals were referred to food assistance programs, and over 200 were identified as at-risk for developing diabetes; over half of whom participated in nutrition counseling.

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***Community Benefit Governance Structure***

The trustees, executive management, physicians, employees of SJH-SC and surrounding community are all involved in providing on-going feedback/monitoring and informing the direction of policies and programmatic content of community benefit activities. In addition, community benefit plans, processes and programs reflect both the SJH strategic health system and entity goals and objectives. In the section of this strategic plan included under "Community Outreach and Social Change" the following goals are listed which are reflected throughout our community benefit programming:

- Increasing cultural and linguistic competency of all services and programs.
- Strengthening the continuum of care within the community, in collaboration with community partners.
- Enhancing community access to specialty care by building or expanding relationships with community health centers and district hospitals.
- Continuing to provide mobile health and dental services.
- Advocating for health care programs and services that respond to identified community health care needs, specifically advocating for mental health and for expanded access and healthcare reform.
- Developing a countywide indigent care approach that engages all providers and increases access to care.
- Engaging the community to be involved in health and or quality of life issues.

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St. Joseph Health - Sonoma County demonstrates organizational commitment to the community benefit process through the allocation of staff, financial resources, participation and collaboration. The Area Vice President of Mission Integration is responsible for coordinating implementation of Senate Bill 697 provisions as well as the opportunities for Executive Management Team, physicians and other staff to participate in planning and carrying out the Community Benefit Plan.

The Community Benefit Committee is a joint committee of the Boards of Trustees of Santa Rosa Memorial and Petaluma Valley Hospitals (SJH-SC entities), and supports these boards in overseeing community benefit activities in accordance with its Board approved charter. The Committee consists of at least three members of the Boards of Trustees and has a majority of members from the community who have knowledge or experience with populations with disproportionate unmet health needs in the communities served.

***Overview of Community Needs and Assets Assessment***

The Community Health Needs Assessment 2011 is a collaborative effort by Sutter Medical Center of Santa Rosa, St. Joseph Health – Sonoma County, which consists of St. Joseph Health-Petaluma Valley and St. Joseph- Santa Rosa Memorial, Kaiser Permanente Medical Center – Santa Rosa and the Sonoma County Department of Health Services to spotlight the health, well-being and future of the children of Sonoma County. Since 2001, these partners have joined forces in their needs assessments to address significant community health issues. This report continues to draw attention to children’s health issues, focusing on four areas: dental health; maintaining a healthy weight through nutrition and physical activity; avoiding alcohol and drugs; and ensuring that babies are born drug free. This needs assessment takes a close look at progress toward improvements in health through initiatives, innovation and community collaboration and continues to search out “Windows of Opportunity” to prevent serious children’s health problems and to bring the community together to envision and realize a “Lifetime of Health” for our children.

The Community Health Needs Assessment points to and acknowledges the good work of the many important efforts underway throughout the county to address child health: Health Action, the Community Activity and Nutrition-Coalition (CAN-C), First 5 Sonoma County, Healthy Eating, Active Living (HEAL), The Sonoma County Oral Health Access Coalition, The Pediatric Dental Initiative, and Drug Free Babies among others. These are spotlighted to provide an opportunity for those in the community who want to support this work to do so. It takes commitment from individuals and organizations, adding their resources and strength to these local efforts, to be successful in making critical shifts in children’s health in our community. It also relies on the Spectrum of Prevention, a public health model that recognizes the broad range of factors influencing health, to help guide analysis and planning.

Underlying themes emerged in the Community Health Needs Assessment. The first of these being that the health problems raised in the Needs Assessment are preventable—with concerted action on the part of partners and the community. The Needs Assessment reinforces

the county's focus on social determinants of health (e.g., race and poverty, neighborhoods, community connections, resiliency, and parenting) and stresses upstream solutions to reduce downstream costs to the county and families. Secondly, the Needs Assessment is a tool to enhance understanding among the public about the link between childhood dental disease, obesity, and teen alcohol, tobacco and other drug use and the long-term health of children and teens. In the "Indicators" section, the Needs Assessment revisits the data indicators proposed in 2008, aligns them with the Healthy Sonoma.org indicators and offers new ones to gain a fuller picture of Sonoma County children and youth, which can be used to measure the community's progress in improving these child health issues.

The third theme is that of health disparities. Across the nation and in California, communities of color and low-income families and individuals suffer disproportionately from lack of access to health care and myriad health problems. Children are no strangers to the "health disparities" linked to socio-economic status and race/ethnicity. Of the issues raised in this Needs Assessment, this disparity is most evident in the areas of oral health and overweight/obesity. Finally, the Needs Assessment is a critical planning document for the hospitals, and a call to action for the community on children's health. The community is clearly moving forward, and much more is needed. Every individual and organization can find a place on *The Spectrum of Prevention* sections throughout this Needs Assessment and join the work to improve children's health in our community.

### **Summary of Key Findings**

**Children's Oral Health.** Dental disease is completely preventable and yet the most recent local survey found that almost half of Sonoma County's kindergartners and about 60% of its third graders have already experienced tooth decay, and over 16% of them have untreated decay.<sup>1</sup> For many children, poor oral health is a painful ongoing problem, increasing their chances of falling behind in school and social development, and suffering painful bouts of toothache and infection. Low-income children suffer the most tooth decay. With a focus on prevention and more access to care, all Sonoma County children can experience optimum oral health. Key findings on children's oral health include:

- Tooth decay is rampant among Sonoma County children.
- Untreated decay is a serious problem for Sonoma County children, especially for low-income children and Hispanic children.
- Sonoma County is making progress in expanding dental coverage for children.
- Children's insurance programs in Sonoma County do not provide equivalent coverage.
- Children who depend on public health insurance experience major barriers to receiving dental care.
- Children are not receiving urgent care for serious conditions such as Early Childhood Caries.
- Children are not receiving needed preventive dental visits.
- Children are not receiving protective dental sealants in sufficient numbers.

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<sup>1</sup> Sonoma Smile Survey, June 2009. p.2

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- Sonoma County children do not have access to fluoridated drinking water.
- Education for parents and children is essential to good oral health.

In response to this critical issue, and as a member of the Sonoma County Oral Health Access Coalition, St. Joseph Health – Sonoma County developed a focused oral health project that is targeting the reduction of tooth decay among the children ages 0-5 years seen in its dental clinics. This project, part of a broader St. Joseph Health learning community effort, is monitored and evaluated through a separate plan, and as such is not reported here in the Priority Initiatives section. Reports on the children’s oral health project are available annually on the St. Joseph Health – Sonoma County website: [www.stjosephhealth.org](http://www.stjosephhealth.org).

**Childhood Obesity, Nutrition and Fitness.** Childhood overweight is an urgent health crisis with no easy solution. Preventing childhood overweight is a collective responsibility requiring individual, family, community, health care, business, and governmental commitments to focus on this critical health issue. Access to affordable and healthy foods, local and safe parks and play spaces, addressing sedentary behavior and promoting physical fitness, all make a difference. Key findings on childhood obesity, nutrition and fitness include:

- Low-income children in Sonoma County are at highest risk for overweight and obesity.
- Higher rates of overweight and obesity are reported among Hispanic children ages 5-19.
- Sonoma County youth are not consuming the five daily recommended servings of fruits and vegetables.
- Many students are not meeting basic fitness standards.
- Anemia is prevalent among low-income children.
- Food insecurity is linked to overweight in Sonoma County.
- Infrastructure, policy and housing contribute to overweight and obesity in Sonoma County.
- Schools must be part of the solution to solving overweight and obesity.

**Youth Alcohol, Tobacco and Other Drug Use.** Alcohol, tobacco and other drug use among Sonoma County youth is a major public health concern. The dangers of such use are extensive, pervasive and lasting for teens and yet the social pressures for teens to drink and use drugs are enormous. Community factors such as permissive attitudes and behaviors, and access from commercial and social sources play a huge role in contributing to underage drinking and drug use. Key findings on youth alcohol, tobacco and other drug use include:

- Community norms and availability affect alcohol use in Sonoma County.
- Alcohol is the leading drug used by Sonoma County youth.
- Sonoma County students of alternative schools show significantly higher rates of alcohol, other drug and tobacco use than peers in comprehensive schools.
- More young people reported using marijuana than tobacco in the past 30 days.
- Tobacco use increases with age.
- Methamphetamine is a serious problem for some Sonoma County youth.
- Sonoma County teens continue to have high rates of binge drinking.
- Motor vehicle crashes are the leading cause of death among teenagers. Alcohol use is a major contributor.

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- Prescription drug abuse has been identified as a growing problem in Sonoma County.
- Sonoma County needs more AOD treatment programs for youth.

**DEFINITION OF THE COMMUNITY BENEFIT SERVICE AREA**

In 2005 Catholic Healthcare West, in partnership with Thomson Reuters, pioneered the nation's first standardized Community Need Index (CNI). The CNI identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations. The ability to pinpoint neighborhoods with significant barriers to health care access is an important advancement for public health advocates and care providers.

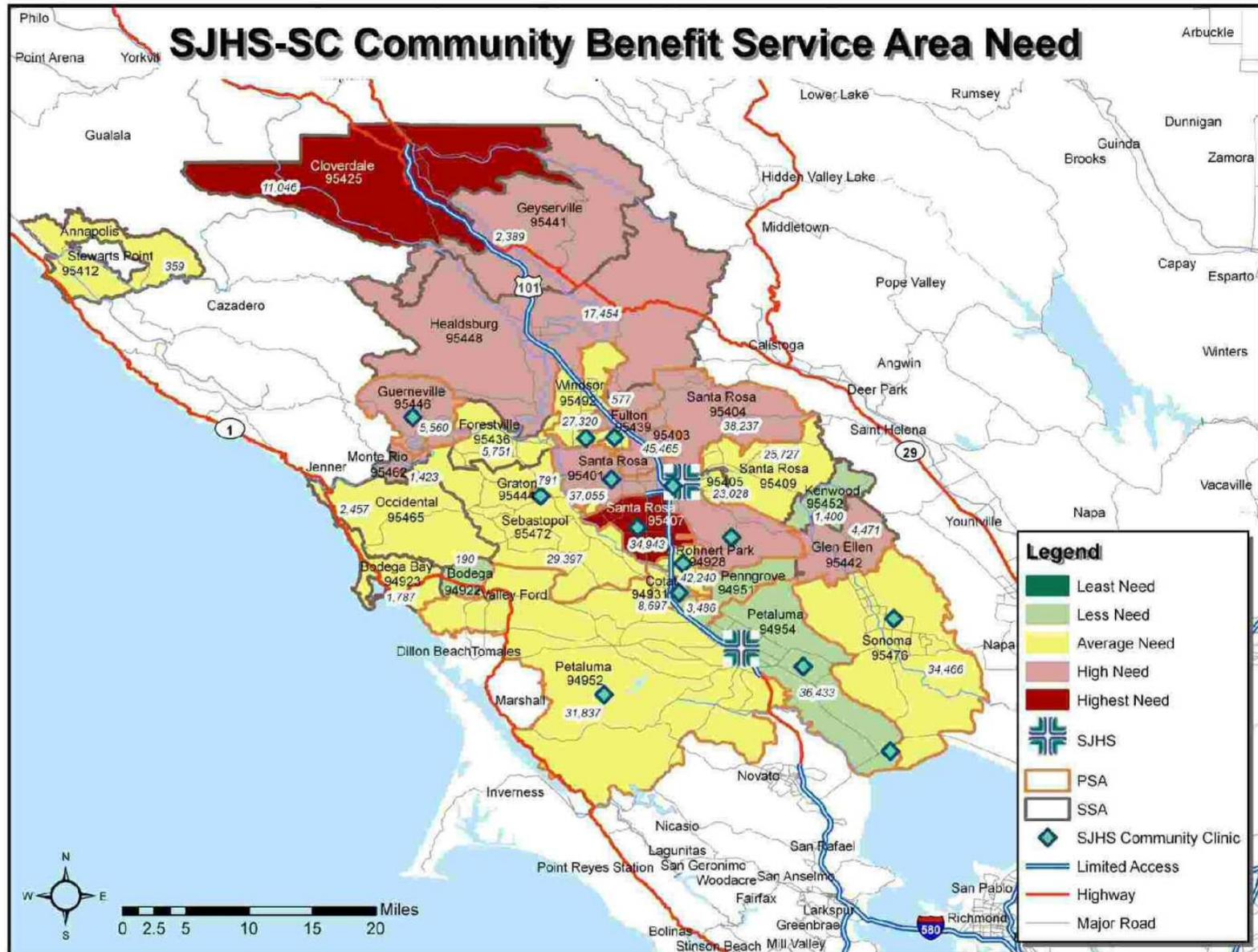
The CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers).

**Barriers**

1. Income: elder poverty, child poverty and single parent poverty
2. Culture: non Caucasian Limited English
3. Education: without HS diploma
4. Insurance: unemployed and uninsured
5. Housing: renting percentage

CNI demonstrated need at the zip code level where each zip is assigned a score from 1 (low need) to 5 (high need) for each barrier. For barriers with more than one measure, the average is used as the barrier score. Once each zip code is assigned a score from 1 to 5 for each of the five barriers, the average score is calculated to yield the CNI.

While there are pockets of significant unmet need throughout the area, the map of the SJHS-SC Community Benefit service area notes the "hot spots" of need: northern Sonoma County, South Santa Rosa, unincorporated Sonoma Valley and Guerneville.



Source: Community Need Index, Catholic Healthcare West, 2011

Prepared by the St. Joseph Health System Community Health Department

**FY 12 – FY 14 Community Benefit Plan/Implementation Strategies**  
**FY 12 CB Priority Initiatives Accomplishments**

**Initiative Name:** *Youth Alcohol Abuse Prevention*

**Key Community Partners:** *Sonoma County Department of Health Services, Drug Abuse Alternative Center, Community Action Partnership, Healthy Communities Partnership, Sonoma County Prevention Partnership*

**Target Population:** *Children and adolescents*

**Goal:** *Reduce the rate of Emergency Room visits due to alcohol abuse*

**Scope:** *Children and adolescents ages 10-17 living in low-income neighborhoods in Sonoma County*

**How will we measure success?:** *Rate of Emergency Department visits in Petaluma Valley Hospital due to alcohol abuse*

**Three Year Target:** *10% reduction. In Fiscal Year 2012, 28 of the 1,062 (2.5%) children and adolescents ages 10-17 years of age seen in Petaluma Valley Hospital's Emergency Department presented with alcohol-related problems.*

**Strategy 1:** *Increase self-esteem through youth programs*

**Strategy Measure 1:** *90% of 137 adolescent girls participating in Circle of Sisters after-school program reported a high degree of self-esteem at the program's close, exceeding the target of 75%. This was achieved through the implementation of 38 modules from the Circle of Sisters curriculum, along with the mentoring of 57 children and youth through Circle of Sisters and Neighborhood Care Staff leadership development activities. As a result of this mentoring, 145 young people provided community service in the low-income neighborhoods where they reside and to vulnerable populations, such as low-income seniors. In addition 35 youth received in leadership development training.*

**Strategy 2:** *Provide parent support through education and social support*

**Strategy Measure 2:** *A remarkable 100% of parents surveyed whose children participated in Circle of Sisters reported a high degree of self-efficacy at the program's end, exceeding the target of 80%. The activities carried out that contributed to this outcome include Parent University, implemented with partners such as Community Action Partnership. In addition 109 parents received mentoring through the Circle of Sisters and Neighborhood Care Staff programs. 70 referrals were made by Community Benefit Department staff to community-based parent support services.*

**Strategy 3:** *Advocate for environmental and policy change*

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**Strategy Measure 3:** *Advocacy results are intended to result in the changing of marketing policies or practices among local advocacy outlets. Due to the nature of achieving these types of community-level changes, this outcome was not yet achieved in Fiscal Year 2012. However, foundational work was carried out. Hospital management and staff participated, along with 53 community stakeholders, in community prevention coalitions, reactivating the hospital's participation in the countywide Prevention Partnership led by the Sonoma County Department of Health Service's Public Health Division. Community stakeholders were educated about the environmental and policy factors influencing youth alcohol use through 31 informational sessions conducted in low-income neighborhoods. 50 youth and adult residents from these neighborhoods were engaged in initial activities to develop a campaign that addresses the negative alcohol marketing practices among some local merchants.*

**Strategy 4:** *Foment trusting relationships between youth and adults*

**Strategy Measure 4:** *93% of the 137 adolescent girls surveyed who participated in Circle of Sisters during Fiscal Year 2012 reported having trusting relationships with adults, exceeding the target of 75%.*

**Strategy 5:** *Identify and refer at-risk youth and their families for appropriate services.*

**Strategy Measure 5:** *Working together across programs in the Community Benefit Department, 100% of the 163 youth and families identified as at-risk for alcohol abuse were referred to community-based services, including parent support, youth and adult mentoring, treatment, and others. 71 members of the Community Benefit team participated in a refresher in-service on youth alcohol abuse, conducted by the Drug Abuse Alternative Center. Members of the team from various departments collaborated in the formulation of an updated brief local resource list to be readily available and used by all Community Benefit program and clinics staff.*

**FY 12 Accomplishments:**

*Families play a critical role in preventing youth alcohol (American Academy of Pediatrics, 2010), making the strengthening of trusting relationships between young people and the adults in their lives essential in supporting healthy choices. In FY 12, SJH-SC's Circle of Sisters found that 93% of the program's participants reported having trusting relationships with adults; exceeding the year's target of 75%. A remarkable 100% of the participants' parents who received support and responded to the survey reported a high degree of self efficacy. These achievements are an important part of the foundation of internal and external assets that support a young person's decision to not use alcohol. Beyond that individual level care, collective efforts with community partners that addressed not only increased awareness and education about the risks associated with alcohol use among young people and support resources available, but also addressing the social norms and other environmental factors influencing this use contributed to a rate of 2.5% of alcohol-related Emergency Department visits for children and youth ages 10-17 at Petaluma Valley Hospital.*

*The hospital is a leading member of Petaluma's Coalition to Prevent Alcohol, Tobacco and Other Drug Problems, which is currently implementing a federal Drug Free Community grant. The*

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hospital continues to be an active member of the Coalition's coordinating agency, the Healthy Communities Consortium. In addition, the manager of its Emergency Department is not only an active member of the Coalition's Speaker's Bureau, participates in advocacy campaigns, and serves as Coalition Chair. Analysis of this year's outcome, as well as the conditions and circumstances surrounding the visits that did occur, is currently underway in order to properly direct future efforts that will continue this positive trend.

**Initiative Name: Children's Healthy Weight**

**Key Community Partners:** Health Action of Sonoma County, Community Activity & Nutrition Coalition, iGROW, iWALK, Redwood Community Health Coalition, School Districts throughout Sonoma County, Boys & Girls Clubs, County of Sonoma Board of Supervisors and Health Department, Redwood Empire Food Bank, Northern California Center for Well-Being, Petaluma Bounty, North County Wellness District



**Target Population:** Low-income and racial/ethnic minority children and youth

**Goal:** Improve the weight status of children in low socio-economic status (SES) neighborhoods

**Scope:** Children and adolescents ages 2- 17 in low-income neighborhoods in Sonoma County comprising SJH-SC's Community Benefit Service Area.

**How will we measure success?:** % of improvement in weight status

**Three Year Target:** 10% improvement. During FY 12 it became clear that the County of Sonoma was limited in its capacity to provide accurate and timely data to monitor this outcome. Through the strength of the collaborative partnership between SJH-SC and the County's Department of Health Services, data was obtained; although it was not entirely comparable to the baseline. The data did show an improvement in the weight status of children ages 2-4 years (1% reduction in overweight/obesity), and a reversal of the trend of significantly negative trending among children ages 5 – 11 (.1% increase overweight/obesity) and youth ages 12 – 17 (.2% increase overweight/obesity). Conversations among the partners yielded a commitment for future monitoring from the Redwood Community Health Coalition to share data on the weight status of the children seen at the community clinics located in the hospital's Community Benefit Service Area throughout Sonoma County. The hospital's Healthy for Life program, however, did exceed the three-year target of a 10% improvement; achieving a countywide result of 14% improvement in the weight status of participating children.

**Strategy 1:** *Increase access to affordable healthy foods*

**Strategy Measure 1:** The Promotores de Salud enrolled 149 new clients in CalFresh and 1,834 individuals were referred to food assistance programs by SJH-SC's Community Benefit programs and clinics during FY 12. In addition, the Neighborhood Care Staff supported 35 low-income residents in completing construction of Sunrise Community Garden, with the support of community partner agencies that include Petaluma Bounty, Leadership Petaluma, and the City of Petaluma.

**Strategy 2:** *Provide mentoring to children and families to support healthy lifestyle choices*

**Strategy Measure 2:** Of the 330 children and adults mentored through Promotores de Salud, Healthy for Life and Circle of Sisters 74% of respondents to pre/post tests reported behavior change, exceeding a target of 68%.

**Strategy 3:** *Build community capacity to support healthy eating and physical activity*

**Strategy Measure 3:** The hospital's Community Benefit programs supported the capacity building of 7 new community partner agencies to implement program activities that support healthy eating and physical activity. Healthy for Life provided new equipment and teacher/staff training in SPARK physical education curriculum for 7 schools and 2 Boys & Girls Clubs; and 38 new Spanish-speaking community volunteers were trained as trainers for the evidence-based Your Heart, Your Life program, an increase of 29% over last fiscal year (11).

**Strategy 4:** *Engage community members in environmental and policy change*

**Strategy Measure 4:** Nearly 500 (494) residents in low-income neighborhoods were engaged by the Neighborhood Care Staff in activities targeting environmental and policy changes that support healthy food and activity habits, including leadership training, outreach, community education, and relationship building with local officials. The hospital's Healthy Communities team participated in 194 community activities organized by local and countywide coalition efforts, including iWALK, iGROW, Health Action, and the Community Activity & Nutrition Coalition. With the support of the Neighborhood Care Staff and its leadership training program, Agents of Change Training in our Neighborhoods, 17 community-driven advocacy action plans were developed in the hospital's Community Benefit Service Area. Follow-up in subsequent years will reveal the effect these plans have on local environments and policies.

**Strategy 5:** *Provide community education on nutrition and physical activity*

**Strategy Measure 5:** Nearly 10,000 (9,911) children, youth, and adults in low-income neighborhoods participated in health and nutrition education through the Circle of Sisters, Promotores de Salud, and Healthy for Life programs. Over 60 community partners - including individual volunteers, neighborhood groups, schools and public and private non-profit agencies - supported the hospital's efforts by providing education to the residents served by its Community Benefit programs.

**Strategy 6:** *Provide nutrition counseling to children and their families*

**FY 2012 Community Benefit Report**

**Strategy Measure 6:** The hospital's Mobile Health Clinic identified 208 patients at risk for developing diabetes, and providing counseling to 125 of these, who consented to participate in the sessions. Of the Mobile Health Clinic and House Calls patients with diabetes, 44% have an HgbA1C status equal to or less than 9%. This compares to 48% among all the patients seen by the Redwood Community Health Coalition, a local coalition of community clinics of which the Mobile Health Clinic is a member; and to 47% for the California Primary Care Association.

**FY 12 Accomplishments:**

SJH-SC's Community Benefit team continues its strong focus on helping communities and families achieve a **healthy weight** for their children. Over 300 children, youth, and adults received ongoing mentoring on healthy eating and physical activity, and nearly 10,000 participated in community education sessions. The Neighborhood Care Staff provided leadership training to 11 residents from low-income residents, and nearly 500 were engaged in environmental and policy change efforts in their communities that support healthy living. Over 1,800 individuals were referred to food assistance programs, and over 200 were identified as at-risk for developing diabetes; over half of whom participated in nutrition counseling.

**Initiative Name: Senior Care Management**

**Key Community Partners:** *Sonoma County Adult Protective Services, Catholic Charities, In-Home Support Services, Petaluma People Services Center, Redwood Community Health Coalition, Sonoma County Area Agency on Aging, Redwood Empire Food Bank*



**Target Population:** *Low-income and homebound seniors*

**Goal:** *Decrease rate of hospital readmission for Congestive Heart Failure (CHF)*

**Scope:** *Individuals ages 65 years and older living in low-income neighborhoods in Sonoma County identified as the SJH-SC Community Benefit Service Area*

**How will we measure success?:** *% of hospital readmissions for CHF*

**Three Year Target:** *3% reduction.* With a baseline of 14% at the beginning of the fiscal year, Petaluma Valley Hospital achieved significant improvement; ending the year with a rate of 7.55% hospital readmissions for the 53 individuals ages 65 and above seen at the hospital for

CHF, as compared to an expected rate of 21.41%. This data show a reduction in the first year of 6.45%, already exceeding the three-year target by more than double.

**Strategy 1:** *Reduce social isolation*

**Strategy Measure 1:** In order to identify and engage isolated seniors living in the low-income neighborhoods they serve, the Neighborhood Care Staff and Circle of Sisters staff collaborated with the Area Agency on Aging to conduct interviews and focus groups with 33 low-income seniors for inclusion in the Agency's updated needs assessment. These program teams also engaged 65 seniors from low-income neighborhoods in inter-generational community activities, such as community gardening.

**Strategy 2:** *Reduce risk for chronic disease*

**Strategy Measure 2:** Despite an effort to increase the number of seniors participating in the Promotores de Salud nutrition education classes over the previous year, the number of participants held steady at 5; of whom 60% reporting a nutrition behavior change after completing the education.

**Strategy 3:** *Provide comprehensive chronic disease management*

**Strategy Measure 3:** The number of patients receiving comprehensive care management increased from 94 during FY11 to 109 during FY 12. Only 4 of House Calls patients required hospitalization due to CHF during FY 12, during which the target was to establish a system for capturing and monitoring this data in the programs Electronic Medical Records.

**FY 12 Accomplishments:**

SJH-SC's Healthy Communities programs increased their engagement with the long-standing efforts of the House Calls program to improve the health and well-being of **frail, low-income seniors**. The Circle of Sisters and Neighborhood Care Staff teams reduced the social isolation of 343 seniors residing in low-income neighborhoods through participation in inter-generational community activities and in the Area Agency on Aging's 5-year needs assessment and planning process through focus groups and individual surveys. House Calls provided integral in-home care and intensive care management to over 100 frail and homebound seniors. As part of a coordinated continuum of care within the hospital that includes case management, hospice, and other departments, as well as community partners, the Community Benefit team contributed to a significant reduction in hospital readmissions for congestive heart failure among low-income seniors. Petaluma Valley Hospital achieved significant improvement; ending the year with a rate of 7.55% hospital readmissions for the 53 individuals ages 65 and above seen at the hospital for CHF, as compared to an expected rate of 21.41%

## **Other Community Benefit Initiatives**

**Initiative:** *Children's Oral Health*

**Key Community Partner:** *Sonoma County Oral Health Access Coalition*

**Target Population:** *Low-income children ages 0 -5 in the hospital's Community Benefit Service Area*

**Goal:** *Reduce % of children ages 0-5 receiving dental care at SJH-SC's Dental Clinic and Mobile Dental Clinic with Class II and Class III (urgent, emergent) dental decay.*

**How will we measure success?:** *% of children ages 0-5 receiving dental care at SJH-SC's Dental Clinic and Mobile Dental Clinic with Class II and Class III (urgent, emergent) dental decay, as measured by Dentrrix software.*

**Three Year Target:** *28% - The California average for Class II and Class III dental decay among this population is 33%. The hospital's oral health clinics achieved a rate of 31% (696 of 2,205) in FY 12.*

### **FY 12 Accomplishments:**

The hospital's oral health clinics helped to build community capacity to improve children's oral health by training and supporting local WIC providers at 5 sites to incorporate oral health education during provision of their nutritional services. In addition, the clinics continued implementation of its Mommy & Me program, sustaining an impressive rate of only 2% decay among participating infants and children; both first time and returning participants. This compares to a rate of 31% among their patients who do not participate in Mommy & Me.

## Community Benefit Investment FY 2012

**FY 12 COMMUNITY BENEFIT INVESTMENT  
ST. JOSEPH HEALTH, PETALUMA VALLEY**

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services <sup>2</sup>	FY 12 Net Benefit
<b>Medical Care Services for Vulnerable<sup>3</sup> Populations</b>	Financial Assistance Program (FAP) (Charity Care-at cost)	\$1,374,108
	Unpaid cost of Medicaid <sup>4</sup>	\$3,661,701
	Unpaid cost of other means-tested government programs	\$774,728
<b>Other benefits for Vulnerable Populations</b>	Community Benefit Operations	\$0
	Community Health Improvements Services	\$92,749
	Cash and In-kind Contributions for Community Benefit	\$38,309
	Community Building	\$0
	Subsidized Health Services	\$3,500
<b>Total Community Benefit for the Vulnerable</b>		<b>\$5,945,095</b>
<b>Other benefits for the Broader Community</b>	Community Benefit Operations	\$0
	Community Health Improvements Services	\$4,039
	Cash and In-kind Contributions for Community Benefit	\$12,217
	Community Building	\$0
	Subsidized Health Services	\$0
<b>Total Community Benefit for the Broader Community</b>		<b>\$16,256</b>
<b>Health Professions Education, Training and Health Research</b>	Health Professions Education, Training & Health Research	\$0
<b>TOTAL COMMUNITY BENEFIT (excluding Medicare)</b>		<b>\$5,961,351</b>
<b>Medical Care Services for the Broader Community</b>	Unpaid cost of Medicare <sup>4</sup> (not included in CB total)	\$7,419,484
<b>TOTAL COMMUNITY BENEFIT (including Medicare)</b>		<b>\$13,380,835</b>

<sup>2</sup> Catholic Health Association-USA Community Benefit Content Categories, including Community Building.

<sup>3</sup> CA SB697: "Vulnerable Populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medicaid, Medicare, California Children's Services Program, or county indigent programs. For SJH, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.

<sup>4</sup> Accounts for Hospital Fee. The pledge/grant (separate from the quality assurance fee) is reported in Cash and In-kind Contributions for other vulnerable populations.

<sup>4</sup> Unpaid cost of Medicare is calculated using our cost accounting system. In Schedule H, we use the Medicare cost report.

## **Telling Our Community Benefit Story: Non-Financial<sup>5</sup> Summary of Accomplishments**

Petaluma Valley Hospital continued its long-standing partnership with the Petaluma Art Counsel by holding an ongoing rotating art show within the hospital facility, demonstrating its relationship to and grounding in the local community. The hospital also continued serving as a community resource for local youth through its Junior Volunteer program. During FY 12, 2 Emergency Department volunteers who began their community service with the hospital as 9<sup>th</sup> graders left to medical center. Other youth volunteers are being mentored in both medicine and nursing. Hospital leadership also provides service to community partners as Board members and volunteers, including the Petaluma Health Center, Rotary, and the Healthy Communities Consortium. The Emergency Department Manager of the hospital accompanied other Health Center Board members and Center employees to Washington, DC to advocate for healthcare reform and increased access to care for the under and uninsured. Petaluma Valley Hospital also partners with the Petaluma Chamber of Commerce, hosting its Ambassador Committee and serving as lead for Health Services Day for the Petaluma Leadership class and for the high school students participating in Tomorrow's Leaders Today.

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<sup>5</sup> Non-financial summary of accomplishments are referred to in SB 697 as non-quantifiable benefits.



St. Joseph Health (SJH) is an integrated healthcare delivery system providing a broad range of medical services. The system is organized into three regions--Northern California, Southern California, and West Texas/Eastern New Mexico - and consists of 14 acute care hospitals, as well as home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician organizations. The ministries that comprise SJH offer a wide variety of services within each of the three regions. From well-established acute care hospitals to clinics in non-traditional settings like school rooms, SJH is establishing a "continuum of care," that is, a system that links and coordinates an entire spectrum of health services.