



St. Joseph Health, Queen of the Valley
FY 12 – FY 14 Community Benefit Plan/ Implementation Strategy Report



Table of Contents

	Page
EXECUTIVE SUMMARY	3
MISSION, VISION AND VALUES	4
INTRODUCTION – WHO WE ARE AND WHY WE EXIST	4
ORGANIZATIONAL COMMITMENT	
Community Benefit Governance and Management Structure	5
PLANNING FOR THE UNINSURED AND UNINSURED	7
COMMUNITY	
Defining the Community Benefit Service Area	9
COMMUNITY NEEDS & ASSETS ASSESSMENT PROCESS AND RESULTS	12
Summary of Community Needs and Assets Assessment Process and Results	12
Identification and Selection of DUHN Communities	16
Priority Community Health Needs	17
COMMUNITY BENEFIT PLANNING PROCESS	18
Summary of Community Benefit Planning Process	
Addressing the Needs of the Community: FY 12 – FY 14 Key Community Benefit Initiatives	22
Other Community Benefit Initiatives	29

EXECUTIVE SUMMARY

For over fifty years St. Joseph Health, Queen of the Valley (referred to in this document as Queen of the Valley) has been a vital resource and integral part of the Napa Valley community. A full service acute care 191-bed medical center, Queen of the Valley employs approximately 1,509 employees. The medical center is located within the City and County of Napa, and is the major diagnostic and therapeutic medical center for Napa County and the surrounding region. Since its beginning, Queen of the Valley Medical Center extended its role far beyond the traditional medical model and has dedicated itself to serving as a catalyst in promoting and safeguarding the health of the community. We continue our commitment to work collaboratively as a key community partner to enhance the health and quality of life for Napa County's most vulnerable communities. The health of our community depends on the creation and maintenance of strong physical and social structures, which promote and contribute to the wellbeing of those who live in Napa County.

Whereas Queen of the Valley Medical Center's primary and secondary service areas (PSA and SSA) include locations outside of Napa County, the community benefit primary and secondary service areas are defined by the geographic boundaries of Napa County. In general, the county is divided into four regions: North County consisting of Calistoga, St. Helena, Deer Park, Rutherford, and Oakville; East County consisting of Angwin, Pope Valley, and Lake Berryessa; Central County consisting of Napa and Yountville, and South County consisting of American Canyon. Approximately 69% of all county residents live in the City of Napa while the remainder lives in the balance of the county. While Napa is not considered a "poor" county relative to other counties, including those with large agricultural areas, about 11.3% of children and 7.2% of seniors age 65+live below the poverty level. Many more live below 200% of the Federal Poverty Level. Twenty-five percent of households speak Spanish as their primary language. An estimated 18,000 are not U.S. citizens; this can swell during the growing season.

FY12 - FY 14 Strategic Priorities identified through engagement with community stakeholders include initiatives to address:

1. Childhood obesity prevention
2. Access to dental care particularly for low income children
3. Behavioral health services for low income adults, older adults and all pregnant women
4. Chronic disease management for low income adults and older adults
5. Community health/prevention education and health literacy

Services will primarily be directed toward those with disproportionate unmet health needs and address access barriers such as language and transportation. In addition, a commitment to partnerships for community health improvement will focus on collaborative governance, community assessment, and systems and policy improvement.

St. Joseph Health, Queen of the Valley anticipates the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2012 CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospital in the CB Plan/Implementation Strategy.

MISSION, VISION AND VALUES

Our Mission

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

Our Vision

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

Our Values

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

INTRODUCTION – WHO WE ARE AND WHY WE EXIST

For over fifty years St. Joseph Health, Queen of the Valley (referred to in this document as Queen of the Valley) has been a vital resource and integral part of the Napa Valley community. A full service acute care 191-bed medical center, Queen of the Valley employs approximately 1,509 employees. The medical center is located within the City and County of Napa, and is the major diagnostic and therapeutic medical center for Napa County and the surrounding region. We recognize and embrace the social obligation to create, collaborate on and implement programs that address identified needs and provide benefits to the communities we serve. Our mission guides us 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.

Key medical center services include a community cancer center accredited by the American College of Surgeons with commendations, regional heart center, robotic and minimally invasive surgery center, acute rehabilitation center, women's health center, and the area's only neonatal intensive care unit. The Queen is committed to community wellness and is one of the first acute care providers to successfully develop and implement a medical fitness model Community Wellness Center on the medical center campus.

Since its beginning, Queen of the Valley Medical Center extended its role far beyond the traditional medical model and has dedicated itself to serving as a catalyst in promoting and safeguarding the health of the community. We continue our commitment to work collaboratively as a key community partner to enhance the health and quality of life for Napa County's most vulnerable communities. The health of our community depends on the creation and maintenance of strong physical and social structures, which promote and contribute to the wellbeing of those who live in Napa County. St. Joseph Health, Queen of the Valley provides programs and community support to address unmet or critical health related needs and improve the health of the community at-large, particularly for low-income underserved community members.

Recent initiatives have addressed dental care for underinsured children, chronic disease management, childhood obesity, access to mental health services for at-risk adults, health literacy for Spanish-speakers, and healthy aging policies and programs. Community Outreach works in concert with community partners to expand access, leverage resources and address broad community concerns.

ORGANIZATIONAL COMMITMENT

Community Benefit Governance and Management Structure

Engagement in Community Benefit Plan Development

The St. Joseph Health, Queen of the Valley Board of Trustees and Administration take an active and informed role in the development and oversight of the Community Benefit Strategic Plan. Members of the Board of Trustees sit on the Community Benefit Committee and executive level staff including the Vice President of Mission Integration, Vice President of Quality and Strategic Planning, and the Executive VP and COO participated as members of an ad hoc Community Benefits Strategic Planning Committee charged with making recommendations on priorities to the overall Community Benefits Committee.

The Strategic Outcomes of the Ministry provide the foundation for both the Ministry's strategic plan the Community Benefit Plan. The Community Benefit plan reflects a continuum of the goals of Healthiest Communities, Perfect Care, and Sacred Encounters from the medical care provided through the hospital to community services provided through community benefit programs. Programs initiated will offer the highest quality care and respect for individuals and culture for everyone regardless of economic status, culture, or language carrying out the core values of dignity, service, excellence and justice. In addition, community benefit initiatives support St. Joseph Health, Queen of the Valley strategic initiatives to reduce costs due to delayed care, inappropriate use of the emergency room and preventable hospitalizations. Efforts to improve health and wellness overall and community-based disease management are carried through the proposed community benefit initiatives.

Commitment to Community Benefit

Queen of the Valley Medical Center demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The Vice President of Mission Integration and Executive Director for Community Outreach are responsible for coordinating implementation of California Senate Bill 697 provisions as well as provide the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and carrying out the Community Benefit Plan.

The Community Benefit Management Team provides orientation for all new Medical Center employees on Community Benefit programs and activities, including opportunities for community participation.

Queen of the Valley supports The St. Joseph Health System Foundation's primary objective to provide care for the poor and medically needy in addition to what is already being provided through charity care write-offs in our hospitals. Projects support community services for the poor and medically needy or other disadvantaged persons. Contributions to other qualified charitable organizations may be used to meet these objectives.

A charter approved in 2007 establishes the formulation of the St. Joseph Health, Queen of the Valley Community Benefit Committee. The role of the Community Benefit Committee is to support the Board of Trustees in overseeing community benefit issues. The Committee acts in accordance

with a Board-approved charter. The Community Benefit Committee is charged with developing policies and programs that address identified needs in the service area particularly for underserved populations; overseeing development and implementation of the Community Needs Assessment and Community Benefit Plan; and overseeing and directing the Community Benefit activities.

The Committee has a minimum of 8 members including 3 members of the Board of Trustees. Current membership includes 6 members of the Board of Trustees and 14 community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. Committee generally meets monthly.

Roles and Responsibilities

Senior Leadership

- CEO and other senior leaders are directly accountable for CB performance and Integrating ASACB Core Principles into hospital-wide practices.

Community Benefit Committee (CBC)

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

Community Benefit Department

- Manage community benefits programs and initiatives. Coordination between CB and finance departments on reporting and planning.
- Data collection, program tracking tools and evaluation.
- Develop specific outreach strategies to access identified DUHN populations.
- Coordinate with clinical departments to reduce inappropriate ER utilization.
- Advocate for CB to senior leadership.
- Investment in programs to reduce health disparities.

Medical Center/Organization

- Integrates ASACB Core Principles in CB and organizational strategic planning
- Physicians engaged in program development, implementation and evaluation.
- Coordination of hospital departments in case management strategy to reduce inappropriate (frequent flier’) visits to ED due to chronic health conditions.
- Seamless continuum of care between physician and community services.

Community

- Partnership to implement and sustain collaborative activities.
- Formal links with community partners.
- Recognition of priority health issue and collaborative activities to address it
- Engagement of local government officials in strategic planning and advocacy on health related issues on a city, county, or regional level.

PLANNING FOR THE UNINSURED AND UNDERINSURED

Financial Assistance Program

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why St. Joseph Health, Queen of the Valley has a Patient Financial Assistance Program that provides free or discounted services to eligible patients.

Depending upon individual patient eligibility, financial assistance may be granted for full charity write-off or for a partial discount. Financial assistance may be denied when the patient or other responsible family representative does not meet the Financial Assistance Policy requirements. Eligibility exists for any patient whose family income is less than 500% of the current federal poverty level, and if not covered by third party insurance or if covered by third party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account. If the patient's family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements ("Qualified at 200% FPL or less"), the entire (100%) patient liability portion of the bill for services will be written off.

Process to Ensure Implementation of Policy

The St. Joseph Health, Queen of the Valley Financial Assistance Program utilizes a single, unified patient application for both full Charity and partial Charity Discounts. The process to obtain assistance is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The financial assistance application provides patient information necessary for the hospital to determine patient eligibility and such information will be used to qualify the patient or family representative for maximum coverage under the SJHS Financial Assistance Program.

St. Joseph Health, Queen of the Valley posts notices and brochures in Spanish and English informing the public of the Financial Assistance Program. Notices are posted in high volume inpatient, and outpatient service areas of the hospital, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas or other common patient waiting areas of the hospital. Notices are also posted where patients may pay their bill. Notices include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance. When patients are pre-registered for services, central scheduling staff provides them with information about financial assistance and refers the patient to our Financial Counselor to link them to any potential payer sources and assist them with enrollment for St. Joseph Health, Queen of the Valley support.

Staff with patient contact receives training to talk with patients about the financial assistance available and process for applying. Personnel are trained to assist patients with the forms and to review financial assistance applications for completeness and accuracy will review completed applications as quickly as possible and provide a timely response. In addition, St. Joseph Health, Queen of the Valley provides information about the program to private practices.

Public Notification of Policy

Patients or their family representative who are provided an application for the Financial Assistance Program and who elect to complete it on their own are told of the availability of assistance to complete the application, where to turn in the application once complete, and what they can expect in follow-up.

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. A patient information brochure that describes the features of the St. Joseph Health, Queen of the Valley Financial Assistance Program will be made available to patients and members of the general public. A copy of the Financial Assistance Policy is made available to the public on a reasonable basis.

The St. Joseph Health, Queen of the Valley Financial Assistance Program utilizes a single, unified patient application for both Full Charity and Partial Charity Discounts. The process to obtain assistance is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The financial assistance application provides patient information necessary for the hospital to determine patient eligibility and such information will be used to qualify the patient or family representative for maximum coverage under the SJHS Financial Assistance Program.

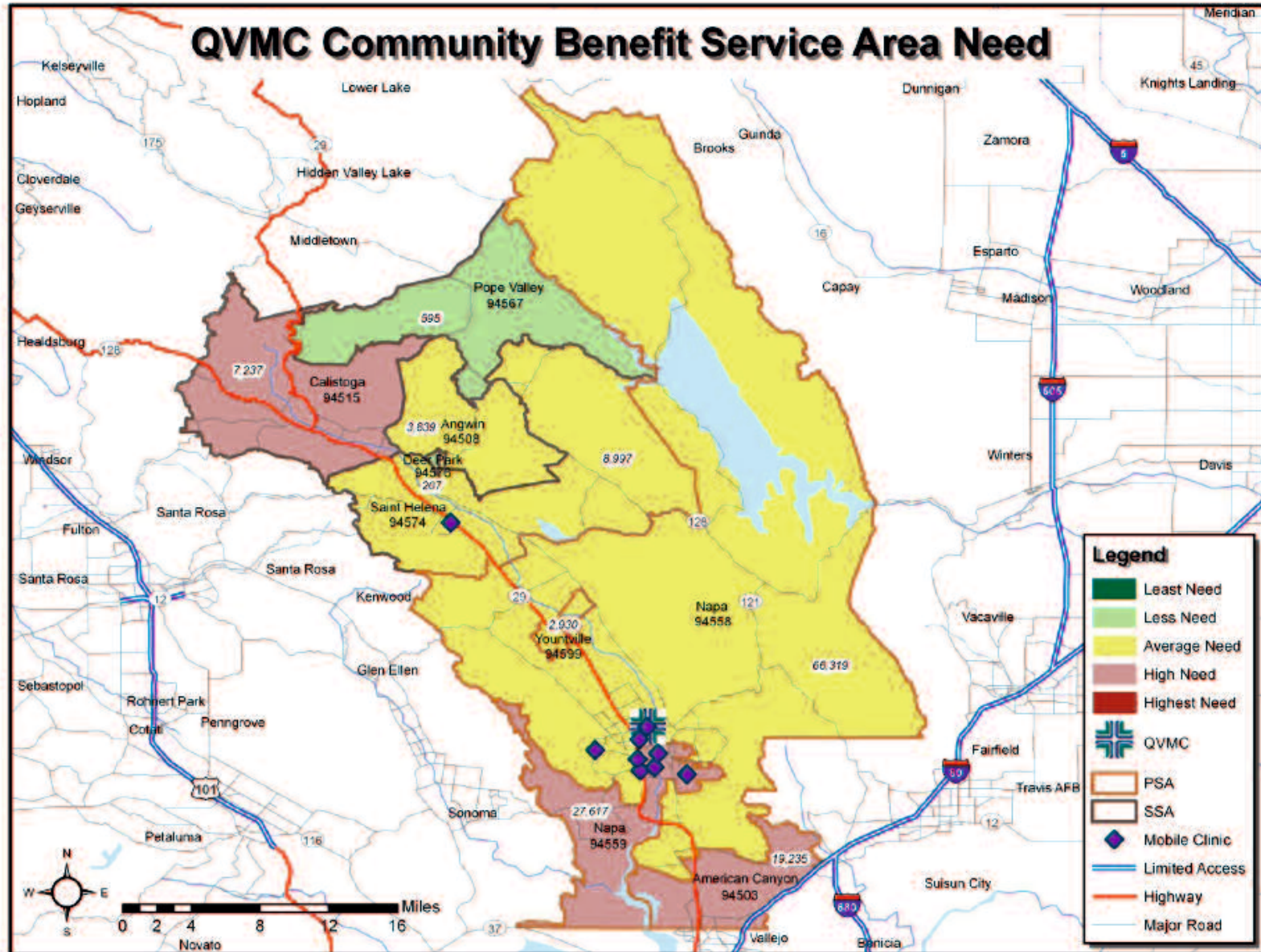
COMMUNITY

Definition of The Community Benefit Service Area

Whereas St. Joseph Health, Queen of the Valley's primary and secondary service areas (PSA and SSA) include locations outside of Napa County, the community benefit primary and secondary service areas are defined by the geographic boundaries of Napa County. In general, the county is divided into four regions: North County consisting of Calistoga, St. Helena, Deer Park, Rutherford, and Oakville; East County consisting of Angwin, Pope Valley, and Lake Berryessa; Central County consisting of Napa and Yountville, and South County consisting of American Canyon. Approximately 69% of all county residents live in the City of Napa while the remainder lives in the balance of the county. While the population of Napa County increased overall since 2000, the city of American Canyon has nearly doubled in size and is already the second-largest city in Napa County. Services for residents in this area are still being established—and various community agencies continue to work to understand what individuals and families in this expanding community need.

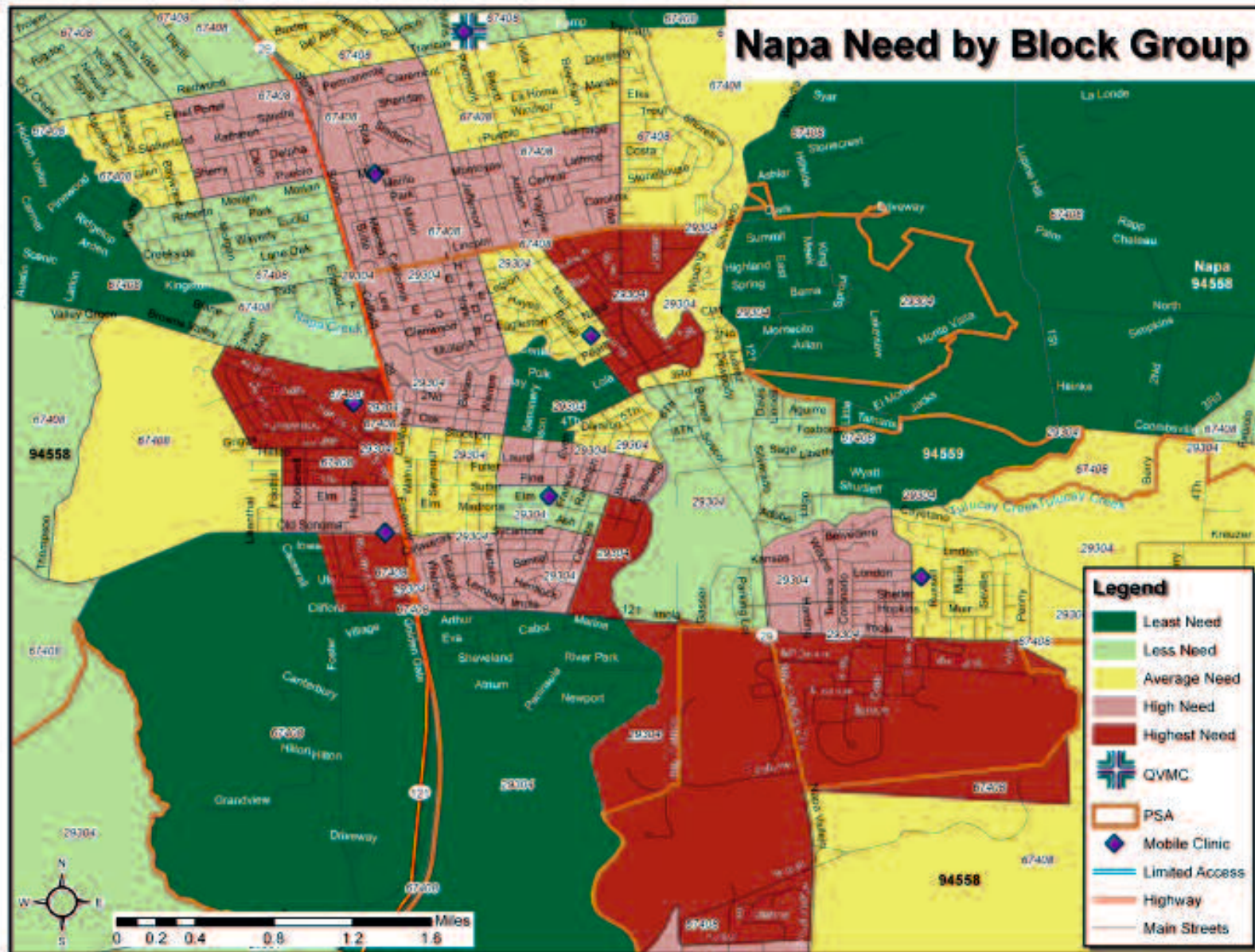
While Napa is not considered a “poor” county relative to other counties, including those with large agricultural areas, about 11.3% of children and 7.2% of seniors age 65+live below the poverty level. Many more are live below 200% of poverty. A greater proportion of children live in poverty in the cities of Napa (14.9%), Anguin (11.9%), Yountville (17.8%) than in other cities in the county. Twenty-five percent of households speak Spanish as their primary language. An estimated 18,000 are not U.S. citizens; this can swell during the growing season. With 15% of the population is over 65 years of age, Napa County has a higher proportion of older adults compared to California as a whole and the third highest proportion of those 75 and older. 22.5% of the population is 17 years of age and younger. Nearly 58% of the population is White, 31.8% are Latino, 6.15% are Asian, 1.87% are African American, 3.62% are other. (Source: Community Benefit Service Area Mapping of Need, St. Joseph Health, February 2011)

The maps on page 10 and 11 depicts the CBSA highlighting those areas of the county where need is greater including Calistoga in north county and Napa and American Canyon in south county (by zipcode and block group respectively).



Source: Community Need Index, Catholic Healthcare West, 2011

Prepared by the St. Joseph Health System Community Health Department



COMMUNITY NEEDS & ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs and Assets Assessment Process and Results

A community health needs assessment is conducted every 3 years to assist hospitals and county public health in determining health priorities, emerging gaps and ongoing needs. The 2010 Napa County Community Health Needs Assessment was a combined venture of area hospitals (Queen of the Valley Medical Center, Kaiser Permanente, St. Helena Hospital) and the County Public Health Department.

Quantitative and qualitative methods were used to collect information for this assessment, which included both primary and secondary data sources. Community needs assessments and environmental scanning—which involves gathering, analyzing and *applying* information for strategic purposes—provide the necessary information to inform decision makers and funders about the challenges they face in improving community health, and the priority areas where support is most needed. The information is also useful for community organizations by having comprehensive, local data located in one document.

Existing Document and Data Review

A document review collected relevant information about the community, health status, where health services are obtained, other related services, and gaps in services. This information was found in documents and records of facilities such as data from local clinics and state government, reports from earlier needs assessments conducted related to health, and reports about specific health programs or services.

Existing data were collected from all applicable existing data sources including government agencies (e.g., California Department of Finance, Office of Statewide Health Planning and Development, California Department of Health Care Services), and other public and private institutions. These data included demographics, economic and health status indicators, and service capacity/ availability. All needs assessments are dependent on access to timely and reliable data. While data at the national and state level are generally available for community health-related indicators, local data—from counties and cities—are less accessible and sometimes less reliable. For example, small sample sizes can result in statistical “instability,” and well-meaning data collection methods without appropriate “rigor” may limit the value of the findings. Because data from publicly-available sources typically lag by at least 2 years—because it takes time for reported data to be received, reviewed, approved, analyzed, and prepared for presentation—data may not always be as current as needed. And, some data may only be reported as 3-year averages, not annually.

Community Input

Three primary methods of collecting input from the community were used in the collaborative needs assessment process: Community questionnaires, focus groups, and key informant interviews. A questionnaire developed in English and Spanish for the general public inquired about most-important health needs, ideas for responsive solutions, and habits they used to maintain their own personal health. Certain questions that served as markers for access to services were also included. The survey was distributed in hard copy by the consultants and members of the Collaborative to locations where the groups of interest would best be reached, such as at health

fairs, branches of public libraries, and Boys and Girls Clubs, and family resource centers throughout the county. In addition, the survey was made available by computer (English/Spanish) and notices about the online version were posted on various organizations' websites and in their newsletters including, to a limited degree, Spanish-speaking media outlets. All of the electronic and hard-copy survey data were cleaned, coded, and entered into an Excel spreadsheet and analyzed using SPSS Version 15.0.

Four locations—Napa, Calistoga, St. Helena, and American Canyon—were chosen to ensure geographic representation and 9 community focus groups were conducted at sites intended to draw populations that typically gathered there. Key community-based organizations were identified by the Collaborative and asked to host a focus group. Focus groups were co-scheduled at the sites among participants who were already meeting there for other purposes (e.g., young mothers at a parenting class) to facilitate access and promote attendance. Although the participants constituted a convenience sample, there was the expectation that *in the aggregate* the groups would be diverse and include the populations of highest interest.

To ensure that working people could attend, some of the meetings were held in the evening. One meeting was held in the early morning to accommodate people coming to drop their children off at a preschool, and other daytime meetings were held for seniors or others who had difficulty driving at night or did not like to go out after dark. The groups were facilitated in English and Spanish with a bilingual/bicultural facilitator using a set of key questions (Appendix 4). The questions were generally open-ended; prompting with information or data was limited to reduce the potential for bias or leading of participants to any conclusions. Participants were not asked to “vote” or otherwise rank the items they identified as needs, problems or solutions. The focus group data were recorded on a flip chart by the facilitator during the meetings then transferred to written summary formats where it was coded and analyzed.

In-depth telephone interviews using a structured set of questions were conducted, primarily individually, with a representative group of 20 individuals whose perceptions and experience were intended to inform the assessment. The interviews provided an informed perspective from those working “in the trenches,” increased awareness about agencies and services, offered input about gaps and possible duplications in service, and solicited ideas about recommended strategies and solutions. The interviews also focused the needs assessment on particular issues of concern where individuals with particular expertise could confirm or dispute patterns in the data and identify data and other studies of which the Collaborative might not otherwise be aware.

Countywide Priority Setting Process

After the assessment data were compiled and analyzed, the Collaborative reviewed the draft assessment report and engaged in a discussion that led to recommended priorities for funding. The process included determining criteria for selecting priorities; listing key issues and common themes; identifying findings that were unexpected and surprising and assumptions that were supported by the data; addressing the challenges and barriers; and determining opportunities with long-term benefit for improving community health in Napa County.

Assets and Needs (Source: 2010 Napa County Community Health Needs Assessment)

The public and community leaders identified important factors that act to promote (assets) or hinder (challenges) health in Napa. These include the unusually high degree of collaboration

St. Joseph Health, Queen of the Valley
FY 12- FY 14 Community Benefit Strategic Plan/ Implementation Strategy Report

among organizations was widely recognized as one of the most important assets relative to planning and delivering services in the county. Below is a table describing characteristics that contribute to or impact negatively community health.

The community members made many recommendations about where additional support was needed to improve health in Napa County; the most frequently suggested strategies and solutions—which tie to the needs they identified—are listed below in frequency of mention.

Community Health Survey	Community Focus Groups	Key Informant Interviews
Availability of low-cost health insurance	Availability of low-cost health insurance	Expand community-based mental health services
Access to wellness-type centers/services (especially those that promote exercising)	Availability of low-cost dental services (especially for adults, seniors)	Use mobile dental to deliver more services; support free/low-cost dental for adults and seniors
Year-round activities for youth (that youth can relate to)	Efforts that improve school lunches; that teach kids healthier food choices (gardens)	Address youth substance abuse, especially re. use of alcohol
Efforts to increase cleaner environment (air, water)	Support more options for affordable housing	Provide food as a basic need (food banks, community gardens)
Low-cost mental health counseling services	Promote health education (especially for Spanish-speaking and teens re. risk behaviors)	Support services for the elderly (homebound, frail, low-income)
Support services for the elderly (homebound, frail, low-income)	Support affordable exercise options (low-cost gyms, free bicycles)	Support efforts that increase awareness of services/where to go for help

Much of the infrastructure needed to provide health services appears to be in place in Napa County, particularly for those with employer-based insurance. A comprehensive community health clinic, widely recognized as being a major safety net provider, serves the neediest residents along with two non-profit hospitals and a public health system.

The provision of clinical services is not the only thing that contributes to health: numerous nonprofit organizations play unique and critical roles. An adequate number of primary care physicians and general dentists practice in the community. Health insurance is available for low-income children, at least in the short term, from the progress made by the Children’s Health Initiative.

The gaps are most evident in the limitations to the infrastructure relative to affordability, accessibility, distribution, flexibility, or emphasis of the following: community-placed mental health services; dental services for adults; health care for adults without insurance, not eligible for Medi-Cal, and unable to pay sliding fees; providers in some specialty areas, willingness of physicians and dentists to accept Medi-Cal; transportation options; bilingual healthcare workforce; and comprehensive communitywide preventive health in all aspects of community life in Napa County.

Other assets and resources to address community health and wellbeing were catalogued in the needs assessment survey of the community. While Napa has a strong nonprofit community, many are stretched as government and philanthropic resources are less available to support provision of their services.

Recommended Priorities of the Countywide Needs Assessment

(Source: 2010 Napa County Community Health Needs Assessment)

The Needs Assessment Collaborative agreed that an important opportunity exists in Napa County for all health partners—regardless of their own organization’s mission and priorities—to focus on the following 4 priority areas (in no order of significance):

- Strategies that address the growing epidemic of obesity and all of the health and cultural factors that contribute to the problem;
- Senior support services that encompass mental, social, and physical health and well-being, including needed support for caregivers;
- Substance abuse as an issue for families, schools, businesses, and the safety of the community—ranging from use during pregnancy to underage drinking to abuse of prescription drugs by seniors and other adults—that recognizes and integrates biological and socio-cultural factors into models of prevention and care;
- Mental and emotional health and its relationship to overall health that needs to be more adequately understood, addressed, and resources provided for.

Identification and Selection of DUHN Communities

Communities of disproportionate unmet need in Napa County include low-income children, adults and elders in need of dental care and mental health services, chronic disease management, and access to community-based services, youth and adults at risk of alcohol abuse and culturally and linguistically appropriate health education, and prevention of childhood obesity, including:

1. Low income children including Latino children and their families where English is limited and access to information and services is difficult
 - a. Expand access to affordable, quality oral health services
 - b. Child and family health education to promote wellness, prevent obesity and reduce asthma risks
 - c. Access to affordable health care
 - d. Parent education and leadership development to participate more fully in supporting their children’s academic success
2. Low income pregnant women particularly those who do not speak English
 - a. Access to prenatal education to improve birth outcomes and infant care
 - b. Reduction of risk factors associated with perinatal depression
3. Low income adults and older adults
 - a. Access to services to improve quality of life and disease management
 - b. Access to affordable, community-based mental health services for depression and other behavioral health issues
 - c. Access to affordable primary health care
4. Low income older adults
 - a. Access to affordable, quality dental care

St. Joseph Health, Queen of the Valley
FY 12- FY 14 Community Benefit Strategic Plan/ Implementation Strategy Report

- b. Access to mental health services
- c. Access to community-based support

The table below describes DUHN populations, key needs and community assets:

DUHN GROUPS AND KEY COMMUNITY NEEDS AND ASSETS SUMMARY TABLE		
DUHN Population Group	Key Community Needs	Key Community Assets
Low income children Latino children and their families	Continued access to affordable, quality oral health services including preventive services and education	QVMC Mobile Dental Van Sister Anne's Dental Clinic Community sites Head Start
	Prevention and early intervention to improve nutrition, physical activity and prevent obesity	QVMC Bilingual community education program Children & Weight Coalition Healthy for Life Program Schools QVMC Wellness Center Parent University Family Resource Centers
	Access to affordable healthcare	Children's Health Insurance Initiative Gardiner & Associates Community Clinic Ole
	Reduce educational opportunity gap (social determinant of health): Increase education parental involvement in schools	Title I schools Bilingual health education Parent University On the Move
Low income pregnant women particularly women who do not speak English	Access to prenatal education to improve birth outcomes, encourage breastfeeding including number of low birth weight infants	QVMC Perinatal Spanish Workshops Healthy Moms and Babies Linkage to clinical care programs for pregnant women
	Access to screening and early intervention for perinatal depression	Perinatal Mood Disorders program) QVMC
Low income adults, including Spanish-speaking adults	Chronic disease management: Access to care, support, education and mental health services to improve quality of life and disease management	QVMC Care Network QVMC (hospital) Community Clinic Ole Family Service of Napa Valley Wellness Center
	Access to affordable, community-based behavioral health services for depression and other behavioral health issues	Family Service of Napa Valley Clinic Ole County Mental Health Services Family Resource Centers
	Access to affordable dental care	Sister Anne's Dental Clinic
	Access to affordable health care	Community Clinic Ole QVMC

Low income seniors	<u>Access to affordable, quality dental care</u>	Sister Anne's Dental Clinic
	<u>Access to affordable mental health services including preventive programs</u>	Family Services of Napa valley Area Agency on Aging Adult Day Services CSOA
	<u>Chronic disease management</u>	QVMC CARE Network QVMC Community Clinic Ole Family Service of Napa Valley Wellness Center
	<u>Access to community-based supports for independent living</u>	AAA CANV CSOA IHSS Senior Centers Home Health care agencies

Priority Community Health Needs

The following figure describes the Community Health Needs identified through the SJH, Queen of the Valley CHNA as priorities. Those needs that the hospital does not plan to address are noted¹.

Health Needs Identified through CHNA	Plan to Address
• Lack of Affordable Accessible Care	Yes
• Lack of Affordable Dental Care	Yes
<i>Community Collaborative Identified Priority Areas:</i>	
• Strategies that address obesity	Yes
• Senior Support Services	Yes
• Substance abuse	No
• Mental & emotional health	Yes
Other identified needs/gaps in the CHNA	
• Health Insurance (more affordable medical and dental services)	Yes
• Dental for seniors and adults	Yes
• Prevention related (nutrition, exercise, weight control)	Yes
• Basic needs (housing)	No
• Basic needs (jobs)	No
• Basic needs (transportation)	No
• Basic needs (environmental)	No

¹ A number of community health needs are already addressed by other organizations and will not be addressed in the implementation plan report.

Health Needs Identified through CHNA	Plan to Address
• Specific health conditions (chronic disease)	Yes
• Lack of awareness of health prevention services	Yes
• Senior supportive services	Yes
• Senior mental health	Yes

The following health needs will not be addressed directly through a St. Joseph Health, Queen of the Valley initiative or program because they are already directly addressed by local non-profit organizations that have the expertise to directly address the following areas of need: basic needs (housing), basic needs (jobs), basic needs (transportation), basic needs (environmental), and substance abuse.

St. Joseph Health, Queen of the Valley, will collaborate with local organizations that address aforementioned community needs, as appropriate, to coordinate care and referral and address these unmet needs.

ST. JOSEPH, QUEEN OF THE VALLEY COMMUNITY BENEFIT STRATEGIC PLANNING PROCESS

Summary of Community Benefit Planning Process

The Community Benefit Committee convened a representative Planning Committee including staff, community members, professionals and hospital trustees to review the community needs assessment and determine how best to align the community benefits efforts of the Queen of the Valley over the next three years to address the unmet needs in the community.

The Planning Committee convened in two meeting over 6 hours and developed criteria for selection of priorities and prioritized health needs using these criteria.

The processes included reviewing and discussing:

- SB697 guidelines and core principles
- The Ministry Goals
- Past and current community benefit activities including charity care contribution
- Community Health Needs Assessment
- Communities and populations where disproportionate health needs exist.

To determine priority initiatives the committee identified:

- Key health issues for consideration, current trends/community context and common themes;
- Findings that were unexpected and surprising as well as assumptions that were supported by the Needs Assessment data
- Trends
- Challenges and barriers and determining specific opportunities for Queen of the Valley to contribute to improving community health in Napa County, particularly for those with disproportionate need.

Prior to the convening of the Planning Committee, Community Outreach staff conducted a comprehensive cost benefit analysis of current initiatives and programs. To assess ongoing community need, effectiveness and efficiency of the services provided, and leveraging of community resources. The Planning Committee reviewed these existing community benefit programs addressing DUHN communities and identified health priorities.

Implications from a discussion about trends and the context for planning resulted in some themes to guide initiative development and success factors for addressing community health more broadly:

Themes:

1. Coordination and collaboration is more important than ever to conserve and utilize resources
2. Strong linkages and continuums of care and services among organizations and agencies are critical to support effective use of resources
3. Leadership is needed to promote systematic approach to addressing community issues and needs.

Vision for Community Health in Napa County

The committee articulated a shared vision adopted by the Community Benefits Committee to serve as an overall guidepost for the plan.

COMMUNITY HEALTH VISION FOR NAPA COUNTY
<ul style="list-style-type: none">+ <i>Napa County becomes a model for community health</i><ul style="list-style-type: none">o We have widely shared vision of community healtho Community health planning is collaborativeo We are preventing health problems upstreamo We are meeting Healthy People 2020 objectiveso Health of the community is taken into account in all policies; e.g., physical environment, food access, housing, transportation+ <i>We have a strong, accountable continuum of health care</i>+ <i>Important services and programs have been sustained</i>+ <i>Health reform is implemented effectively and more people have access to care</i>+ <i>People know where and how to access services</i>

Priority Setting

The Planning Committee discussed and agreed upon specific initiatives and strategies to address the unmet and ongoing health needs based on the criteria in the table below. The following criteria were used to select priority health initiatives. The proposed initiatives were developed through an individual ranking and consensus process.

INITIATIVE SELECTION CRITERIA

The Initiative should:

- Align with ASACB Core Principles
- Build upon and aligns current programs with identified priority community health needs
- Be appropriate to our mission, goals and expertise
- Serve most vulnerable
- Leverage and align with hospital resources and goals
- Provide opportunities for linkages with other organizations, institutions and stakeholders
- Have potential for high impact on issue/individuals
- Be cost effective
- Inspire passion and commitment to address
- Is achievable with sufficient resources available to address
- Be able to be implemented utilizing best practices and innovation
- Be Measurable
- Address multiple factors: environmental, individual, root causes

The highest priorities identified were consistent with ongoing community health needs, St. Joseph Health, Queen of the Valley goals and strategic initiatives, and new or emerging health needs identified in the 2010 Community Health Needs Assessment:

Ongoing Community Health Needs (evident in 2007 and 2010 Community Health Needs Assessment) included the following:

1. Access to Dental Care
2. Chronic Disease Management
3. Childhood Obesity
4. Access to Mental Health Services and Supports
5. Community Health Education (focused on preventing health problems and addressing barriers to health and health care access.)

In addition, the Committee recommended two efforts to build community capacity and governance to understand and address issues affecting access to care and health of the whole community and particularly those with disproportionate health needs.

1. Assuring a strong, accountable continuum of affordable health care, particularly for low income and un- or underinsured residents
2. Building a community health vision and partnership to take action to address health inequities based on an understanding of how where we live, work and play has an impact on health, may accumulate over individuals' lifetimes and continue unbroken through generations.

In addition, the Community Needs Assessment identified youth at risk of abuse of alcohol, tobacco and other drugs. Recommended needs included the following:

St. Joseph Health, Queen of the Valley
FY 12- FY 14 Community Benefit Strategic Plan/ Implementation Strategy Report

- a. Community awareness to reduce high rates of underage drinking
- b. Community policies to reduce access to alcohol
- c. Risk reduction for driving accidents and violence associated with alcohol and drug use

Primary leadership for this issue will be undertaken by County Substance Abuse Services, the Vintners' Association and a community coalition focused on policy change. St. Joseph Health, Queen of the Valley will support these endeavors.

Recommendations from the Planning Committee were presented to the Community Benefits Committee in the form of a framework depicting initiatives and potential programs. In addition, rationale for the initiatives was articulated in 3W template form for the Community Benefit committee review and discussion. This Community Benefits plan framework was approved prior to the development of the plan.

Community Outreach Department staff developed logic models (4Es) for each initiative describing outcomes, strategies, measures and tools for evaluation. They conducted cost analysis and considered ways to leverage internal and external resources to increase impact of the initiatives. The plan was then presented to the Community Benefit Committee for approval and forwarded to the St. Joseph Health, Queen of the Valley Board of Trustees.

Addressing the Needs of the Community: FY 12 – FY 14 Community Benefit Plan/Implementation Strategies

Disease Case Management for Low-Income Chronically Ill CARE Network (Case Management, Advocacy, Resources, & Education)

Chronic disease is among the most prevalent and costly of all health problems. Adequate management of chronic diseases is difficult enough for persons with financial resources and social support; however, for those with few financial resources and/or social supports chronic disease management can be overwhelming. Research has demonstrated that chronic disease care is most effective in an outpatient care setting. Use of the emergency department and in-patient hospital care is costly and less effective in improving the quality of life for patients with chronic conditions. As a result, SJH, QV has developed the CARE Network, an American Hospital Association NOVA award winning program, to enable community dwelling residents with chronic disease access to disease management and social services maximizing wellness and quality of life.

Key Community Partners: Adult Day Services of Napa Valley, Community Health Clinic Ole (FQHC), Family Services of Napa Valley, Hospice of Napa Valley, Food Bank, Legal Aid of Napa Valley, local healthcare providers, Napa Community Housing, Napa County Comprehensive Services for Older Adults (CSOA), Napa County Health and Human Services, State Office of AIDS, St. Joseph Health Queen of the Valley's Synergy Medical Fitness Center, Cardiac Rehabilitation, Discharge Planning, and Cancer Center

Target Population: Low-income, chronically ill Napa County residents, their families and caregivers.

Goal: Improve the quality of life of low-income adults with chronic diseases and/or co-morbidities and complex socio-economic needs.

Scope: All CARE Network clients

How will we measure success?: Community-based disease management requires assistance with medical resources as well as assistance with basic needs such as food and housing. The desired result is that client has an increased understanding of his or her chronic disease, an increased ability to successfully manage at home, and ultimately an improved quality of life. Therefore the measure of success is the median change score on a quality of life survey (SF12v2). The quality of life survey is conducted upon program entry and again after 3 months or at closure to the program (depending on which occurs first).

Three-Year Target: By 6/30/2014 increase the median change score of SF12v2 from baseline (5.13) to 7.5

Strategy 1: Deliver necessary medical resources.

Strategy Measure 1: Percentage of care plan medical resources acquired/timeframe (reduction in acuity level)

Strategy 2: Provide linkage to community support services through case management.

Strategy Measure 2: Percentage of care plan resource referrals completed within 3-6 months.

Strategy 3: Enhance disease self-management.

Strategy Measure 3: Pre/post ER utilization

Addressing the Needs of the Community: FY 12 – FY 14 Community Benefit Plan/Implementation Strategies

Dental Care for Low-Income Children Children's Mobile Dental Clinic

The importance of oral health in the context of overall health and quality of life cannot be underscored. For children, oral pain or discomfort impacts the ability to concentrate in school, the ability to eat a healthy diet, and can lead to serious infection and other medical problems. In light of a community needs assessment indicating a need for oral health care for Napa's low-income children, SJH, QV implemented the Children's Mobile Dental Clinic in 2005.



Key Community Partners: Browns Valley Elementary School, Child Development Programs, Dos Mundos, Harvest Middle School, Los Niños, Menlo, Napa County Child Start Programs, Napa County Health and Human Services Napa County Office of Education, Napa Valley Language Academy, Napa Valley Unified School District, Phillips Elementary School, Puertas Abiertas Family Resource Center, Shearer Elementary School, St. Helena High School, Therapeutic Child Care Center, , Valley Oak Alternative High School

Target Population: Low-income, uninsured and under-insured children 6 months to 21 years of age in Napa County.

Goal: To improve the oral health of children 6 months to 21 years of age in Napa County, particularly those who are uninsured or underinsured.

Scope: Mobile Dental Clinic Patients

How will we measure success?: Percent of patients who demonstrate oral health improvement at recall visit based on set of clinical criteria

Three-Year Target: 6/30/2014, increase percentage from baseline (90%) by 10%

Strategy 1: Provide oral health screening and education in preschools and elementary schools.

Strategy Measure 1: Number of low income preschool and elementary children screened for dental problems

Strategy 2: Provide Mobile Dental clinic 6-month examinations and cleaning.

Strategy Measure 2: Percentage of patients having seen a dentist within 6 months to one year following initial examination

Strategy 3: Provide patient and parent/caregiver education on oral health behaviors

Strategy Measure 3: Percentage of patients/parents reporting improved oral health behaviors

Strategy 4: Provide Mobile Dental procedures as necessary and indicated by patients

Strategy Measure 4: Number of services

Addressing the Needs of the Community: FY 12 – FY 14 Community Benefit Plan/Implementation Strategies

Reducing Prevalence of Childhood Obesity in Napa County

Childhood obesity in the United States has more than tripled in the past thirty years, and carries both immediate and long-term health impacts. Children and adolescents who are obese are at greater risk for bone and joint problems, sleep apnea, and are more likely than normal weight peers to be teased and stigmatized which can lead to poor self-esteem. Moreover, obese youth are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure. Finally, overweight and obese youth are more likely than normal weight peers to be overweight or obese adults and are therefore at risk for the associated adult health problems, including heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis. In Napa County, 17% of preschool children ages 2-4 living in households with an income less than 200% of the federal poverty level were obese with BMI's above the 95th percentile (Napahealthmatters.org). In an effort to address this critical health issue, Queen of the Valley has implemented a variety of initiatives targeting newborns to entire families.

Healthy for Life

St. Joseph Health adopted a system-wide, school-based childhood obesity prevention program titled “**Healthy for Life,**” designed to emphasize lifelong fitness and healthy eating behaviors among children and adolescents. The program incorporates physical assessments by pediatricians, the provision of training and exercise equipment to schools, as well as guest instructors for a variety of classes including kick boxing, circuit training and nutrition.

Goal: Increase knowledge on topics related to childhood obesity among populations in Napa who are most at risk.

Community Partners: Schools, Districts, Office of Education, Teachers, Healthcare providers, County Public Health, Community Organizations, Hospital, Breastfeeding Coalition members, Children & Weight coalition members, Wellness Center, Breastfeeding Coalition

Outcome Measure:

Number of pregnant women, children and families that increase knowledge of healthy behaviors to prevent or reduce childhood obesity

Scope: The initiative will target infants and children who are overweight or obese or at risk for obesity and their families in Napa County.

Strategy 1: Implement school-based obesity prevention

Strategy 1 Measure:

Strategy 2: Provide interventions with children at risk for obesity

Strategy 2 Measure: Percentage of students with improvement in lifestyle choices on the Lifestyle Survey at end of year.



Strategy 3: Provide community/ parent education (breastfeeding, healthy lifestyles, nutrition)

Strategy 3 Measure: Percentage of participants that report increase in knowledge and adoption of healthy behaviors from pre to post survey

Strategy 4: Provide breastfeeding education

Strategy 4 Measure: Number of healthcare providers trained in breastfeeding

Strategy 5: Community and school policy advocacy

Strategy 5 Measure: Number of policies supported through coalition effort; Number implemented

Addressing the Needs of the Community: FY 12 – FY 14 Community Benefit Plan/Implementation Strategies

Behavioral Health

Perinatal Emotional Wellness, Healthy Minds Healthy Aging, CARE Network Behavioral Health

Research indicates that mental health disorders are among the most important contributors to the burden of disease and disability nationwide. Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. Access to low cost mental health services ranked as a top priority in the last two community health needs assessments for Napa County. To address this need, SJH, QV took a multipronged approach. In 2006 SJH, QV launched a **perinatal emotional wellness program** providing free counseling and referral services for pregnant and postpartum women experiencing depression and other behavioral health concerns. In 2008 SJH, QV **integrated behavioral health** into the chronic disease management program, **CARE Network**, providing free mental health services to low-income chronically ill clients.

Key Community Partners: Area Agency on Aging (AAA), Family Service of Napa Valley, Napa County Health and Human Services - Mental Health Division, Napa Valley Hospice and Adult Day Services (NVHADS), area obstetricians (OB) and pediatricians.

Target Population: Low-income older adults, adults (of any age) with chronic disease, pregnant and postpartum women

Goal: Reduce depression for low-income older adults, those with chronic disease and pregnant and postpartum women.

Scope: Clients of Perinatal Emotional Wellness, CARE Network, or Healthy Minds, Healthy Aging programs.

How will we measure success?: Percentage of clients that reduce depression as measured through PHQ9

Three-Year Target: By 6/30/2014 increase percentage of clients that improve PHQ9 depression score by 10% of baseline (baseline 57%).

Strategy 1: Provide universal screening for depression

Strategy Measure 1: Number screened

Strategy 2: Conduct assessment of needs

Strategy Measure 2: Number of eligible clients/Number of assessments

Strategy 3: Provide or refer to appropriate behavioral health intervention services and resources.

Strategy Measure 3: Number of clients/Number of interventions/Number of referrals

Addressing the Needs of the Community: FY 12 – FY 14 Community Benefit Plan/Implementation Strategies

Community Education and Empowerment

One approach for addressing social determinants of health is to provide education and facilitate empowerment for vulnerable populations. SJH, QV is a primary provider of community health education among low-income Spanish-speaking community members in Napa. We provide health education that seeks to teach community members how to prevent health problems, navigate the system of care, enhance health and wellness and empower changes that can contribute to health now and in the future. Whereas Napa is not considered a “poor” county, the substantial wealth of a disproportionate small number of Napa residents skews the economic indicators for a sizeable portion of the population.



According to 2012 Migration Policy Institute Profile of Immigrants in Napa County, Latinos are leading the county’s population growth. Twenty six percent of households in Napa County are immigrant households. For the 2008 -09 school year Latinos were 46% of students in Napa County public schools, the majority were English language learners. Disparities are evident in academic achievement and health. Between 2002 and 2009, 11.3% of Latino high school graduates in NVUSD were eligible to enter the UC and CSU system, as compared to 31.6% of their White peers. Additionally, the 2010 Napa Community Health Needs Assessment identified an ongoing need for health education aimed at prevention of health problems particularly for those disproportionately affected by health conditions.

Queen of the Valley will implement three efforts facilitating community education and empowerment: Parent University, perinatal education series (pre and post natal classes for parents and siblings), and a bilingual community health education curriculum with a variety of topics.

Key Community Partners: Adult Education, Head Start, McPherson Elementary School, Napa Community Housing, Napa County Health and Human Services, Napa Valley Community Foundation, Napa Valley Unified School District (NVUSD), On the Move, Parents CAN, Philips Elementary School, Puertas Abiertas, Salvador Elementary School, Shearer Elementary School

Scope: Health Education and Parent University are directed toward low-income community members whereas perinatal education is directed toward the broader community.

Goal: To improve self-efficacy of participants that can contribute to lifelong health and wellbeing.

Scope: Participants of Parent University, perinatal education and community health education programs.

How will we measure success?: Percentage of participants who report improved self-efficacy as measured through surveys and questionnaires.

Three-Year Target: By 6/30/2014 decrease the self-efficacy gap by 10 percent. Baseline measure is 88% with a 12% gap. A 10% gap reduction represents 1.2% gain in self-efficacy.

Strategy 1: Utilize culturally appropriate educational tools for all Health Education classes.

Strategy Measure 1: Percentage of programs utilizing culturally appropriate tools

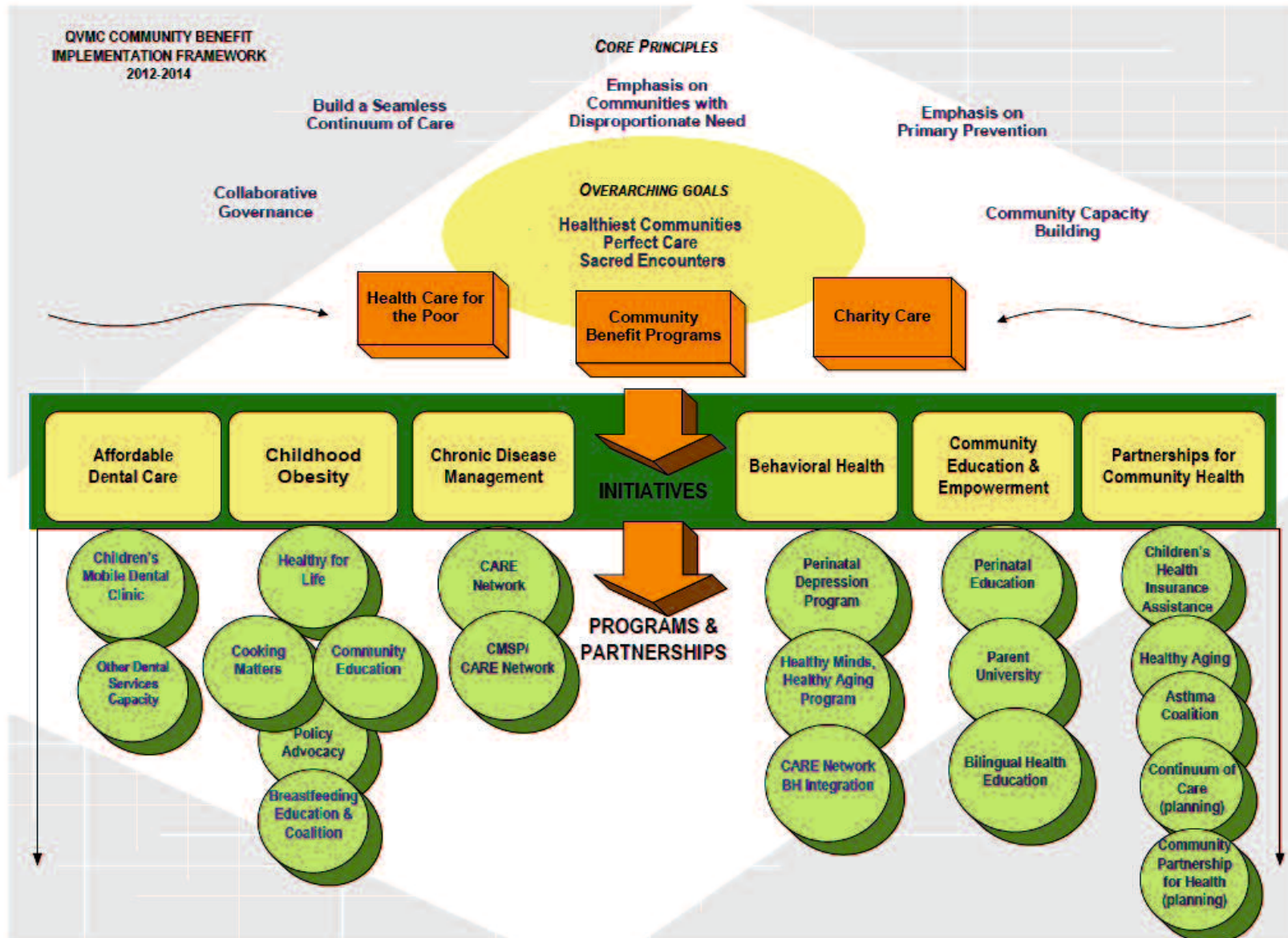
Strategy 2: Provide culturally appropriate health education for the target population

Strategy Measure 2: Percentage of participants reporting improved knowledge

Other Community Benefit Initiatives

Additionally incorporated in the Community Benefit Strategic Plan is an initiative, **Partnerships for Community Health**, which supports goals of building a Continuum of Care, and increasing Community Capacity and Collaborative Governance. The table below describes the key strategies and programs to be included in this overall approach to community health improvement.

COMMUNITY PARTNERSHIPS FOR HEALTH		
PROPOSED STRATEGIES	PRIMARY TARGET POPULATION	POTENTIAL PROGRAMS/STRATEGIES *Existing program/strategy
Healthcare Access	Low income children	Children’s Health Insurance Initiative*
Continuum of Care Partnership Development	Health care systems/provider (Convening)	<ul style="list-style-type: none"> ▪ Develop a human centric framework for a continuum of healthcare services ▪ Convene partners to address gaps, set goals and codify roles and responsibilities/accountability, linkages, relationships among health care partners. ▪ Develop agreements regarding HIPAA, data sharing; access points for patients
Community Health Partnership	Community-wide (Planning stage)	<ul style="list-style-type: none"> ▪ With County Public Health and Community Partners: ▪ Conduct study of contributors to community health ▪ Assess Health & Wellness issues including social determinants of health ▪ Engage the community ▪ Develop and implement policies and strategies county-wide
Healthy Aging	Community-wide	<u>Healthy Aging Population Initiative:</u> * Planning, community education, strategies to address behavioral health, fall prevention, transportation, and policy and resource advocacy to improve health of older adults in Napa Valley



St. Joseph Health

<http://www.stjhs.org/>

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