FY25

COMMUNITY BENEFIT REPORT/

PROGRESS ON 2024-2026 COMMUNITY HEALTH IMPROVEMENT PLAN

Santa Rosa Memorial Hospital

Santa Rosa, California

Reporting Period: July 1, 2024 - June 30, 2025

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Providence
Santa Rosa
Memorial Hospital

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EXECUTIVE SUMMARY

Providence continues its Mission of service in Sonoma County through Santa Rosa Memorial Hospital (SRMH), Petaluma Valley Hospital (PVH), and Healdsburg Hospital (HH). SRMH is an acute-care hospital with 338 licensed beds, founded in 1950 and located in Santa Rosa, CA. The hospital's service area is the entirety of Sonoma County which includes five federally recognized tribes and is inclusive of approximately 492,000 people.

SRMH dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically disadvantaged and vulnerable. In FY25, the hospital provided $63,227,137 in Community Benefits to address unmet needs. FY25 CB Report can be located online at: Community Support | Santa Rosa Memorial Hospital | Providence The most recent CHNA and CHIP can be located online at: CHNA and CHIPs | Providence under Northern California then Santa Rosa.

In compliance with state and federal requirements, SRMH approved its most recent Community Health Needs Assessment (CHNA) in October 2023 and its Community Health Improvement Plan (CHIP) in April 2024. The CHNA is a key tool for informing the hospital's community benefit plan, as mandated by California law, which outlines how we respond to identified community needs.

2024-2026 Santa Rosa Memorial Hospital Community Health Improvement Plan Priorities

As a result of the findings of our 2023 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Santa Rosa Memorial Hospital will focus on the following areas for its 2024-2026 Community Benefit efforts:

PRIORITY 1: BEHAVIORAL HEALTH AND SUBSTANCE USE

Publicly available data, along with Providence hospitalization data, show worsening trends of individuals experiencing a behavioral health crisis, many of whom are utilizing emergency rooms for care.

Substance Use Disorder was identified as the leading behavioral health diagnosis being treated at Santa Rosa Memorial and Petaluma Valley Hospitals. Key Informants, community members, and caregivers noted that the lack of behavioral health and substance use services is a significant barrier in Sonoma County. Lack of bilingual/bicultural providers and absence of medical detox were also commonly voiced needs. Data showed particular concern for youth.

FY25 Accomplishments

We focused on increasing access to mental health and substance use services and reducing barriers for underserved populations:

- **Providence Community Benefit Programs, Sonoma County:**
    - **Substance Use Navigators (SUNs):** Embedded in Santa Rosa Memorial, Petaluma Valley, and Healdsburg Hospitals, SUNs assist emergency department patients and the community with substance use disorders. They coordinate medication-assisted

    - treatment (MAT) and distribute and educate around harm-reduction tools like Naloxone.
    - **CARE Network:** Continues to provide comprehensive medical care management and social support to vulnerable populations, including those experiencing homelessness, Serious Mental Illness (SMI), and Substance Use Disorder (SUD). The team collaborated with Sonoma County Behavioral Health for higher levels of care and partnered closely with Buckelew Programs during the rollout of the Orenda Detox Center to help ease the patients transition from the hospital to Orenda Detox Center. CARE Network also deepened collaboration with Providence Behavioral Health services to bridge patients with SMI to appropriate mental health care.
    - **Mobile Health Clinic (MHC):** The MHC serves some of the most vulnerable members of our community by providing primary care and behavioral health screenings and connecting patients to appropriate resources. The team strengthened partnerships with community-based organizations such as Buckelew Programs, Catholic Charities, and St. Vincent de Paul, building trust and improving access to behavioral health services. The MHC also collaborates closely with the hospital's Substance Use Navigators (SUNs) to connect patients with medication-assisted treatment (MAT) programs. In FY25, the team participated in a targeted outreach in Rohnert Park at the "Safe Sleeping" site along the creek, providing care and behavioral health navigation services to unsheltered residents.
    - **Dental Clinic:** Conducts tobacco use screenings for patients aged 12 and older, providing education on health impacts and information on cessation treatments.
- **Sonoma County Community Benefit Funding:** Providence supports several programs aimed at addressing behavioral health and substance use in Sonoma County. Through our annual grantmaking process, we awarded 7 grants to local organizations totaling $1,116,962 county-wide. Funded projects provide bilingual and culturally responsive counseling for youth and families, mobile crisis response services, perinatal mental health support, integrated behavioral health care in primary and dental settings, and expanded access to mental health services for BIPOC and LGBTQIA+ communities.

PRIORITY 2: HOMELESSNESS AND HOUSING INSTABILITY

Over 25% of Sonoma County is experiencing severe housing cost burden, spending 50% or more of their household income on housing. Additionally, over 2,800 individuals were found to be experiencing homelessness in 2022. Most key informants identified the need for additional permanent supportive housing, wider acceptance of housing vouchers, affordable housing, and shelter beds. Older adults and BBIPOC population experience additional barriers to housing in Sonoma County.

FY25 Accomplishments

In FY25, we aimed to increase access to affordable housing and enhance supportive services to prevent homelessness and help unhoused individuals regain stability and health:

- **Providence Community Benefit Programs, Sonoma County:**
    - **CARE Network:** Continues to provide community-based care management for vulnerable populations, including those referred from hospitals and emergency

departments. The multidisciplinary team conducts home visits or on-site care at homeless shelters offering medical care management, transportation assistance, and support to address social drivers of health for individuals facing homelessness or housing instability. As an Enhanced Care Management (ECM) provider, the team works specifically with those suffering from Serious Mental Illness (SMI) and Substance Use Disorders (SUD).
    - **Mobile Health Clinic:** The MHC continues to provide healthcare navigation services at 18 sites, specifically targeting homeless shelters and supportive housing centers across the county. The program connects individuals experiencing homelessness to medical care, transportation vouchers, medication assistance, and mental health referrals, ensuring access to essential healthcare services.
- **Policy Advocacy:** Providence partnered with Generation Housing, a nonprofit advancing pro-housing policies in the North Bay, and other community organizations to support the development and passage of the $0 Impact Fee Affordable Housing Incentivization Program in Santa Rosa. This policy reduces costs for affordable housing projects and streamlines development, helping to expand housing options for low-income families and other vulnerable populations.
- **Sonoma County Community Benefit Funding:** Providence supports several programs aimed at addressing homelessness and housing instability in Sonoma County. Through our annual grantmaking process, we provided 6 grants to local organizations totaling $1,139,232 county-wide. Funded projects include recuperative care beds, permanent supportive housing, wrap-around housing for women and children, supportive housing for transition-age youth, motel-to-housing conversions, and policy initiatives to expand affordable housing.

PRIORITY 3: ACCESS TO HEALTH CARE AND DENTAL SERVICES

Fewer people saw primary care doctors or dentists in recent years. This trend, coupled with qualitative data expressing lack of primary medical and dental providers, highlighted the lack of appropriate levels of health care access in Sonoma County. Emergency transport times were some of the longest in the State of California in Northern Sonoma County. Key Informants and Caregivers expressed the need for extended hours, bilingual/bicultural providers, and transportation options to break down access barriers for older adults, people experiencing homelessness, and agricultural workers. Access was noted to be highly linked to economic insecurity.

FY25 Accomplishments

In FY25, we concentrated on improving access to health and dental care for underserved populations. Key accomplishments include:

- **Providence Community Benefit Programs, Sonoma County:**
    - **CARE Network:** Continues to provide complex care management for vulnerable populations, ensuring access to primary and specialty care as well as medications. This team also addresses social drivers of health, including benefit application assistance and connecting with community resources.

- **Dental Clinic:** The clinic operates programs ensuring access to dental care for underserved communities:
    - **Fixed-Site Clinic:** Provides comprehensive dental care for pediatric and emergency patients from across Sonoma County. In FY25, the clinic added three new chairs to expand capacity, using the mobile dental clinic. The Dental Clinic also offers *Special Needs Saturdays*, in partnership with the North Bay Regional Center, offering a calm and supportive environment for patients with autism and special needs, with 144 encounters in FY25.
    - **Mighty Mouth:** A school-based dental prevention program serving preschool through sixth grade, offering screenings, fluoride treatments, sealants, and education. In FY25, the program expanded to Brook Hill, Cloverdale, J.X. Wilson, R.L. Stevens, and Steele Lane elementary schools, reaching a total of 35 sites. During the year, 3,774 children received screenings, and 6,632 participated in dental health education. Sealants were provided for 253 children, with 823 teeth sealed.
    - **Mobile Dental Clinic:** Continues to deliver essential care in rural and underserved communities. The mobile dental clinic operates at 10 established sites county-wide, serving schools, low-income housing, and at community health fairs. Maintains its partnership with Mendonoma Health Alliance to provide services to children in Timber Cove at Fort Ross Elementary. Continues offering clinic at the Graton Day Labor Center, with 101 adult patients being served in FY25.
- **Mobile Health Clinic (MHC):** The MHC is a mobile medical clinic that provides free primary care, health screenings, immunizations, and referrals to medical homes and social support services. The MHC operates at over 38 sites across Sonoma County, focusing on underserved populations, including low-income, uninsured, undocumented residents, asylum seekers, and individuals experiencing homelessness. The MHC team is fully bilingual (English/Spanish), improving communication and care for diverse populations. In FY25, the clinic collaborated with community-based organizations to work towards establishing new service locations in West, South, and North Counties. The clinic also collaborates with the Dental Clinic to coordinate care and address dental emergencies.
- **Promotores de Salud *(Community Health Promotion)*:** The Promotora, also referred to as the Community Health Worker (CHW), is part of the Mobile Health Clinic team and organizes public health events that offer screenings for hypertension and diabetes, nutrition education, and referrals. In FY25, the program conducted 1,485 screenings, maintained 17 established community sites, and in addition participated in 18 health fairs and special events county-wide. The Promotora also supported vaccine distribution efforts in FY25, administering a total of 303 vaccines, including 163 flu, 60 COVID-19, and 80 combination flu/COVID-19 doses.

- **Legal Aid of Sonoma County Medical Legal Partnership (MLP):** Provides legal support for health-related issues such as eviction, domestic violence, and public benefits, helping vulnerable individuals improve their health and living situations.

- **Sonoma County Community Benefit Funding:** Providence supports several programs aimed at expanding access to health and dental care in Sonoma County. Through our annual grantmaking process, we provided 8 grants to local organizations totaling $728,805 county-wide that provide primary and specialty care access, counseling, and wrap-around services. These investments help uninsured and underserved patients overcome barriers to medical and dental care, ensuring more equitable access to essential health services.

PRIORITY 4: OLDER ADULT HEALTH AND WELL-BEING

There is a growing population of older adults (over 60) in Sonoma County without adequate resources to meet their needs. As identified in the Community Health Improvement Plan (CHIP) under "Aging Issues," older adults experiencing homelessness and housing instability, barriers to accessing care, as well as behavioral health challenges due to isolation are on the rise in Sonoma County. A lack of providers with experience with geriatric conditions is also of concern.

FY25 Accomplishments

In FY25, we prioritized serving the older adult population, recognizing their unique needs and challenges. Our primary accomplishments include:

- **Providence Community Benefit Programs:** Our programs targeted the needs of older adults, ensuring they receive the care and support necessary for their well-being:
    - **CARE Network:** Provides comprehensive care management tailored to older adults, including fall-prevention and addressing social drivers of health. A Community Health Worker trained in *Matter of Balance* techniques provides education and support for those at risk of falls. Caregivers also assist patients with food access, housing support, benefits and other general assistance applications. In FY25, CARE Network served 163 older adults (over 60) via 342 encounters throughout Sonoma County.
    - **Dental Clinic:** Although the focus population for dental is children, the team served 38 older adults (over 60) that had urgent dental needs and were unable to get a timely dental appointment elsewhere.
    - **Mobile Health Clinic (MHC):** Of the 38 sites countywide, the MHC expanded access for older adults specifically with the addition of the Rohnert Park People Services Center. In FY25, the MHC served 386 older adults (over 60) via 912 encounters throughout Sonoma County.
- **Providence Permanent Supportive Housing (PSH):** Engaged in ongoing discussions to develop a PSH complex in Rohnert Park specifically for seniors, aimed at assisting chronically homeless individuals aged 55 and older. With this project, 70 seniors and veterans in Sonoma County will have a place to call home. Providence has committed $630,000 to support the project, with funding scheduled for 2026 when the development is anticipated to launch.
- **Community Benefit Funding:** Providence supports programs aimed at improving older adult health and well-being in Sonoma County. Through our annual grantmaking process, we awarded

a grant of $17,500 to a local organization that provides medically tailored meals to seniors, helping to address nutrition needs and support their overall health.

EQUITY, RACISM, AND DISCRIMINATION

The Committee Benefit Committee and the Community Benefit department recognize that racism, discrimination, and inequity are crosscutting themes and root causes that impact all prioritized need areas. These issues are specifically addressed in each area as outlined in our Community Health Improvement Plan.

FY25 Accomplishments

With focus on inclusivity, we strive to dismantle barriers to healthcare and improve health outcomes for those facing systemic inequities, empowering individuals to advocate for their rights and access the care they deserve. Our primary accomplishments include:

- **Providence Community Benefit Programs, Sonoma County:** In alignment of our mission and heritage, addressing inequities is at the root of our work in community benefit. We are committed to serving populations disproportionately affected by inequity, racism, and discrimination. We prioritize efforts targeting marginalized communities to ensure they have access to essential services, resources, and support. Examples include CARE Network, Mobile Health units, dental services, and health screenings all focused on high-need, underserved populations. Our caregivers work to create inclusive environments, dismantle barriers to care, and improve health outcomes for those most impacted.

  One example of this commitment is the Providence Mobile Health Clinic team's development of a bilingual, visual health education booklet. Designed in partnership with patients, the booklet provides simple, culturally relevant guidance for managing chronic illnesses such as diabetes and hypertension. By using color-coding, images, and familiar foods, the resource empowers patients to better understand their health, improves engagement, and has already led to measurable improvements in health outcomes.
- **Community Benefit Funding:** While all community benefit grants focus on vulnerable populations, in FY25 we approved 2 grants totaling $520,000 specifically for local organizations whose work serves marginalized communities and addresses systemic barriers to health.

About Providence

Providence St. Joseph Health (Providence) is a national, not-for-profit Catholic health system comprising a diverse family of organizations driven by a belief that health is a human right. With 51 hospitals, over 1000 clinics, and many other health and educational services, our health System employs more than 122,000 caregivers serving patients in communities across seven Western states – Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. Our caregivers provide quality, compassionate care to all those we serve, regardless of coverage or ability to pay.

Providence across five western states:

- Alaska
- Montana
- Oregon
- Northern California
- Southern California
- Washington
-

The Providence affiliate family includes:

- Covenant Health in West Texas
- Facey Medical Foundation in Los Angeles, CA.
- Kadlec in Southeast Washington
- Pacific Medical Centers in Seattle, WA.
- Swedish Health Services in Seattle, WA.

As a comprehensive health care organization, we are serving more people, advancing best practices, and continuing our more than 100-year tradition of serving the poor and vulnerable. Delivering services across seven states, Providence is committed to touching millions of more lives and enhancing the health of the American West to transform care for the next generation and beyond.

INTRODUCTION

Who We Are

Our Mission	As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.
Our Vision	Health for a Better World.
Our Values	Compassion — Dignity — Justice — Excellence — Integrity

Part of a larger healthcare system known as Providence; Santa Rosa Memorial Hospital (SRMH), Petaluma Valley Hospital (PVH) and Healdsburg Hospital (HH) serve the communities located in Sonoma County. The health care services provided by these three hospitals include, in part, the provision of acute care services, behavioral health, and other facilities for treating the healthcare needs of the community in Sonoma County.

SRMH is an acute-care hospital founded in 1950 and located in Santa Rosa, CA. The hospital has 338 licensed beds, and a campus that is approximately 5 acres in size with additional off-site facilities throughout Sonoma County. SRMH has a staff of more than 2,000 caregivers (employees) and professional relationships with more than 430 local physicians. As the designated Level II Regional Trauma Center for Sonoma, Mendocino, Napa and Lake counties, Santa Rosa Memorial Hospital provides a wide range of specialty services including critical care, cardiovascular care, stroke care, women's and children's services, cancer care, and orthopedics. The hospital is home to the Norma & Evert Person Heart & Vascular Institute and the UCSF Neonatal Intensive Care Nursery.

In addition, SRMH offers a variety of community-based programs, such as a free mobile health clinic, a mobile dental clinic, a fixed-site dental clinic, health promotions, and CARE Network. These programs and services offered to the community are designed to meet the needs of vulnerable populations and focus on health equity, primary prevention, health promotion and community building.

Our Commitment to Community

Providence health system dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. In FY25, SRMH provided $63,227,137 in Community Benefit[1] in response to unmet needs. Our service area also includes Providence Medical Group, Providence Home Care Network, and multiple urgent care facilities.

Providence hospitals in Sonoma County further demonstrate organizational commitment to the community through the allocation of staff time, financial resources, and participation and collaboration to conduct the Community Health Needs Assessment (CHNA) and then to address

[1] Per federal reporting and guidelines from the Catholic Health Association.

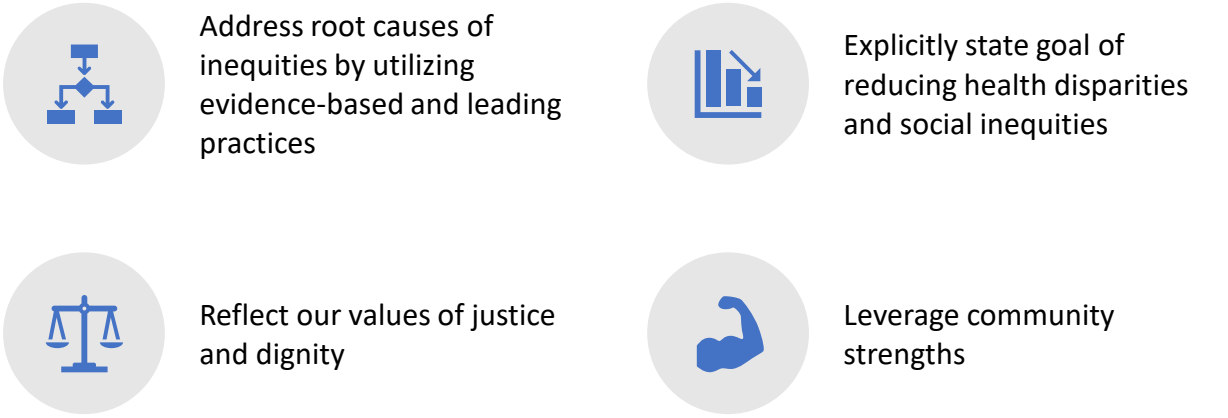
community identified needs. The Senior Director of Community Health for Northern California, Dana Codron, is responsible for ensuring compliance with Federal 501r requirements as well as providing the opportunity for community leaders, hospital leadership, and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

Health Equity

At Providence, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the best practices that each of our hospitals will implement when completing a CHIP. These practices include, but are not limited to the following:

Figure 1. Best Practices for Centering Equity in the CHIP



Community Benefit Governance

Santa Rosa Memorial Hospital (SRMH) demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, and participation and collaboration with community partners. The Senior Director of Community Health for the Northern California service area is responsible for coordinating the implementation of state and federal 501r requirements.

The SRMH Community Benefit Committee (CBC) is the board appointed oversight committee of the Community Health department for Providence SRMH. The CBC is composed of Santa Rosa Memorial

Hospital community board members, internal Providence stakeholders and staff (Chief Executive or designee, mission leader, community health leaders), external community stakeholders representing subject matter experts, and community constituencies (i.e. faith based, Federally Qualified Health Center's, mental health, homeless services, and education). The Community Benefit Committee reviewed the data collected in the 2023 Community Health Needs Assessment process to identify and prioritize the top health-related needs in Sonoma County for this 2024-2026 CHIP.

Planning for the Uninsured and Underinsured

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 Santa Rosa Memorial Hospital (SRMH) has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way SRMH informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. In FY25, SRMH provided $11,044,391 in free and discounted care through our Financial Assistance Program. For information on our Financial Assistance Program click here.

Medi-Cal (Medicaid)

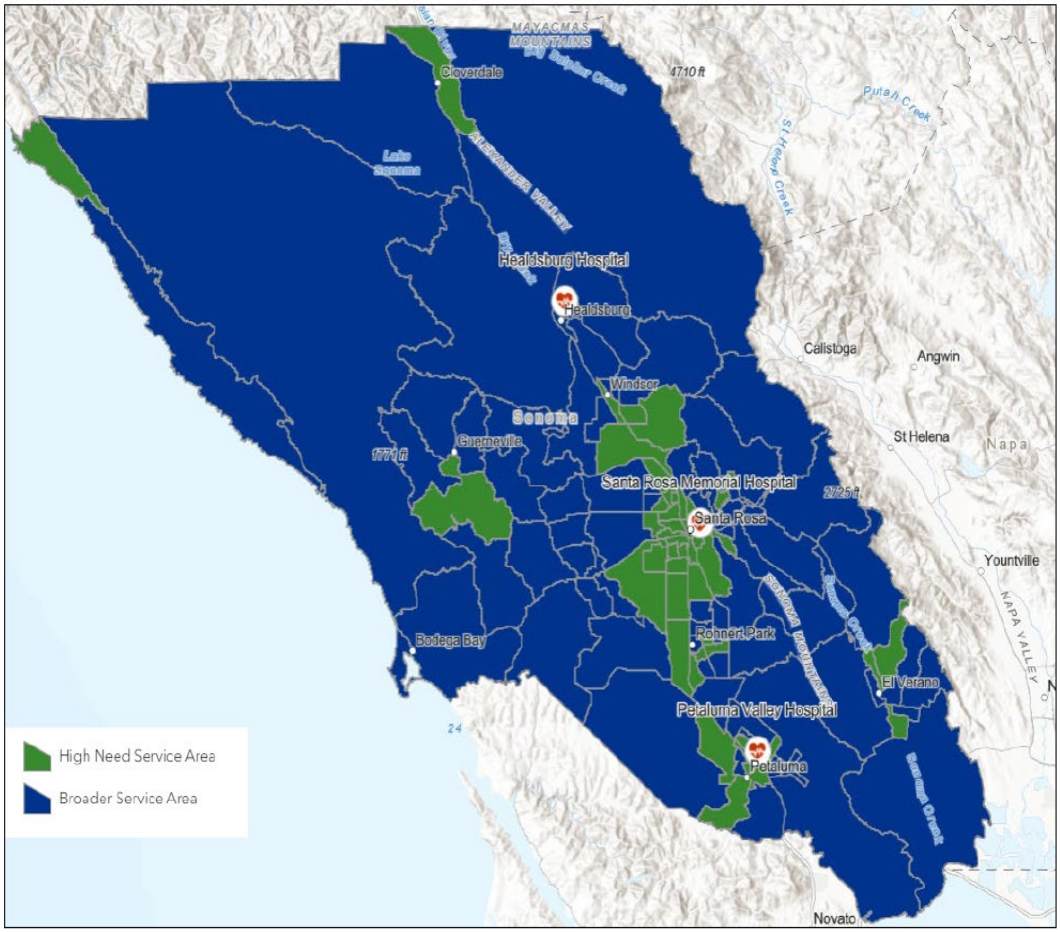
Santa Rosa Memorial Hospital provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY25, Santa Rosa Memorial Hospital provided $44,296,382 in Medicaid shortfall.

OUR COMMUNITY

Description of Community Served

Santa Rosa Memorial Hospital's service area is the entirety of Sonoma County which includes five federally recognized tribes and is inclusive of approximately 492,000 people.

Figure 2. Santa Rosa Memorial Hospital, Healdsburg Hospital, and Petaluma Valley Hospital



To facilitate identifying health disparities and social inequities by place, we designated a "high need" service area and a "broader" service area, which together make up the Sonoma County Service Area. Based on work done by the Public Health Alliance of Southern California and their Healthy Places Index

(HPI) tool, we identified the high need service area based on income, education, English proficiency, and life expectancy.[2]

Community Demographics

POPULATION AND AGE DEMOGRAPHICS

The following population demographics for Sonoma County are from the 2021 American Communities Survey 5-year estimates. 50.9% of people living in Sonoma County are female and 49.1% are male. The high need service area predominantly houses a younger population, with individuals under the age of 55 being more prevalent. Conversely, the broader service area tends to host a higher proportion of older adults aged 55 and above. This demographic distribution may be attributed partially to the prevalence of secondary and/or vacation homes.

POPULATION BY RACE AND ETHNICITY

In Sonoma County, there are noticeable disparities in the distribution of racial and ethnic groups across different census tracts. The 'other race' population is notably overrepresented in high-need census tracts compared to the county's overall population. Conversely, individuals who identify as white are less likely to reside in high-need communities.

Additionally, there is a significant overrepresentation of individuals identifying as Hispanic in high-need communities, constituting nearly 38% of the population in those areas, compared to just under 20% in the broader service area. In Sonoma County, approximately 6.5% of the population are veterans, slightly higher than the 4.8% in the state of California.

SOCIOECONOMIC INDICATORS

Table 1. Income Indicators for Sonoma County Service Area

Indicator	Broader Service Area	High Need Service Area	Sonoma County	California
Median Income Data Source: 2021 American Community Survey, 5-year estimate	$117,926	$77,152	$90,867	$83,226
Percent of Renter Households with Severe Housing Cost Burden Data Source: 2021 American Community Survey, 5-year estimate	25.4%	27.9%	25.0%	26.3%

[2] The following variables were used for the PNI analysis: Population below 200% the Federal Poverty Level (American Community Survey, 2021); Percent of population with at least a high school education (American Community Survey, 2021); Percent of population, ages 5 Years and older in Limited English Households (American Community Survey, 2021); Life expectancy at birth (estimates based on CDC, 2010 – 2015 data)

Household median incomes include the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, the average household income is usually less than the average family
income.

The broader service area has a median income of $117,926, which is $27,059 greater than Sonoma County and $40,774 greater than the high need service area.

Severe housing cost burden is defined as renter households that are spending 50% or more of their income on housing costs. About 25% of households in Sonoma County are severely housing cost burdened, which is slightly lower than the state of California overall.

In the high need service area, about 28% of renter households are severely housing cost burdened. Within Sonoma County there are census tracts in which over 40% of households are experiencing severe housing cost burden.

Full demographic and socioeconomic information for the service area can be found in the 2023 CHNA for Santa Rosa Memorial Hospital.

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

In our Community Needs Assessment process, we employed a mixed-methods approach, integrating both quantitative and qualitative data. Data was collected from various reliable sources, including the American Community Survey, Behavioral Risk Factor Surveillance System, local public health databases, hospital-level records, and public health datasets focusing on health behaviors, morbidity, and mortality.

To ensure active community engagement, we collaborated with On the Margins, Inc., a trusted local community-based organization, to facilitate listening sessions. Hosted throughout the county with La Plaza in Santa Rosa, Corazón Healdsburg, and the Petaluma Family Resource Center, these sessions were specifically designed to gather insights from individuals with chronic conditions, diverse backgrounds, low-income households, and those who are medically underserved. Participants included Latinx and Indigenous residents (speaking Spanish, Mixteco, Purépecha, and Mayan), as well as immigrant and refugee families who engaged in English, Spanish, Dari, Arabic, and Indigenous dialects.

In addition to community voices, a caregiver listening session was held with Providence staff, including community health workers, social workers, nurses, physicians. This provided important internal perspectives on patient and community needs, care delivery challenges, and opportunities for hospital–community collaboration.

We also conducted 14 key informant interviews with leaders from community-based organizations, healthcare, housing, public health, legal services, philanthropy, and social services, as well as with Providence executive leaders. These informants represented organizations from across Sonoma County, ensuring broad regional input. Collectively, they provided valuable perspectives on the needs of vulnerable populations including people experiencing homelessness, low-income households, older adults, youth, people with disabilities, LGBTQIA+ residents, and uninsured individuals.

Through these interviews, our aim was to delve deeper into understanding community strengths and opportunities.

Some key takeaways include the following:

- Lack of affordable housing with increased barriers for those with disabilities, older adults, and the BBPIOC community.
- Limited access to and availability of behavioral health and substance use services.
- Limited access to primary and specialty medical care providers.
- Economic insecurities with increased barriers related to racism and discrimination.
- Strengths included community resiliency and community-based organization collaboration.

Significant Community Health Needs Prioritized

The list below summarizes the rank-ordered significant health needs identified through the 2023 Community Health Needs Assessment process:

BEHAVIORAL HEALTH AND SUBSTANCE USE

Publicly available data, along with Providence hospitalization data, show worsening trends of individuals experiencing a behavioral health crisis, many of whom are utilizing emergency rooms for care. Substance Use Disorder was identified as the leading behavioral health diagnosis being treated at Santa Rosa Memorial and Petaluma Valley Hospitals. Key Informants, community members, and caregivers all shared that lack of behavioral health and substance use services was a major barrier in Sonoma County. Lack of bilingual/bicultural providers and absence of medical detox were also commonly voiced needs. Data showed particular concern for youth.

HOMELESSNESS AND HOUSING INSTABILITY

Over 25% of Sonoma County is experiencing severe housing cost burden, spending 50% or more of their household income on housing. Additionally, over 2,800 individuals were found to be experiencing homelessness in 2022. Most Key Informants identified the need for additional permanent supportive housing, housing accepting housing vouchers, affordable housing and shelter beds. Older adults and BBIPOC population experience additional barriers to housing in Sonoma County.

ACCESS TO HEALTH AND DENTAL CARE

Fewer people saw primary care doctors or dentists in recent years. This trend coupled with qualitative data expressing lack of primary, medical and dental providers highlighted lack of appropriate level of health care access in Sonoma County. Emergency transport times were some of the longest in the State of California in Northern Sonoma County. Key Informants and Caregivers expressed the need for extended hours, bilingual/bicultural providers and transportation options to break down access barriers for older adults, people experiencing homelessness, and agricultural workers. Access was noted to be highly linked to economic insecurity.

OLDER ADULT HEALTH AND WELL-BEING

There is a growing population of older adults (over 60) in Sonoma County without adequate resources to meet their needs. As identified in the Community Health Improvement Plan (CHIP) under "Aging Issues," older adults experiencing homelessness and housing instability, barriers to accessing care, as well as behavioral health challenges due to isolation are on the rise in Sonoma County. A lack of providers with experience with geriatric conditions is also of concern.

EQUITY, RACISM AND DISCRIMINATION

The Committee Benefit Committee and the Community Benefit department recognize that racism, discrimination, and inequity are crosscutting themes and root causes that impact all prioritized need areas. These issues are specifically addressed in each area as outlined in our Community Health Improvement Plan.

Needs Beyond the Hospital's Service Program

While hospitals play a vital role in addressing community health needs, it is recognized that no single facility can comprehensively tackle all health challenges within its locality. At Santa Rosa Memorial Hospital, we remain steadfast in our mission by fostering collaborations with community organizations to augment our efforts.

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

- Economic Insecurity: Economic insecurity affects many other needs, including educational opportunities, food resources, employment, transportation, and physical and mental health.

While economic insecurity was an identified significant need, Providence Community Benefit Sonoma County lacks an effective method of intervention. However, systemic impacts of economic insecurity are identified and addressed through the chosen priority need areas outlined in this document.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The 2024-2026 Community Health Improvement Plan (CHIP) is designed to address the needs identified and prioritized through the 2023 Community Health Needs Assessment (CHNA). We recognize the greatest needs of our community will change over time, and we are dedicated to adapting our efforts accordingly. Our commitment remains steadfast in supporting, strengthening, and serving our community in alignment with our Mission, utilizing our expertise, and maximizing the impact of Community Benefit resources.

The Santa Rosa Memorial Hospital CHIP process was led by the Senior Manager of Community Health and the Community Health staff with review and approval from the Community Benefit Committee. Strategies outlined in the CHIP encompass a diverse array of approaches, including direct service programming goals, support for community organizations, and collaborative commitments aimed at addressing the identified priority need areas.

While Equity, Racism, and Discrimination were not designated as a standalone priority area, the Community Benefit Committee made a deliberate decision to incorporate strategies addressing the needs of the Black, Brown, Indigenous, and People of Color (BBIPOC) community and those most likely to experience discrimination within each priority area. This acknowledgment underscores our commitment to addressing health disparities and promoting equity across all facets of our community health initiatives.

Addressing the Needs of the Community: 2024-2026 Key Community Benefit Initiatives and Evaluation Plan

FY25 Accomplishments

COMMUNITY NEED ADDRESSED #1: BEHAVIORAL HEALTH AND SUBSTANCE USE

Long-Term Goal(s)/ Vision

To reduce substance use disorders (SUD) and mental health conditions through evidence-based and community-led prevention, treatment, and recovery support services that are equitable, high-quality, culturally responsive, and linguistically appropriate, especially for populations with low incomes.

Table 2. Strategies and Strategy Measures for Addressing Behavioral Health and Substance Use

Strategy	Population Served	Strategy Measure	FY25 Progress	2026 Target
1. Leverage partnerships between the Mobile Health Clinic and behavioral health community-based organizations (CBOs) **Providence Program: Mobile Health Clinic**	Unhoused, rural communities, seniors, undocumented, BBIPOC population experiencing behavioral and substance use disorder	# of referrals to behavioral health and substance use disorder programs	71 referrals SRMH 81 referrals county-wide 6% of unduplicated patients served were referred to BH programs in FY25, representing an 81% increase from the 2024 baseline of 3.3% *On track. Referral rates have more than doubled, showing significant progress towards the 20% increase target.*	Increase referrals by 20% county-wide
2. Connect patients to Medication-Assisted Treatment programs through substance use navigation **Providence Program: CARE Network**	Hospital emergency department and admitted patients experiencing substance use disorders	# of encounters # of patients connected to a MAT program	302 SUN encounters SRMH 861 SUN encounters county-wide 187% increase county-wide over the 2024 baseline of 300 encounters 302 patients connected to MAT SRMH 377 patients connected to MAT county-wide	15% increase in encounters county-wide 15% increase in patients connected to MAT program county-wide

			109% increase county-wide over the 2024 baseline of 180 connections to MAT programs *On track. FY25 results show substantial growth in both encounters and patient connections, demonstrating continued progress toward the 15% county-wide increase target by 2026.*	
3. Provide comprehensive case management to high-risk and severe and persistent mental illness populations through Enhance Care Management (ECM) **Providence Program: CARE Network (CN)**	Patients identified by CN or referred through Partnership HealthPlan as having a behavioral health diagnosis and are at risk of homelessness	# of patients enrolled in ECM % of enrolled ECM patients screened for depression with the PHQ-2 or PHQ-9	52 patients enrolled in ECM SRMH 84 patients enrolled in ECM county-wide 147% increase county-wide over 2024 baseline 34 enrolled 572 ECM encounters county- wide 77% of ECM patients screened with PHQ-2 or 9 *On track. FY25 results show substantial growth in ECM enrollment and consistent depression screening, indicating continued progress toward the 2026 targets for increased enrollment and screening rates.*	Work in coordination with care partners and organizations to increase county-wide ECM enrollment by 10% 90% of patients screened county-wide

4. Administer county-wide community grants to CBOs addressing behavioral health and substance use disorder	Vulnerable populations, unhoused, rural communities, seniors, undocumented, BBIPOC, uninsured/underinsured	25% of grant funds invested in programs to address behavioral health (BH) and substance use (SU)	$550,000 invested in BH/SU SRMH $1,116,962 invested in BH/SU county-wide (32% of overall grant dollars invested) *Investments in FY25 continued to exceed the 25% threshold, keeping us on track to meet target.*	25% of grant dollars invested in BH and SU county-wide

Key Community Partners

- Alexander Valley Health Center
- Alliance Medical Center
- Buckelew Programs
- California ED Bridge
- Committee on the Shelterless (COTS)
- Community Support Network
- County of Sonoma, Department of Health Services
- Kaiser Permanente, North Bay
- Mother's Care
- NAMI Sonoma
- Partnership Health Plan of California
- Petaluma Health Center
- Petaluma People Services Center
- Providence Healdsburg Hospital
- Providence Petaluma Valley Hospital
- Santa Rosa Community Health
- Sonoma County Indian Health Project
- Sutter Health, North Bay
- West County Health Centers

COMMUNITY NEED ADDRESSED #2: HOMELESSNESS AND HOUSING INSTABILITY

Long-Term Goal(s)/ Vision

A sufficient supply of safe, affordable, and equitable housing units to ensure that all people in the community have access to a healthy place to live that meets their needs. A coordinated and holistic community approach to providing increased linkages to supportive services for people experiencing homelessness.

Table 3. Strategies and Strategy Measures for Addressing Homelessness and Housing Instability

Strategy	Population Served	Strategy Measure	FY25 Progress	2026 Target
1. Invest in the maintenance and expansion of existing recuperative beds and services	Individuals experiencing homelessness, including older adults	# of recuperative beds	Financially contributed to 33 recuperative care beds SRMH 53 recuperative care beds county- wide *Investments helped sustain existing capacity, keeping us on track to meet target.*	Commit to funding that maintains the operation at full capacity of recuperative care programs county-wide
2. Prioritize funding towards maintaining operational expenses at established permanent supportive housing (PSH) locations for sustainability of housing units	Individuals experiencing homelessness and those at risk of homelessness, including families, BBIPOC, transitional-age youth, and older adults	# of PSH programs/sites supported	$600,000 invested in PSH SRMH (1 project) $692,120 invested in PSH county-wide (2 projects) *Target met. The target of funding at least three PSH programs county-wide was achieved through investments made in FY24 and FY25.*	Commit to continue funding of at least 3 PSH programs county-wide

3. Provide comprehensive case management to unhoused population through Care Network's (CN) Enhanced Care Management (ECM) program **Providence Program: CARE Network**	Patients identified by CN or referred through Partnership HealthPlan as being unhoused or at risk of homelessness	# of patients enrolled in CN's ECM program	23 unhoused patients enrolled in ECM SRMH 35 unhoused patients enrolled in ECM county- wide 41% of enrolled individuals were unhoused county-wide *On track. FY25 results show increased ECM enrollment among unhoused individuals, reflecting continued progress toward the target to increase county-wide enrollment by 10%.*	Work in coordination with care partners and organizations to increase county-wide ECM enrollment by 10%
4. Provide support to community-based organizations (CBOs) focused on advocating for housing initiatives with the goal of increasing the supply and affordability of homes in Sonoma County	Current and future Sonoma County residents	Amount invested # of endorsements	Invested $271,000 for housing advocacy efforts 0 endorsements in FY25 *On track. FY25 investments demonstrate continued progress toward the target to sustain funding for CBOs focused on housing policy advocacy. The target of increasing endorsements related to housing policy and supply was achieved in FY24.*	Commit to continue funding to CBOs focused on housing policy advocacy Increase endorsements related to housing policy and supply

Key Community Partners

- Buckelew Programs
- Burbank Housing
- Catholic Charities of the Diocese of Santa Rosa
- City of Santa Rosa
- Committee on the Shelterless (COTS)
- Community Support Network
- County of Sonoma, Community Development Commission
- Generation Housing (Gen H)
- HomeFirst
- Kaiser Permanente, North Bay
- Legal Aid of Sonoma County
- The Living Room Center, Inc.
- Providence Healdsburg Hospital
- Providence Petaluma Valley Hospital
- Providence Supportive Housing
- Santa Rosa Community Health
- Sonoma County Continuum of Care
- Sutter Health, North Bay
- West County Community Services
- West County Health Centers

COMMUNITY NEED ADDRESSED #3: ACCESS TO HEALTH AND DENTAL CARE

Long-Term Goal(s)/ Vision

To improve access to equitable and culturally responsive health care and preventive resources for people with low incomes and those underinsured by deploying programs to assist with navigating the health care system. This will ease the way for people to access the appropriate level of care at the right time.

Table 4. Strategies and Strategy Measures for Addressing Access to Health and Dental Care

Strategy	Population Served	Strategy Measure	FY25 Progress	2026 Target
1. Engage high-risk individuals with CARE Network's (CN) complex care management and Enhanced Care Management teams to increase access to health care **Providence Program: CARE Network**	High-risk individuals with complex socioeconomic and chronic conditions, especially patients with an identified social determinant of health need, including substance use disorder	# of individuals enrolled with CN	1,708 patients enrolled in CARE Network SRMH 2,662 patients enrolled in CARE Network county-wide 20,728 encounters SRMH 27,548 encounters county-wide *On track. FY25 results demonstrate consistent delivery of complex care management services.*	Increase enrollment to 1,500 patients enrolled annually county-wide
2. Provide Community Health Worker (CHW) services including screenings, education, navigation, and advocacy for BBIPOC and vulnerable populations **Providence Program: Promotores de Salud**	Low-income adult community members of the public, primarily Latino/a populations	# of encounters	1,364 encounters SRMH 1,850 encounters county-wide *On track. FY25 results demonstrate steady delivery of CHW services and outreach to support improved access to care county-wide.*	Commit to continue the provision of these county-wide services to the benefit of the community

3. Provide dental care to un- and underinsured patients through Providence Dental Clinic **Providence Program: Dental**	Uninsured and underinsured adults including unhoused and those who identify as having developmental disabilities, MediCal pediatric population	# of encounters receiving dental care	11,949 Fixed-Site encounters SRMH 12,449 Fixed Site encounters county-wide 4,999 Mobile Dental encounters and screenings county-wide 6,632 Education encounters county-wide *On track. FY25 results demonstrate steady delivery of fixed-site, mobile, and education services to support improved access to dental care county-wide.*	Commit to continue the provision of these county-wide services to the benefit of the community
4. Provide primary care and linkages to medical homes for un- and underinsured patients through Providence Mobile Health Clinic with the goal of reducing avoidable emergency department visits **Providence Program: Mobile Health Clinic**	Low-income, uninsured, under-insured, undocumented, unhoused, or other vulnerable populations	# of patients receiving treatment, services, or referrals from the Providence Mobile Health Clinic # of Emergency Room (ER) avoidable encounters	1,065 unduplicated patients SRMH 1,333 unduplicated patients county-wide 2,388 encounters SRMH 2,879 encounters county-wide 61 avoidable ED encounters SRMH 83 avoidable ED visits county-wide	Commit to continue the provision of these county-wide services to the benefit of the community Continue to track ER avoidable encounters county-wide

			On track. FY25 results demonstrate steady delivery of mobile health services and continued tracking of avoidable emergency visits to support improved access to care county-wide.	

Key Community Partners

- Aliados Health
- Bellevue Union School District
- Buckelew Programs
- Burbank Housing
- Ceres Community Project
- County of Sonoma, Department of Health Services
- Give Kids a Smile
- Graton Day Labor Center
- Fulton Day Labor Center
- Humanidad Therapy and Education Services
- Kaiser Permanente, North Bay
- La Luz Center
- Legal Aid of Sonoma County
- Mendonoma Health Alliance
- NAMI Sonoma
- North Bay Children's Center
- Operation Access
- Petaluma People Services Center
- Providence Healdsburg Hospital
- Providence Petaluma Valley Hospital
- Roseland Public Schools
- Santa Rosa City Schools
- Santa Rosa Community Health
- Santa Rosa Junior College
- Shoreline Unified School District
- Sonoma Valley Unified School District
- Sonoma County Public Health
- Sutter Health, North Bay
- The Key Private Duty Caregiving
- West County Community Services
- West County Health Centers

COMMUNITY NEED ADDRESSED #4: OLDER ADULT HEALTH AND WELL-BEING

Long-Term Goal(s)/ Vision

To provide direct services and funding to address the unique needs of vulnerable older adults in Sonoma County, including transportation, healthcare, resource navigation, and in-home support services.

Table 5. Strategies and Strategy Measures for Addressing Older Adult Health and Well-Being

Strategy	Population Served	Strategy Measure	FY25 Progress	2026 Target
1. Support community-based organizations through grants and partnerships to increase transportation access	Older adults (60 and over) who are most at risk for experiencing access barriers	# of grants administered	*Target met. The target of administering at least 1 transportation-related grant county-wide was achieved through investments made in FY24.*	Administer 1 transportation-related grant county-wide
2. Serving seniors through direct service programs **Providence Program: Mobile Health Clinic**	Older adults (60 and over) who are most at risk for experiencing access barriers	# of senior housing or resource sites	1 site added in FY25 (Rohnert Park People Services Center) *Target met. The target of adding two senior sites across mobile services in Sonoma County was achieved through additions made in FY24 and FY25.*	Add 2 senior sites in Sonoma County across mobile services
3. Private duty caregiving	Older adults unable to perform activities of daily living independently	% of seniors (60 years or older) served through caregiving contract annually	95% county-wide *On track. FY25 results demonstrate steady service delivery and continued progress toward maintaining access to caregiving support for older adults.*	Maintain services to at least 70% of eligible patients county-wide

4. Administer community grants to address aging issues	Older adults in Sonoma County	# of grants administered	1 grant county- wide in FY25 *Target met. A total of 6 grants supporting older adults were administered across FY24 and FY25, fulfilling the target to administer at least 3 by 2026.*	Administer 3 grants that address the needs of older adults county-wide

Key Community Partners

- AgeWell PACE
- Area Agency on Aging
- Council on Aging
- Emergency Prep Help
- Legal Aid of Sonoma County
- Petaluma People Services
- Providence Healdsburg Hospital
- Providence Petaluma Valley Hospital
- Providence Supportive Housing
- Reach for Home
- TheKey Private Duty Caregiving
- West County Community Services

FY25 COMMUNITY BENEFIT FINANCIALS

In FY25, Santa Rosa Memorial Hospital invested a total of $63,227,137 in key community benefit programs. $62,473,864 was invested in community benefit programs for the poor, including $11,044,391 in charity care and $44,296,382 in unpaid cost of Medical. $753,273 was invested in community benefit programs for the broader community. Santa Rosa Memorial Hospital applies a ratio of cost to charge to quantify financial assistance at cost, unreimbursed Medicaid, other means-tested government programs. The cost to charge ratio is aligned with the IRS Form 990, Schedule H Worksheet 2. Our community benefit program expenses are reported in alignment with the total cost incurred to run our programs, and we offset any restricted revenue received to arrive at our net community benefit expense.

FY2025 Santa Rosa Memorial Hospital
(July 1, 2024 - June 30, 2025)

Financial Assistance and Means-Tested Government Program	Vulnerable Population	Broader Community	Total
Traditional Charity Care	$11,044,391	$0	**$11,044,391**
Medi-Cal	$44,296,382	$0	**$44,296,382**
Other Means-Tested Government (Indigent Care)	$0	$0	**$0**
Sum Financial Assistance and Means-Tested Government Program	**$55,340,773**	**$0**	**$55,340,773**

Other Benefits			
Community Health Improvement Services	$4,287,536	$0	**$4,287,536**
Community Benefit Operations	$449,635	$353,273	**$802,908**
Health Professions Education	$0	$0	**$0**
Subsidized Health Services	$353,629	$0	**$353,629**
Research	$0	$0	**$0**
Cash and in-kind Contributions for Community Benefits	$2,042,291	$400,000	**$2,442,291**
Other Community Benefits	$0	$0	**$0**
Total Other Benefits	**$7,133,091**	**$753,273**	**$7,886,364**

Community Benefits Spending			
Total Community Benefits	$62,473,864	$753,273	**$63,227,137**
Medicare (non-IRS)	$73,173,571	$0	**$73,173,571**
Total Community Benefits with Medicare	**$135,647,435**	**$753,273**	**$136,400,708**

Telling Our Community Benefit Story: Non-Financial Summary of Accomplishments

Before the inception of Community Benefit, the Sisters of St. Joseph of Orange established a priority to care for the poor and vulnerable. Carrying out their mission that extends back to LePuy, France, 1650, these women were brought together by a Jesuit priest, Father Jean Pierre Medaille, who formed a new association of women, without cloister or distinctive dress, consecrated to God, to live together combining a life of prayer with an active ministry to the sick and poor. He instructed these women to go into the community, divide it into sectors, identifying the greatest needs while also seeking like-minded people who can help. To this day, now entrusted in the hands of the laity, we continue with this mission and follow these same instructions and inspiration from our founding Sisters.

Through active engagement and partnerships with local organizations in public and private sectors, we leverage resources to improve access to healthcare and to address social drivers of health.

Advocacy and Government Affairs

Providence actively engages at the local, state, and federal levels to advocate for policies that strengthen health care access, equity, and community well-being. Locally, we keep community members and elected stakeholders informed about healthcare changes through hospital tours and community events, fostering collaboration and transparency. At the state level, we joined with other health care organizations to support legislation improving behavioral health treatment, ensuring ethical use of AI in health care, and reforming seismic regulations. Federally, Providence opposed harmful funding cuts in H.R. 1 (One Big Beautiful Bill Act of 2025) and amplified community voices through our *Many Faces of Medicaid* campaign, which mobilized caregivers and patients to send more than 7,000 messages to lawmakers. Collectively, these efforts ensure that the voices of our communities are represented in decisions shaping the health system.

Boards and Committees Participation

Our staff members contribute their time and expertise by serving on various boards and committees across the state. These include the Sonoma County Binational Health Planning Committee, Blue Zones, California Rural Indian Health Board, Coordinated Entry Advisory Committee, Mendonoma Health Alliance, NAMI Sonoma County, Redwood Empire Dental Society, and Sonoma County Indian Health Project, Inc. Through this involvement, we foster collaboration and drive positive changes in the health and well-being of our community.

Staff also participate in several community-wide and state-wide meetings and initiatives, such as the Community Transitions of Care, Dental Health Network, Housing is Healthcare Collaborative, and the county-wide Interdepartmental Multi-Disciplinary Team.

Community and Health Fairs Events

Staff from across our department's programs actively participate in community events, providing vital health education, resources, and support to ensure that critical services and information are accessible to all members of the community. By engaging with diverse populations and addressing key health challenges, our presence at these events strengthens community ties and empowers individuals to take

control of their health. These efforts reflect our commitment to building a healthier, more informed community.

Vaccine Equity and Communications

Community Benefit actively participates in a variety of initiatives aimed at promoting vaccine equity and enhancing communication channels. These initiatives include participation in:

- Sonoma County Binational Health Planning Committee
- Vaccine Equity and Communications Committee
- Hearts of Sonoma
- Project HOPE
- Women's and Children's Health at Memorial (WHAM)
- Community Health Worker Advisory Council
- Community Transitions of Care

These collaborations ensure that underserved populations receive vital health services and resources.

Health Equity

We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that play an active role in determining health outcomes. Our Community Benefit staff is dedicated to addressing the root causes of racial and economic inequities that contribute to health disparities. Throughout FY25, staff have served as subject matter experts in assessing and addressing social determinants of health (SDOH), partnering with inpatient health equity teams to promote equitable outcomes for all patients.

South Park Community Building Initiative (CBI)

The Community Building Initiative (CBI) was created by the St. Joseph Fund as a long-term model for building resident leadership and community power. South Park is a neighborhood in southwest Santa Rosa with about 3,300 residents (43% Latino and 21% living below the poverty level). Providence Community Benefit serves as the fiscal sponsor and technical support provider.

Through CBI, residents formed the South Park Coalition, which organizes neighbors to address local priorities such as safety, crime, homelessness, and illegal dumping. With the neighborhood park as a central focus, the Coalition has advanced projects and advocacy efforts resulting in:

- Changes to the Mandatory Rental Inspection Policy
- Creation of Spanish-language code enforcement and crime reporting forms
- New murals in the neighborhood park
- An expanded youth soccer program
- Ongoing neighborhood events and a monthly newsletter
- Advocacy to name a new affordable housing complex, South Park Commons

The South Park Coalition continues to strengthen community pride, mobilize residents, and ensure that the neighborhood has an active voice in shaping its future.

Volunteer Engagement

The Community Benefit programs offer opportunities for nursing students from Sonoma State University, Chico State, Santa Rosa Junior College, and other schools to complete their community health rotation hours. By volunteering with the Mobile Health Clinic, students gain invaluable insights into public and community health, including outreach to homeless populations and culturally diverse groups such as migrant workers and undocumented individuals.

In addition to students, nurses from Santa Rosa Memorial Hospital, Petaluma Valley Hospital, and Healdsburg Hospital also volunteer with the Mobile Health Clinic, contributing to vital signs checks, wound care, flu clinics, and patient navigation.

Dental Education and Outreach

Providence's Dental Program also provides hands-on learning and outreach opportunities that inspire both students and patients:

- **Student Collaboration:** Through a partnership with Santa Rosa Junior College's Registered Dental Assistant (RDA) program, students are trained in oral health education for children. This collaboration gives students direct experience in community dental clinics, where they often serve as role models to children in the same schools they once attended. Teachers report that students are viewed as inspiring role models, motivating children to adopt better oral health habits.
- **Give Kids a Smile (GKAS):** Our Dental Clinic participated in *Give Kids a Smile*, a national initiative launched by the American Dental Association in 2003. In 2025, our clinic served 69 children, with a reported tooth decay rate of 46%. This program provides free dental care and education for children who might otherwise lack access, emphasizing prevention and early treatment to support lifelong oral health.

Community Partnerships

We work closely with community-based organizations (CBOs) throughout the county, serving as thought partners on various community initiatives. Our team provides presentations on our services, shares valuable information about access to healthcare, writes letters of support, and serves as references or CBOs seeking grant funding. In addition, we maintain close collaborations with our counterparts at Kaiser Permanente and Sutter Health to leverage resources to address high priority health needs in Sonoma County.

As we continue to build these meaningful partnerships and foster collaborative efforts, we remain dedicated to strengthening the health and well-being of Sonoma County's most vulnerable populations. Through our commitment to community-driven solutions and equitable healthcare access, Providence Sonoma County is making a lasting, positive impact on the communities we are privileged to serve.

2025 CB REPORT GOVERNANCE APPROVAL

This 2025 Community Benefit Report was adopted by the Community Benefit Committee of the Santa Rosa Memorial Hospital's Board of Trustees on October 28, 2025. The final report was made widely available by November 20, 2025.

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Barry Friedman
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11/3/2025

Barry Friedman — Date
Chair, Community Benefit Committee
Providence, Santa Rosa Memorial Hospital

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Garry Onley
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11/6/2025

Garry Onley — Date
Chief Executive
Providence, South Division

Signed by:
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11/9/2025

Michael Robinson — Date
Chief Community Health Officer
Providence, South Division

Contact:

Dana Codron, RN, MPH
Senior Director, Community Health
dana.codron@providence.org

To request a printed copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CHI@providence.org.