



**St. Joseph Health System of Sonoma County  
Santa Rosa Memorial Hospital  
Petaluma Valley Hospital**

**FY 09 – FY 11 Community Benefit Plan**

**St. Joseph Health System – Sonoma County  
Community Benefit Plan  
FY 2009- FY 2011**

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## Executive Summary

St. Joseph Health System - Sonoma County (SJHS-SC) serves all of Sonoma County, the northernmost of the nine greater San Francisco Bay Area counties. The land area is 1,576 square miles, with 291 persons per square mile. Santa Rosa Memorial Hospital is situated in a Primary Metropolitan Statistical Area (PMSA), while most of the rest of Sonoma County is in areas defined as rural. Most of these rural areas have been federally classified as a Medically Underserved Population (MUP) based on low-income population factors and also as Primary Care Health Professional Shortage Areas (HPSA). As a designated regional trauma center, Santa Rosa Memorial Hospital draws patients from all over Sonoma County as well as the surrounding counties and region. In 2007, the population of Sonoma County was approximately 483,728, with an estimated increase of 12,082 projected by 2012. In terms of ethnic groups, 68% of the population in 2007 was White, projected to decline to 64% in 2012. Latinos comprise 22% of the population, projected to increase to 25% within 5 years.

As a member of the Sonoma County Health Alliance, SJHS-SC worked together with Sutter, Kaiser Permanente and the Sonoma County Health Department to complete a needs assessment that includes local, regional, and national surveillance and epidemiological data in the areas of oral health, substance abuse and obesity and nutrition. Secondary level quantitative data includes large scale state, county and other regional level surveys, census level, and other demographic data. Major findings of the needs and asset assessments include the following:

- Tooth decay, both treated and untreated is rampant in children; Latino children are at greater risk for treated and untreated decay than other children.
- Overweight and obesity are increasing in Sonoma County, with low-income children at higher risk than others.
- Sonoma County children are not consuming daily recommended five servings of fruits and vegetables.
- Alcohol is the leading drug of choice for Sonoma County youth and many youth report exceeding state averages for high risk behaviors.
- Drug use by pregnant women in Sonoma County is a major problem on par with or greater than the national average.
- Alcohol is the most frequently used substance by pregnant women in Sonoma County.

In response to both the findings of this needs assessment, as well as input from key community stakeholders, SJHS-SC selected three key initiatives through which it will focus its community benefit activities: Children's Oral Health, Childhood Obesity & Overweight and Youth & Peri-Natal Substance abuse. These initiatives will focus on the primary populations with Disproportionate Unmet Health Need (DUHN) served by SJHS-SC, those being undocumented immigrants, migrant workers, low-income individuals and families, Latino families, youth and seniors. The goals selected for each initiative are based on local collaborative planning efforts, and will engage the breadth of SJHS-SC's Community Benefit programs and clinics.

## A. Community Profile

The Community Benefit Department of St. Joseph Health System - Sonoma County (SJHS-SC) is a county-wide department with primary offices in the Southwest quadrant of Santa Rosa (Sonoma County government seat). Sonoma County is the northernmost of the nine greater San Francisco Bay Area counties, is bordered on the north by Mendocino County, on the east by Lake and Napa counties, on the south by Marin County and San Pablo Bay, and on the west by the Pacific Ocean. The land area is 1,576 square miles, with 291 persons per square mile. Santa Rosa Memorial Hospital is situated in a Metropolitan Statistical Area (PMSA), while most of the rest of Sonoma County is in areas defined as rural. Most of these rural areas have been federally classified as a Medically Underserved Population (MUP) based on low-income population factors and also as Primary Care Health Professional Shortage Areas (HPSA). As a designated regional trauma center, Santa Rosa Memorial Hospital draws patients from all over Sonoma County as well as the surrounding counties and region.

SJHS-SC's primary service area consists of the county's nine incorporated cities. It stretches from Cloverdale in the north to Petaluma in the south and is bounded by multiple secondary services areas including parts of Lake and Napa counties. In 2007, the population of Sonoma County was approximately 483,728, with an estimated increase of 12,082 projected by 2012. In terms of ethnic groups, 68% of the population in 2007 was White, projected to decline to 64% in 2012. Latinos comprise 22% of the population, projected to increase to 25% within 5 years. Other statistics include:

- Persons aged 65 and over account for 12% of total population. From 2000 to 2010, people 85 and older will be the fastest growing population in Sonoma County, increasing by 35.5% to 11,161. The population group from 65 to 84 will grow by 28.0% to over 63,000<sup>1</sup>
- The median age in the county, 38 years, is older than the California median age of 33.<sup>2</sup> The median age is expected to increase to 39 by 2020, compared to the state's median age of 33.<sup>3</sup>
- Age group 5-year growth rates – 2007 to 2012 include the following trends:
  - Pediatric group (0 to 17) shows slight 2% decline
  - Young Family/Childbearing shows some growth (ages 18 to 34): 4%
  - 35 to 49 aged individuals shows 6% decline
  - The 50+ age group only segment with significant growth: 15%<sup>4</sup>
- The ethnic composition of the county is less diverse than the state as a whole. However, it is gradually changing: by 2020, Whites will represent 73% of the total population, down from 81% in 2000.<sup>5</sup>

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<sup>1</sup> Sonoma County 2005 – SB-697 Needs Assessment.

<sup>2</sup> Health Profile 2000, California Department of Finance Demographic Unit, Population Projections, <http://factfinder.census.gov>

<sup>3</sup> California Department of Finance Demographic Unit, Population Projections.

<sup>4</sup> Sonoma County 2005 – SB-697 Needs Assessment.

<sup>5</sup> State of California, Department of Finance, *Projections with Race/Ethnic Detail*. Sacramento,

- The Latino population is expected to be the fastest growing ethnic group in the county and is expected to increase 300% from 80,742 to 250,692 from 2000 to 2050.<sup>6</sup>
- Approximately 71,412 students were enrolled in Sonoma County public schools in 2006-2007.<sup>7</sup> 22% of all students are English language learners, up from 2% in 1998.
- There are over 27,000 migrants, seasonal farm workers and household members working in Sonoma County in 2000, primarily in vineyards across the county.
- In 2000, 6.9% of families with children under the age of 18 had incomes below the federal poverty level. This compares to 18.5 % of families with a single female as the head of household. ([www.factfinder.census.gov](http://www.factfinder.census.gov) )
- The unemployment rate in Sonoma County has steadily increased in the past two years from 2.6% in 2000 to 5% in August 2003. This is due primarily to loss of work in the high technology sector and the service sector, which depends on tourism.
- The estimated number of people who experience a homeless episode in a given year in Sonoma County is 7,000 or about 2% of the population in the county.

*Community Benefit Service Area Description*

**Sonoma County Population Demographics: 2006 Update<sup>8</sup>**

<b>People Quick Facts</b>	<b>Sonoma County</b>	<b>CA.</b>
Population 2006 estimate	466,891	36,457,549
Population, 2000	458,614	33,871,648
Persons under 5 years old, %, 2006	6.2%	7.3%
Persons under 18 years old, %, 2006	22.9%	26.1%
Persons 65 years old and over, %, 2006	12.7%	10.8%
White persons, %, 2000 (a)	89.9%	76.9%
Black or African American persons, %, 2000 (a)	1.7%	6.7%
American Indian and Alaska Native persons, %, 2000 (a)	1.4%	1.2%
Asian persons, percent, 2000 (a)	4.0%	12.4%
Persons reporting some other race, percent, 2000 (a)	No data	No data

<sup>6</sup> California, December 1998.

<sup>6</sup> Health Profile 2000.

<sup>7</sup> California Department of Education Educational Demographics Unit, Enrollment in Public Schools

<sup>8</sup> U.S. Census

Persons reporting two or more races, percent, 2000	2.8%	2.4%
Persons of Hispanic or Latino origin, percent, 2000 (b)	22.0%	35.9%
White persons, not of Hispanic/Latino origin, percent, 2000	69.4%	43.1%
Homeownership rate, 2006	64.1%	54.9%
Median household money income, 2000	\$53, 645	\$49, 894
Persons below the poverty level	8.4%	13.2%

*(a) Includes persons reporting only one race. (b) Hispanics may be of any race (included in applicable race also)*

## **B. Community Needs & Assets Assessment Process**

Data used to support the findings that led to the priority health issues discussed in the needs assessment includes local, regional, and national surveillance and epidemiological data in the areas of oral health, substance abuse and obesity and nutrition. Secondary level quantitative data includes large scale state, county and other regional level surveys, census level, and other demographic data.

The Sonoma County Health Alliance was formed in 2000 with the goal of improving the health of Sonoma County through collaboration among the many health systems and providers in the County. The Alliance formed a Community Health Improvement subcommittee to foster community health improvement through collaborative planning, investment and action, with participation of Sutter, SJHS-SC, Kaiser Permanente, and the Sonoma County’s Health Department. Key experts in priority health areas were engaged and consulted on an ongoing basis and when the assessment was completed, invited to participate in discussions around further opportunities to collaborate on identified issues. Steering committee members interviewed and met with the groups and individuals who are listed in the Acknowledgements at the beginning of the Needs Assessment. A presentation was also made to the County Board of Supervisors, as well as Santa Rosa City Council members and the City Manager.

Major findings of the needs and asset assessments include the following:

- Potential actions on various levels to impact policies, programs, individual and organizational practices were identified.
- Tooth decay, both treated and untreated is rampant in children; Latino children are at greater risk for treated and untreated decay than other children.
- Overweight and obesity are increasing in Sonoma County, with low-income children at higher risk than others.
- Sonoma County children are not consuming daily recommended five servings of fruits and vegetables.
- Alcohol is the leading drug of choice for Sonoma County youth and many youth report exceeding state averages for high risk behaviors

- Drug use by pregnant women in Sonoma County is a major problem on par with or greater than the national average.
- Alcohol is the most frequently used substance by pregnant women in Sonoma County.

### C. Identification and Selection of DUHN Communities

DUHN Group	Key Community Needs	Key Community Assets
<p><b>Undocumented immigrants who do not speak English</b></p>	<p>Assistance accessing Immigration Resources</p> <p>Processes that facilitate access to medical care</p> <p>Wider outreach &amp; access to healthy food through more food pantries</p> <p>Affordable Housing for single parents/families with small children</p> <p>Process to facilitate housing availability for families with special needs</p>	<p><u>Media outlets</u> provide bilingual &amp; bicultural programming</p> <p><u>Local church</u> Holds Immigration forums.</p> <p><u>Healthcare Services</u> for undocumented &amp; uninsured.</p> <p><u>Food pantry</u> increases food security</p> <p><u>Community agencies</u> Employment, education, and family support programs</p> <p><u>Housing Assistance</u> addressing needs of undocumented and low income residents.</p>
<p><b>Low income families</b></p>	<p>Childhood Obesity prevention and awareness programs</p> <p>Community Redevelopment programs</p> <p>Economic Capacity-building</p>	<p><u>Affordable Housing</u> for low income families</p> <p><u>Action Groups</u> Resident led actions addressing quality of life concerns</p> <p><u>Food Security and Nutrition</u> Community Garden</p> <p><u>Medical services</u> for undocumented and uninsured</p> <p><u>Food pantries</u> increase food security</p> <p><u>Local church</u> Holds Immigration forums.</p>

		<p><u>Community agencies</u> Employment, education, and family support programs</p> <p><u>Coalitions</u> Addressing substance abuse and obesity; agencies &amp; residents together</p>
<b>Agricultural/Day workers</b>	<p>Permanent building that can house day labor employment resources</p> <p>Traffic Calming measures near day laborers center</p> <p>Affordable Housing</p> <p>Employment Resources</p> <p>Gang prevention measures</p> <p>Economic Rebuilding measures</p> <p>Alcohol and drug prevention measures</p>	<p><u>Churches</u> strong connections to community</p> <p><u>Filipino Community Center</u> provides resources to Filipino and broader community</p> <p><u>Local Fruit Stand</u> provides local produce</p> <p><u>Healdsburg Labor Center</u> Coordinates and provides employment opportunities</p> <p><u>Medical care</u> for undocumented and uninsured</p> <p><u>Community agencies</u> Employment, education, and family support programs</p>
<b>Latino community</b>	<p>Substance Abuse prevention.</p> <p>Family violence prevention</p> <p>Gang prevention measures</p> <p>Informational Immigration forums</p> <p>Health Needs</p> <p>Healthy and nutritious foods</p>	<p><u>DAAC (Drug Abuse Alternative Center)</u>: Resources to address substance abuse.</p> <p><u>Law Enforcement</u> Support residents addressing gang graffiti, traffic calming, crime prevention education</p> <p><u>Medical services</u> for undocumented and uninsured</p> <p><u>Food pantries</u> increase food security</p> <p><u>Local church</u> Holds Immigration forums</p> <p><u>Community agencies</u></p>

		<p>Employment, education (literacy, GED, language), health and family support programs</p> <p><u>Media outlets</u> provide bilingual and bicultural programming</p> <p><u>Transitional Housing</u> for people breaking out of homelessness,</p> <p><u>Emergency Shelters</u> for homeless women and children</p> <p><u>Fair Housing</u> information and tenant's rights.</p> <p><u>Coalitions</u> Addressing substance abuse and obesity; agencies &amp; residents together</p>
<b>Youth</b>	<p>Gang Prevention Measures</p> <p>Substance Abuse prevention</p> <p>Civic engagement opportunities</p> <p>Organized youth activities</p> <p>Higher education mentorship programs</p> <p>Student retention</p> <p>STD education and awareness</p> <p>Sports Teams and Resources</p> <p>Childhood Obesity Health education and awareness</p>	<p><u>Schools</u> ESL classes for parents, Spanish and English classes for youth</p> <p><u>After school programs for youth of all ages</u></p> <p><u>Community Clinics</u> Access to care for low income families</p> <p><u>DAAC (Drug Abuse Alternative Center)</u>: Resources to address substance abuse</p> <p><u>Local sports clubs</u> recreation opportunities for youth</p> <p><u>City Parks &amp; Recreation Dept's</u> recreation opportunities</p> <p><u>City libraries</u> Computers &amp; tutors for youth in need of homework help</p> <p><u>Head Start</u> Early childhood social skills and self esteem building</p>

	After School Programs Library	<u>Community agencies</u> opportunities for youth to build resiliency, work skills, tutoring  <u>Grassroots Groups</u> Leadership development and social engagement opportunities
<b>Seniors</b>	Affordable housing  Access to health services ( transportation )  Recreational Activities  Informational Forums  Home Care  Senior Center Resources	<u>Affordable Housing</u> Provides low income housing  <u>Medical Care</u> Clinic offers services for low income people, and also those who are undocumented and uninsured.  <u>Senior programs</u> Senior Center offers classes and courses.  <u>St. Joseph Home Care</u> Home care visits to residents.

#### D. Program Prioritization Process

The process used to prioritize and select key DUHN initiatives is documented in the Community Benefit policy manual which was created and finalized as part of the ASACB demonstration phase in 2005, and states the following criteria:

- Congruency and relevance to the mission and vision;
- Size of the issue;
- Seriousness of the issue;
- Community identification of issue as a priority;
- Community capacity to address the issue;
- Organizational capacity to address the issue;
- Feasibility of addressing the issue (time, financial...);
- Potential community and stakeholder engagement in efforts; and
- Potential for sustainability of efforts.

The processes to be employed in the selection are:

- Completion and analysis of 3-Year Community Needs Assessment;
- Yearly updating of data through monitoring of Community Benefit activities outcomes;
- Discussion and analysis of information by Community Benefit staff, initial brainstorm on areas of priority focus;

- Discussion and analysis of information by Community Benefit management team, and formulation of recommendations for selection of priority areas of focus;
- Discussion and analysis of data and recommendations by Community Benefit Committee, and selection of priority focus areas;  
Discussion of Community Benefit Committee selection and any discussion of any further recommendations; and
- Final approval of Community Benefit plan by Community Benefit Committee.

Involvement of Community Stakeholders and Residents is documented in the Community Benefit policy manual document: “Engagement of External Stakeholders.”

Consultation with members of the community regarding health and quality of life indicators is a key component of the three-year Sonoma County Community Needs Assessment. Individuals, groups and organizations are selected for participation based on clinical or policy expertise, familiarity with a variety of health and quality of life issues, representation of a population with Disproportionate Unmet Health Needs or a special familiarity with community needs based on neighborhood location, race, ethnicity or age.

Structured forums or focus groups are conducted in both Spanish and English in which participants review needs assessment data and analysis and respond to standard questions. These meetings are used to check the indicator and benchmark data for gaps, and to identify health and community issues of concern to the individuals and groups consulted.

Questions asked of community stakeholders include:

- What are the barriers to staying healthy in Sonoma County?
- What stands out for you among the indicators?
- What are your biggest health care issues?
- What helps people stay healthy?
- What are the unmet health needs?
- How should healthcare organizations respond to these needs?

Input is also received on an on-going basis into some Community Benefit activities through program-specific Community Advisory Boards.

Information regarding Community Benefit plans, activities and evaluations are disseminated through various means, which include:

- Posting of the Community Benefit plan, updates and reports on the hospital’s web site;
- Coverage of Community Benefit activities in local media;
- Presentations at community events; and
- Program-specific Community Advisory Boards.

## E. KEY DUHN INITIATIVES

**Initiative:** Children's Oral Health

**Activity/Program Name(s):**

1. Oral Health Services
2. Promotores de Salud
3. Neighborhood Care Staff
4. Advocacy

**Outcome Measure:** Proportion of children with dental decay

**DUHN Target group:** Low income, Immigrant, and Latino Children

**Activity 1: Content category of activity/program:** Community based Clinical Services

**Sub-content category of activity/program:** Dental Care

**Activity 2: Content category of activity/program:** Community Health Improvement Services

**Sub-content category of activity/program:** Individual health education for uninsured/under insured

**Activity 3: Content category of activity/program:** Community Health Improvement Services

**Sub-content category of activity/program:** Community Health Education

**Activity 4: Content category of activity/program:** Community Building Activities

**Sub-content category of activity/program:** Community Health Improvement Advocacy

**How does this initiative fit with the identified DUHN needs and assets?** The oral health of low-income, immigrant and Latino children is especially poor in Sonoma County. A combination of advocacy, prevention, and provider and patient education will result in better access to care, and policies that enable better oral health for the DUHN population.

**How many unduplicated persons do you target to serve in this initiative in FY 09? 2969**

Community Health -Dental Clinics will serve 596 children ages 0 - 4, 1626 children ages 5 -12, & 543 Teens ages 13 -19

Healthy Communities programs will serve 200 individuals through community meetings and local action plans

Advocacy programs will serve 4 stakeholders through stakeholder meetings and tours

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
<p>Reduce proportion of children, with untreated dental decay by 9%</p> <p>Local Data Sources:                      *Give Kids a Smile Day                      *Mighty Mouth Participants                      *Fluoridation Information</p>	<p>1. Influence Policy &amp; Legislation</p> <p>2. Mobilize Neighborhoods &amp; Communities</p> <p>3. Educate Providers</p>	<p><i>Strategy 1 – Measure 1:</i> By 2011, community membership of SCOHAC fluoridation committee will increase by 25%.(CH)</p> <p><i>Strategy 1-Measure 2-</i>Children’s Oral Health will be cited as priority issue at least 15 times in local media outlets by at least 5 different legislators or persons of influence. (CH)</p> <p><i>Strategy 2 – Measure 1:</i> Residents in 3 DUHN communities will engage in dialogue with representatives of the Oral Health Access Coalition (HC)</p> <p><i>Strategy 2 – Measure 2:</i> Goals for improving children’s oral health are identified by residents in 2 DUHN communities.(HC)</p> <p><i>Strategy 2 – Measure 3:</i> A minimum of 10 advocacy tours and efforts will be conducted with stakeholders. (AD)</p> <p><i>Strategy 3 – Measure 1:</i> By 2011, 85% of daycare providers and preschool providers will report increased knowledge of oral health resources and education. (CH)</p> <p><i>Strategy 3 – Measure 2:</i> By 2011, oral health education will be provided 5 times to pediatric hospitalists, pediatricians, ER physicians and family practitioners. (CH)</p> <p><i>Strategy 3 – Measure 3:</i> Oral Health Status for children in Sonoma County will be re-evaluated in 3 years based on</p>

	<p>4. Strengthen Individual Knowledge &amp; Skills</p> <p>5. Promote Community Education</p>	<p>assessment data (AD)</p> <p><i>Strategy 4 – Measure 1:</i> There will be a 10% increase in oral health visits for children 0-5 at free-standing and mobile dental clinics. (CH)</p> <p><i>Strategy 5 – Measure 1:</i> there will be a 20% increase in 1 year olds receiving first dental exams. (CH)</p>
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## E. KEY DUHN INITIATIVES

**Initiative:** Youth & Peri-Natal Substance Abuse

- Activity/Program Name(s):**
1. Oral Health Services
  2. Promotores de Salud
  3. Mobile Health Clinic
  4. Neighborhood Care Staff
  5. Circle of Sisters
  6. Quality of Life Initiative
  7. Advocacy
  8. Community Health
  9. Healthy Communities

**DUHN Target group:** Low income, Immigrant, and Latino youth and pregnant women

**Activity 1: Content category of activity/program:** Community based Clinical Services

**Sub-content category of activity/program:** Dental Care

**Activity 2: Content category of activity/program:** Community Health Improvement Services

**Sub-content category of activity/program:** Individual health education for uninsured/under insured

**Activity 3: Content category of activity/program:** Community based Clinical Services

**Sub-content category of activity/program:** Primary Care

**Activity 4:** Community Health Improvement Services

**Sub-content category of activity/program:** Community Health Education

**Activity 5: Content category of activity/program:** Community Health Improvement Services

**Sub-content category of activity/program:** Support Groups

**Activity 6: Content category of activity/program:** Community Health Improvement Services

**Sub-content category of activity/program:** Community Health Education

**Activity 7: Community Building Activities**

**Sub-content category of activity/program:** Community Health Improvement Advocacy

**How does this initiative fit with the identified DUHN needs and assets?** A combination of policy, action plans, individual and partner education activities will assist in reducing substance abuse rates in the DUHN target group

**How many unduplicated persons do you target to serve in this initiative in FY 09?** 14,314

Community Health-Mobile Health Clinic will serve 1293 unduplicated patients & Promotores de Salud will serve 3228 clients with outreach and education and enroll 1127 children in insurance.

Healthy Communities-8500 (new youth engaged in Petaluma Prevention Coalition, 50 Latino families advocating in Sonoma, new partner organizations, mental health provider education and Cinco de Mayo)

Advocacy-Circle of Sisters will serve 160 children/youth per year and 6 staff in FY09 and 4 staff members in FY10-11

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
<p>Reduce substance abuse to protect the health, safety, and quality of life for all, especially children.</p> <p>Local Data Sources            *Healthy Kids Survey            *CA Dept of Alcohol and Drug Programs            *Drug Free Babies Study            *Vega Study            *Sonoma Cty AODS</p>	<p>1. Influence Policy &amp; Legislation</p> <p>2. Mobilize Neighborhoods &amp; Communities</p>	<p><i>Strategy 1 – Measure 1</i> Through advocacy and policy change, limit the # of new liquor licenses granted to vendors in neighborhoods that are already impacted by an excess # of alcohol outlets. (AD)</p> <p><i>Strategy 2 – Measure 1:</i> 4 youth leaders will be active members of the Petaluma Coalition to Prevent Under-age and High Risk Drinking (HC)</p> <p><i>Strategy 2 – Measure 2:</i> 200 youth in DUHN communities will engage in activities that promote abstaining from alcohol and drug use (Strategy 3, 6) (HC)</p>





## E. KEY DUHN INITIATIVES

**Initiative:** Childhood Obesity

- Activity/Program Name(s):**
1. Oral Health Services
  2. Promotores de Salud
  4. Mobile Health Clinic
  5. Neighborhood Care Staff
  6. Circle of Sisters
  7. Quality of Life Initiative
  8. Advocacy
  9. Community Health
  10. Healthy Communities

**Outcome Measure (if available):** proportion of children and adolescents who are overweight or obese

**DUHN Target group:** Low Income, Immigrant and Latino children

**Activity 1: Content category of activity/program:** Community based Clinical Services

**Sub-content category of activity/program:** Dental Care

**Activity 2: Content category of activity/program:** Community Health Improvement Services

**Sub-content category of activity/program:** Individual health education for uninsured/under insured

**Activity 3: Content category of activity/program:** Community based Clinical Services

**Sub-content category of activity/program:** Primary Care

**Activity 4:** Community Health Improvement Services

**Sub-content category of activity/program:** Community Health Education

**Activity 5: Content category of activity/program:** Community Health Improvement Services

**Sub-content category of activity/program:** Support Groups

**Activity 6: Content category of activity/program:** Community Health Improvement Services

**Sub-content category of activity/program:** Community Health Education

**Activity 7:** Community Building Activities

**Sub-content category of activity/program:** Community Health Improvement Advocacy

**How does this initiative fit with the identified DUHN needs and assets?**

A combination of collaborative action plans to increase access for DUHN populations to healthy foods and exercise, education around nutrition and overweight.

**How many unduplicated persons do you target to serve in this initiative in FY 09?** 4,560

Community Health-Mobile Health Clinic will serve 340 children

Healthy Communities-Action plans, Partnership activities will reach 4,000 individuals

Advocacy-Circle of Sisters will serve 220 children/youth per year

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
<p>Reduce the proportion of children and adolescents who are overweight or obese by 5%</p> <p>Local Data Sources            *Pediatric Nutrition Surveillance Survey            *CA Health Interview Survey            *CA Physical Fitness Report</p>	<p>1. Influence Policy &amp; Legislation</p> <p>2. Mobilize Neighborhoods &amp; Communities</p>	<p><i>Strategy 1 – Measure 1:</i> 4 local governments in Sonoma County will be engaged in dialogue and action that support social &amp; physical environments conducive to healthy nutrition and physical activity choices. (HC)</p> <p><i>Strategy 2 – Measure 1:</i> 100 grassroots leaders will engage residents from their DUHN communities in action to increase neighborhood safety. (HC)</p> <p><i>Strategy 2 – Measure 2:</i> By 2011, there will be a 10% improvement in neighborhood safety indicators in DUHN</p>





Through the ASACB alignment process initiated in 2007, all community benefit programs underwent an assessment process to bring them into alignment with the 5 Core Principles. The following are examples of collaborative governance structures for each priority health initiative.

Oral Health

- Oral Health Coalition of Sonoma County
- SJHS-SC Neighborhood Care Staff's Resident Advisory Committee
- Mental Health Coalition of Sonoma County

- SJHS-SC Neighborhood Care Staff's Resident Advisory Committee
- Mental Health Coalition of Sonoma County

Childhood Obesity

- Community Activity & Nutrition Coalition (CAN-C)
- SJHS-SC Circle of Sisters Advisory Board

Youth and Perinatal Substance Abuse

- SJHS-SC Circle of Sisters Advisory Board
- Petaluma, Santa Rosa, and Sonoma Coalitions to Prevent Underage Drinking and Substance Abuse
- Mental Health Coalition of Sonoma County

As mentioned above, all community benefit programs underwent the ASACB assessment process in 2007. As a result, individualized multi year action plans, recommendations, and indicators were developed to bring programs into better alignment with the 5 Core Principles. Where appropriate, programs will continue to integrate recommendations around documentation and measuring outcome measures into work addressing the priority health initiatives.

**F. All Other Community Benefit Programs**

#	St. Joseph Community Health Clinics and Programs
1	<p><b>House Calls</b> (DUHN Population &amp; Broader Community)</p> <p><b>Program Description:</b> House Calls 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.</p> <p><b>Target Population:</b> Culturally diverse, immigrant, Latino, frail elderly seniors and adults with chronic diseases.</p>
2	<p><b>Home Sweet Home</b> (DUHN Population &amp; Broader Community)</p> <p><b>Program Description:</b> Home Sweet Home enables frail elders to continue residing in their homes by providing them with personal care services. This allows seniors to remain independent and improve their quality of life.</p> <p><b>Target Population:</b> Frail culturally diverse seniors who lack access to care givers due to lack of financial resources or lack of family support.</p>
3	<p><b>St. Joseph Mobile Health Clinic</b> (DUHN Population &amp; Broader Community)</p> <p><b>Program Description:</b> Mobile Primary care clinic serving culturally diverse low income persons of all ages who are without a regular physician or have difficulty accessing healthcare services. Travels to high need 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</p> <p><b>Target Population:</b> Low-income, recent immigrant, Latino, homeless, migrant and/or seasonal agricultural workers children and adults.</p>
4	<p><b>St. Joseph Dental Clinic</b> (DUHN Population &amp; Broader Community)</p> <p><b>Program Description:</b> St. Joseph's Dental Clinic serves children ages 0-16 providing basic, preventive, restorative, emergency and dental care and treatment with a strong focus on education. We provide emergency dental care to adults in the morning on a first come first served basis and have a special program for pregnant women. The clinic offers a special desensitization program for special needs patients with developmental disabilities.</p> <p><b>Target Population:</b> Recent Immigrants, low income Latino, children ages 0-16, special needs, pregnant women and emergency care to adults.</p>

**Cultivando La Salud / Cultivating Health-Mobile Dental Clinic (DUHN Population & Broader Community)**

5

**Program Description:** A mobile community dental clinic provides basic, preventive, restorative and emergency dental care. The clinic travels to high need sites throughout the county that include churches, schools, migrant camps and homeless shelters.

**Target Population:** Recent Immigrants, Latino, low income, seasonal agricultural and migrant workers, low-income families and special targeted efforts to serve children 0 to 5years of age, pregnant women and special needs patients.

**Promotores de Salud (Promoters of Health) (DUHN Population & Broader Community)**

6

**Program Description:** The Promotor(a) de Salud is a trusted community resource with specialized knowledge and experience, who bridges language and culture, provides health information, referrals, and access to services. The Promotores enroll uninsured families into publicly funded health plans; they conduct cooking and nutrition classes, outreach and enrollments in the MiVIA Electronic Personal Health Record (PHR) [www.mivia.org](http://www.mivia.org) . The MiVIA PHR is web based secure technology that houses personal health information that can travel with the client wherever they may go. It includes a photo ID emergency card.

**Target Population:** Recent Immigrants, low- income, Latino, individuals, families and communities.

**Children's Dental Disease Prevention Program/ Mighty Mouth Dental Health Education (DUHN Population & Broader Community)**

7

**Program Description:** A school-based children's dental program to help prevent dental disease and promote dental health by teaching children to brush, floss, eat nutritious snacks also includes weekly fluoride rinses and tooth brushing incentives. Includes school based dental screening, fluoride varnish treatments and dental sealants.

**Target Population:** Low income, culturally diverse pre-school and primary school children.

8

**Activity/Program Name:** *Neighborhood Care Staff (DUHN Population & Broader Community)*

**Program Description:** Mentoring grassroots leadership to address local community health and quality of life issues; supporting the developing of local action plans to improve safety and infrastructure, address substance abuse, engage residents in gang prevention efforts, and reduce obesity; and the development of partnerships and collaboration to implement those plans.

**Target Population:** Low-income, Latino and immigrant individuals and families, and other residents living in their communities

- 9 **Activity/Program Name:** Quality of Life Initiative: Community Mental Health (DUHN Population & Broader Community)

**Program Description:** Supporting the development of the Mental Health Coalition of Sonoma County, including outreach and partnership building, social marketing and community & provider education to reduce the stigma associated with mental illness, promoting a model of integrative health through education and a collaborative website, and strengthening the local system of care and ensuring the collaboration needed to sustain a safety net, using ASACB criteria to do so.

**Target Population:** Children, Adolescents and Adults who receive or may receive mental health services (preventive and treatment), and the Providers who serve them; with a particular focus on the Latino population.

- 10 **Activity/Program Name:** Agents of Change Training in Our Neighborhoods – A.C.T.I.O.N. (DUHN Population and Broader Population)

**Program Description:** Providing leadership and advocacy training to community leaders and grassroots groups in vulnerable neighborhoods, as well as to organizations and agencies that serve them.

**Target Population:** Low-income, Latino and immigrant individuals; and the Agencies and Organizations that serve them.

- 11 **Activity/Program Name:** Healthy Communities Consortium (Broader Community)

**Program Description:** Supporting community members in working together on projects that impact quality of life; facilitating community coalitions and initiatives; and providing technical assistance to community-based organizations in board development, strategic planning, and outreach

**Target Population:** Youth and Seniors in Petaluma, and their families and the Agencies that serve them.

- 12 **Activity/Program Name:** Community Activity & Nutrition Coalition (Broader Community)

**Program Description:** A group of individuals, professionals and community based organizations promoting optimal health for residents, with a focus on nutrition and physical activity, and promoting access to services for children who have nutritional needs.

**Target Population:** Children and families in Sonoma County

- 13 **Activity/Program Name:** Petaluma Youth Network (Broader Community)

**Program Description:** A learning community made up of a diverse group of youth and adults representing families, education, business, government, law enforcement and youth serving agencies; committed to ensuring that all youth in this community are prepared for learning, thriving, working, and community life

(giving back/civic and family responsibility) by 21.

**Target Population:** Youth in Petaluma, and their families and the Agencies that serve them.

- 14 Activity/Program Name:** Petaluma Coalition to Prevent Underage & High-Risk Drinking (Broader Community)

**Program Description:** Working together to reduce problems associated with underage and high-risk drinking, engaging youth and parents in Parent/Community Pledges, advocating for adoption and enforcement of local ordinances and facilitating community dialogue.

**Target Population:** Youth, and the Broader Community in Petaluma.

- 15 Activity/Program Name:** Children's Mental Health Partnership (Broader Community)

**Program Description:** Bringing greater awareness about the importance of infant and child mental health, and improving access to care by number and expanding the knowledge base of those working with children in varying capacities.

**Target Population:** Children, and the Providers who serve them.

- 16 Activity/Program Name:** Community Partnerships to promote and advocate for Healthy Communities and Community Health: American Red Cross—Sonoma and Mendocino Counties Chapter (Broader Community)

**Program Description:** Humanitarian organization that provides relief to victims of disaster and helps people prevent, prepare for, and respond to emergencies.

**Target Population:** Sonoma County and Mendocino County residents who can benefit from health education, health provision, disaster education and provision of disaster response services, health and safety classes, and water safety classes.

- 17 Activity/Program Name:** Community Partnerships to promote and advocate for Healthy Communities and Community Health: Sonoma County Housing Coalition Consensus Council (Broader Community)

**Program Description:** Works to increase affordable housing stock in Sonoma County through policy change and advocacy.

**Target Population:** Working Families in Sonoma County.

- 18 Activity/Program Name:** United Way Wine Country, Family Impact Team (DUHN Population)

**Program Description:** Works to Strengthen Family Health, Support Family Unification, and reduce child abuse in Sonoma, Lake, and Mendocino Counties

**Target Population:** Vulnerable Families and Children in Sonoma, Lake, and Mendocino Counties

- 19 **Activity/Program Name:** City of Santa Rosa Mayor's Gang Prevention Task Force, Advisory Council (DUHN Population and Broader Community)

**Program Description:** Through coordinated efforts of city government, law enforcement, and local non-profit service providers, reduce the number of gang related violent crimes and the level of gang membership in the City of Santa Rosa

**Target Population:** At-risk youth in the City of Santa Rosa

- 20 **Activity/Program Name:** SJHS-SC Advocacy Visits and Outreach (DUHN Population and Broader Community)

**Program Description:** Focused advocacy efforts to increase awareness of persons of influence around quality of life, Community Health, Healthy Communities and Social Justice issues in our community.

**Target Population:** Local Elected Officials and other stakeholders in Sonoma County.

- 21 **Activity/Program Name:** Circle of Sisters After-School Program (DUHN Population)

**Program Description:** Free violence prevention program for girls 10-14 throughout Sonoma County, developing self-esteem, confidence, and social skills.

**Target Population:** At-risk girls aged 10-14 in Sonoma County.

- 22 **Activity/Program Name:** SJHS-SC Language Access Initiative (DUHN Population)

**Program Description:** Facilitate access and care by providing document translation and interpretation services between care providers and Limited English-speaking patients at SJHS facilities.

**Target Population:** Limited English Proficient Patients at SJHS-SC facilities.

**23**      **Activity/Program Name:** Sonoma County Task Force for the Homeless (DUHN Population)

**Program Description:** Coalition of public and private service providers working to end homelessness in Sonoma County through Advocacy, Resource Development, Community Education, and Collaborative Program Development.

**Target Population:** Homeless members of our community and those at-risk of homelessness in Sonoma County.

### **G. Ministry's Governance and Management Structure**

The role and responsibility of the Community Benefit Committee in planning and monitoring the Community Benefit Departments programs is explicitly laid out in the Community Benefit Policy manual document, "Community Benefit Committee Charter."

Community Benefit Committee: The Community Benefit Committee of the Board of Trustees shall oversee community benefit issues. Specifically, the Committee shall be responsible to the Board of Trustees and will recommend to the Board:

- a. Policies and programs that address the identified needs in the Corporation's service area with particular attention to vulnerable populations with disproportionate unmet needs.  
Programs that target the populations with the greatest disproportionate unmet health needs in the service area of the Corporation.
- b. Development and implementation of a Community Needs Assessment and Community Benefit Plan every three years as well as an annual update.
- c. Identify potential funding sources and partnerships for Community Benefit programs.
- d. Provide for effective communication and engagement of diverse stakeholders in Community Benefit planning and implementation.
- e. Oversee specifically and recommend to the Board of Trustees adoption of the following Community Benefit activities:
  - The Care for the Poor budget and all Community Benefit expenditures annually.
  - New Community Benefit program content.
  - Overall program design that will best meet the need of the population served.
  - Programs for continuation/discontinuation annually.

The Committee shall be composed of at least eight members, including at least three members of the Board of Trustees and at least a majority of members from the community – who have knowledge or experience with populations who have Disproportionate Unmet Health-Related Needs.

### **Community Benefit Committee Involvement**

The Community Benefit Committee is a standing Committee of the Santa Rosa Memorial Hospital Board of Trustees. The Committee has representation from Santa Rosa Memorial Hospital and Petaluma Valley Hospital and members of the community at large. They review the SB697 Plan each year in the fall. The final draft plan was reviewed on July 26, 2005. Members of the Community Benefit Committee are expected to reflect the needs of the community while contributing ideas, information and opportunities for partnership, collaboration and involvement. Most importantly, members are expected to bring to their work a desire to improve the health status of the community. They are also expected to bring different perspectives and challenges to committee discussions.

In overseeing of all Community Benefit activities, the Committee reviews and approves key policy, program content and design and budgetary decisions.

Monthly, written reports from the Community Benefit Department to members of the Santa Rosa Memorial Hospital and Petaluma Valley Hospital Board of Directors and senior management keep them informed on progress toward meeting identified community needs including progress on ASACB and SB697 goals.

### **Management**

The local Executive Management Team is involved in community benefit planning and monitoring as described in the Community Benefit policy manual document detailing the SJHS-SC Community Benefit Plan.

“Coordination and integration of the Community Benefit planning process and the hospital’s strategic planning process will be assured through the participation of the Vice-President of Mission Integration and the Community Benefit Directors in the strategic planning process. The Vice President of Strategic Services and the Vice President of Mission Integration will seek opportunities to strengthen this integration throughout the process”

Further, the job description of the Vice President for Mission Integration includes the following responsibilities:

“Participates as an active member of the Executive Management Team; exerting influence in the decision making processes to ensure the healing mission and

philosophy of the sponsoring congregation is vital and operational at the local setting(s).”