



St. Joseph Health Queen of the Valley Medical Center

**Fiscal Year 2014 COMMUNITY BENEFIT REPORT
PROGRESS ON FY12 - FY14 CB PLAN/IMPLEMENTATION STRATEGY REPORT**



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¹ Non-financial summary of accomplishments are referred to in SB 697 as non-quantifiable benefits.

EXECUTIVE SUMMARY

Our Mission

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

Our Vision

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

Our Values

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

Who We Are and What We Exist

For over fifty years St. Joseph Health Queen of the Valley (SJH-QV) (also referred to as Queen of the Valley Medical Center) has been a vital resource and integral part of the Napa Valley community. A full-service acute care 191 bed medical center, SJH-QV employs approximately 1,300 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. Services include the county's only Level III Trauma Center and neonatal intensive care unit. SJH-QV is committed to community wellness and is one of the first acute care providers to successfully develop and implement a medical fitness center, Synergy, in the Wellness Center on the medical center campus. Other medical specialties include:

- Robotic Surgery
- Cancer Center
- Heart Center
- Maternity / Infant Care
- Neurosciences
- Orthopedics
- Rehabilitation Services
- Women's Services
- Imaging Services
- Wound Care Clinic
- Children's Mobile Dental Clinic
- Community Based Chronic Disease Management
- Community Based Health and Wellness Education
- School Based Obesity Prevention
- School Based Parent Education

As a member hospital of St. Joseph Health, a ministry founded by the Sisters of St. Joseph of Orange, Queen of the Valley devotes resources, activities and services that help rebuild lives and care for the underserved and disadvantaged. We recognize and embrace the social

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obligation to create, collaborate on and implement programs that address identified needs and provide benefits to the communities we serve. Partnerships we've developed with schools, businesses, local community groups and national organizations allow us to focus tremendous skills and commitment on solutions that will have an enduring impact on our community. Based on identified community needs, SJH-QV provides and/or supports an extensive matrix of well-organized and coordinated community benefit service programs and activities addressing issues such as the social determinants of health, obesity, mental health, chronic disease management, dental health, education, access to food, housing, and health care.

Community Benefit Investment

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. We care for the whole community, providing quality care to all our patients regardless of ability to pay. In total, for fiscal year 2014 SJH-QV contributed **\$22,294,199** in community benefit, excluding unreimbursed costs of Medicare. This amount helped care for the poor, vulnerable, low-income persons, the uninsured and underinsured. Separately, the unreimbursed cost of Medicare totaled an additional **\$29,952,201**.

Overview of Community Needs and Assets Assessment

Community Benefit is characterized as programs or activities that promote health and healing in response to identified community needs. In order to accurately define community need, we conduct a Community Health Needs Assessment (CHNA) every three years. Since 2006, St. Joseph Health, Queen of the Valley Medical Center (SJH-QV) has participated in a collaborative approach to the triennial CHNA. The FY10 process consisted of a Napa County Needs Assessment Collaborative of health organizations and funders, including SJH-QV, Kaiser Foundation Health Plan, St. Helena Hospital, Napa County Public Health – including the Public Health Officer and epidemiologist, Community Health Clinic Ole, and Auction Napa Valley. The assessment process includes an extensive review of existing data from government, public and private institutions as well as conducting English and Spanish language community surveys, nine focus groups and 20 key informant interviews.

Community Plan Priorities/Implementation Strategies

Please include a brief summary of major Community Benefit accomplishments in FY14.

- ***CARE (Case Management, Advocacy, Resources, and Education) Network***
 - Without adequate health insurance, income, and support, managing a chronic illness such as diabetes or heart failure can be extremely costly and difficult. A nationally recognized, award winning program, CARE Network promotes disease self-management utilizing an interdisciplinary RN, social work, behavioral and spiritual health approach. CARE Network makes an impact on client's lives through provision of home visits, disease management education, advocacy and socioeconomic support. In FY 14, CARE Network served 344

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clients with an overall **64% decrease in emergency** room visits, and a **66% decrease in hospitalization**.

- ***Children's Mobile Dental Clinic***
 - To address the identified community need of oral health, SJH-QV launched a Children's Mobile Dental Clinic in 2005. This year the clinic spanned 9 locations across Napa County serving **2,040** low-income children and provided **4,680** clinic visits. In addition, **35** low-income pre-school/kindergarten classes were provided free oral health screenings and fluoride varnish to over **800** children.
- ***Healthy for Life***
 - "Healthy for Life" is a school-based obesity prevention program designed to emphasize lifelong fitness and healthy eating behaviors among children and adolescents. The program incorporates baseline and end of school-year assessments, provides training to teachers and exercise equipment to schools, as well as guest instructors for nutrition and a variety of P.E. classes designed to be non-competitive, fun, safe and comfortable for all students. This year targeted expansion into the lower elementary classes (grades K-2) increased the number of classrooms served by 30% (from 23 to 30 classrooms). Over 1,000 students participated in some portion of the program's exercise and fitness classes and 469 students were captured for physical assessments. Of those 469 students, **18% (36) of the 200** students classified as overweight or obese at the beginning of the school year **improved their weight status** by yearend.
- ***Behavioral Health***
 - Access to low cost mental health services ranked as a top priority in the last three community health needs assessments for Napa County. To address this need, SJH-QV took a multipronged approach with three mental health initiatives: one effort targeted postpartum mothers, another effort focused on low-income chronically ill persons, and the third effort focused on underserved older adults at risk for behavioral or cognitive health issues. Altogether **192** individuals were provided mental health assessment and intervention, for a total of **1,026** sessions. Of those completing both pre and post service assessments, **98%** showed **improved depression** scores (52 of 53 clients).
- ***Community Education and Empowerment***
 - Studies show health outcomes are directly related to social determinants of health such as poverty, level of education, access to healthy foods, and other environmental factors. **Parent University** is an initiative in partnership with Napa Valley Unified School District and a local nonprofit, On the Move, that is designed to address elements of the social determinants of health by creating a learning environment for parents to gain critical parenting and leadership skills through offering a series of **84** different class curriculums. With a focus on our Napa County Spanish speaking population, the program was **expanded from 3 to 5 schools** this year reaching **1,176 parents**. Altogether total of 7,436 parent contacts occurred in the classroom setting where topics included: becoming an effective school consumer, helping children with homework, computer literacy,

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becoming a school and community leader, becoming an effective volunteer in the school, raising a healthy child and accessing health services.

- *Community Partnerships for a Healthier Napa County.*
 - Our mission calls us to improve the health and quality of life of our community and we realize the need to partner with others to make this a reality. To this end SJH-QV provided over **\$448,000** in cash and in kind support to local nonprofit organizations to meet identified community health needs such as food security, housing, education, substance abuse prevention and treatment, health insurance enrollment, and healthy aging to name a few.

INTRODUCTION

Who We Are and Why We Exist

As a member hospital of St. Joseph Health, a ministry founded by the Sisters of St. Joseph of Orange, at Queen of the Valley Medical Center we are committed to: "...bring people together to provide compassionate care, promote health improvement and create healthy communities." Since its beginning, St. Joseph Health Queen of the Valley (SJH-QV) 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 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.



For over fifty years St. Joseph Health Queen of the Valley has been a vital resource and integral part of the Napa Valley 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. Through the Community Outreach Department, SJH-QV 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. Community Outreach works in concert with community partners to expand access, leverage resources, and address broad community concerns.

Partnerships are nurtured with schools, businesses, local community groups and national organizations which allow us to strategically focus skills and effort on solutions that will have an enduring impact on our community. Based on identified community needs, St. Joseph Health, Queen of the Valley (SJH-QV) provides and/or supports an extensive matrix of well-organized and coordinated community benefit service programs and activities addressing issues such as obesity, mental health, chronic disease management, dental health, education, access to food, housing, and health care. Many of these programs have received national recognition for providing creative community based solutions to health status improvement.

A full-service acute care 191 bed medical center, SJH-QV employs approximately 1,300 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. Services include the county's only Level III Trauma Center and neonatal intensive care unit. The accredited cancer center is one of only nine cancer programs in California to earn the Outstanding Achievement award recognition from the Commission on Cancer of the American

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College of Surgeons. SJH-QV is committed to community wellness and is one of the first acute care providers to successfully develop and implement a medical fitness center, Synergy, in the Wellness Center on the medical center campus.

Queen of the Valley Medical Center specialties include:

- Level III Trauma Center
- Neonatal Intensive Care
- Medical Fitness and Wellness Center
- Award winning Cancer Center
- Robotic Surgery
- Heart Center
- Maternity / Infant Care
- Neurosciences
- Orthopedics
- Rehabilitation Services
- Women's Services
- Imaging Services
- Wound Care Clinic
- Children's Mobile Dental Clinic
- Community Based Chronic Disease Management
- Community Based Health and Wellness Education
- School Based Obesity Prevention
- School Based Parent Education

ORGANIZATIONAL COMMITMENT

Community Benefit Governance Structure

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, programs and initiatives. Meeting nearly monthly (8 months in FY14), the Community Benefit Committee (CBC) is composed of trustees, the SJH-QV CEO, executive management, physicians, and community representatives, and is staffed by SJH-QV Community Outreach employees. The CBC serves as an extension of the Medical Center's Board of Trustees and is charged with overseeing and directing SJH-QV's Community Benefit activities including: budgeting decisions, program content, geographic/population targeting, fund development support and community wide engagement. In addition, community benefit plans, processes and programs reflect both the SJH strategic system and entity goals and objectives.

St. Joseph Health Queen of the Valley 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 and community benefit provisions related to The Patient Protection and Affordable Care

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Act imposing new requirements on non-profit hospitals. In addition, this team provides 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.

PLANNING FOR THE UNINSURED AND UNDERINSURED

The health of our community depends on the creation and maintenance of strong physical and social structures, which promote and contribute to the well-being of those who live in Napa County. We care for the whole community, providing quality care to all our patients regardless of ability to pay. In total, for fiscal year 2014 SJH-QV contributed **\$22,294,199** in community benefit, excluding unreimbursed costs of Medicare. This amount helped care for the poor, vulnerable, low-income persons, the uninsured and underinsured. Separately, the unreimbursed cost of Medicare totaled an additional **\$29,952,201**.

Patient Financial Assistance Program

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why St. Joseph Health, Queen of the Valley has a **Patient Financial Assistance Program (FAP)** that provides free or discounted services to eligible patients. In FY 14, SJH-QV provided **\$1,976,026** in charity care for **3,334** encounters.

One way St. Joseph Health, Queen of the Valley 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.

COMMUNITY

Defining the Community

Located 50 miles northeast of the San Francisco Bay Area, Napa County encompasses approximately 748 square miles and is one of the most renowned agricultural as well as premium wine-producing regions in the world. The wine, hospitality, and agricultural industries are the county's largest. The 2010 census reported Napa County's population as 136,484. Approximately 56% of all county residents live in the City of Napa while the remainder lives in the balance of the county. Based on the 2010 Census data, 56.4% of Napa County's population is non-Hispanic white, 32% Hispanic/Latino, nearly 7% Asian, multiracial approximately 4%, and other approximately 3 percent. In total numbers, the largest population increase in Napa County between 2000-2010 was among the Hispanic/Latino population, which

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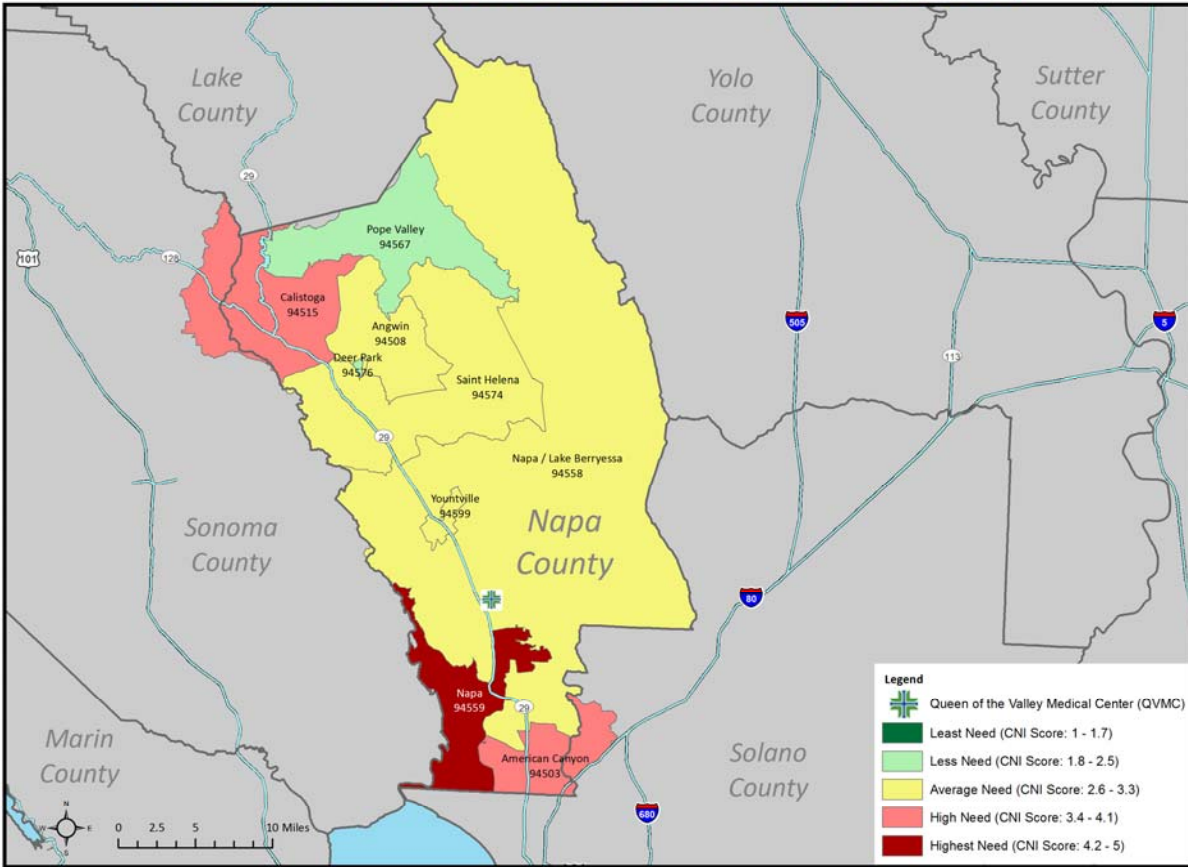
increased from 29,416 people to 44,010 people. Twenty-five percent of households speak Spanish as their primary language. An estimated 18,000 are not U.S. citizens; this can swell during the growing season.

While Napa is not considered a “poor” county relative to other counties, including those with large agricultural areas, between 2006 and 2010 ten percent of Napa residents were living below the federal poverty level (FPL) and 26.4% were living below 200% of FPL. Of importance to note is the high cost of living in Napa County. A family of four is below 200% FPL if their annual income is under \$42,400. In contrast, the estimated annual living wage for a family with two adults and two children is \$46,675, and this cost assumes one adult is providing child care therefore the cost of childcare is not included this estimate. This suggests that using 200% of FPL, twice the federal poverty level, still underestimates the financial burdens of households in Napa County (2013 Napa County Community Health Needs Assessment). The most recent Napa County Community Health Needs Assessment conducted in 2013 includes census tract mapping showing neighborhoods in which 30%-52% of the residents and 39% - 54% of families with children under 18 - live below 200% of the FPL.

The maps on the following pages depict SJH-QV community benefit service area (CBSA) highlighting those areas of the county where need is greater. To note, the city within Napa County identified as the highest need is the city of Napa.

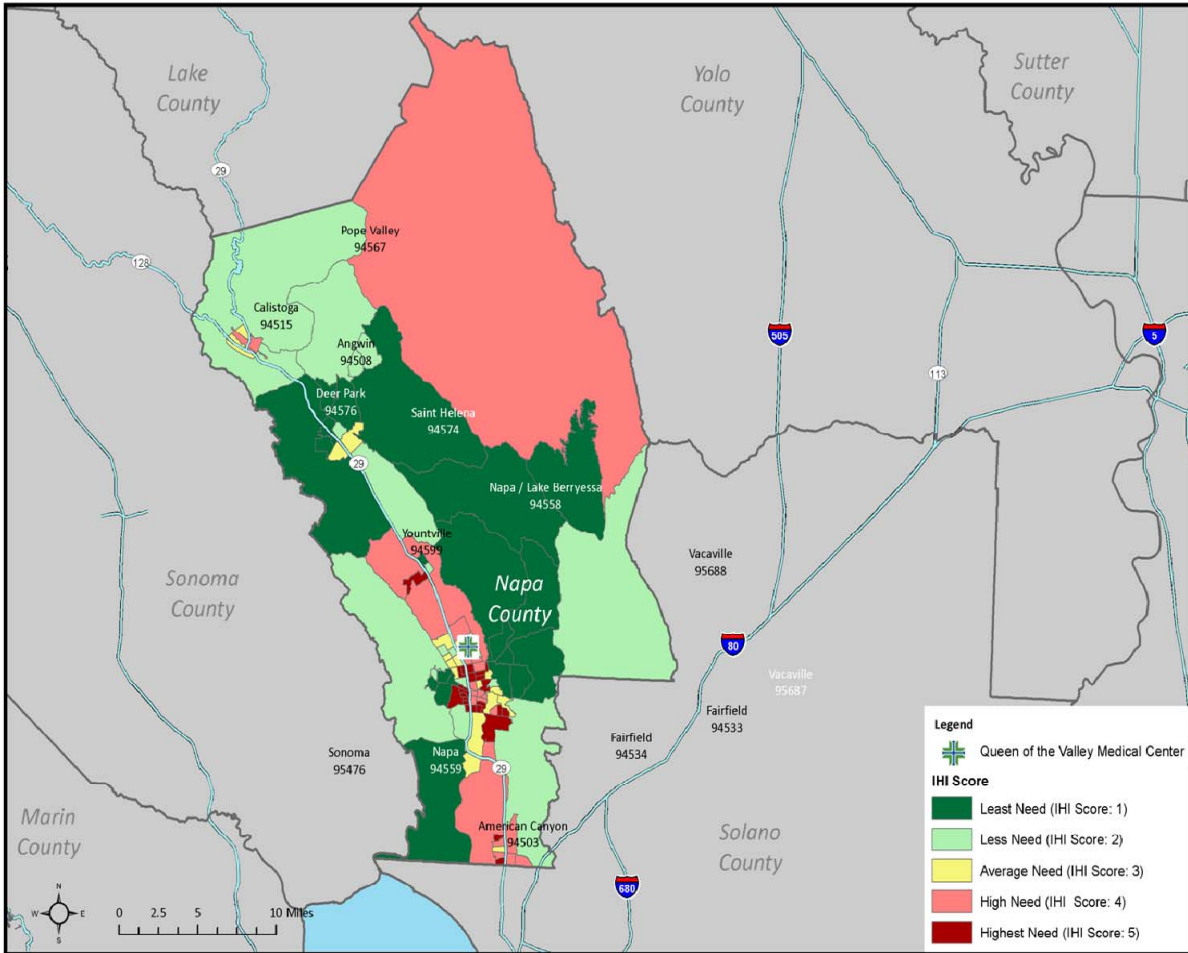
Napa County Area Need by ZIP Code Community Need Index

QVMC Community Benefit Service Area Need (Zip Code Level)



Map Represents HTSA (Hospital Total Service Area) - Angwin (94508), Calistoga (94515), Deer Park (94576), Pope Valley (94567), and Saint Helena (94574)
Prepared by the St Joseph Health Strategic Services Department, May 2014
Source: Dignity Health

Napa County Area Need by Block Group Index InterCity Hardship Index



Map Represents HTSA (Hospital Total Service Area) + Angwin (94508), Calistoga (94515), Deer Park (94576), Pope Valley (94567), and Saint Helena (94574)
Prepared by the St. Joseph Health Strategic Services Department, September 2013

COMMUNITY NEEDS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

Community Benefit is characterized as programs or activities that promote health and healing in response to identified community needs. In order to accurately define community need, we conduct a Community Health Needs Assessment (CHNA) every three years. Since 2006, St. Joseph Health, Queen of the Valley Medical Center (SJH-QV) has participated in a collaborative approach to the triennial CHNA. As part of the FY 2012-2014 community benefit strategic plan which was based on the CHNA conducted in 2010, this FY 2014 community benefit report reflects the CHNA conducted in 2010. The 2010 process consisted of a Napa County Needs Assessment Collaborative of health organizations and funders, including SJH-QV, Kaiser Foundation Health Plan, St. Helena Hospital, Napa County Public Health – including the Public Health Officer and epidemiologist, Community Health Clinic Ole, and Auction Napa Valley.

The assessment process included an extensive review of existing data from 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. 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. The questionnaire was developed in English and Spanish for the general public and inquired about most-important health needs, ideas for responsive solutions, and habits they used to maintain their own personal health. Nine community focus groups were conducted in four cities—Napa, Calistoga, St. Helena, and American Canyon—chosen to ensure geographic representation. 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. In addition to focus groups, 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.

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. 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. 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 overarching 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;

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- 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.

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

Identification and Selection of DUHN Communities

Communities with Disproportionate Unmet Health Needs (DUHN) are communities defined by zip codes and census tracts where there is a higher prevalence or severity for a particular health concern than the general population within our ministry service area. Communities may also be population groups.

DUHN Group and Key Community Needs and Assets Summary Table

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Low income children	Continued access to affordable, quality oral health services including preventive services and education	Mobile Dental Clinic SJH-QV Sr. Anne's Dental Clinic Community sites Head Start
Latino children and families	Prevention and early intervention to improve nutrition, physical activity and prevent obesity	Bilingual community education program SJH-QV Children & Weight Treatment coalition Healthy for Life school based program Wellness Center SJH -QV Parent University Family Resource Centers
	Access to affordable healthcare	Children's Health Initiative Diversified Group at SJH-QV Community Health Clinic Ole (FQHC)
	Reduce educational opportunity gap (social determinants of health); increase parental education and involvement in schools	Title I schools Bilingual health education Parent University On The Move (nonprofit organization)

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DUHN Population Group or Community	Key Community Needs	Key Community Assets
Low income pregnant women - particularly women who do not speak English	<p>Access to prenatal education to improve birth outcomes, encourage breastfeeding in including number of low birth weight infants</p> <p>Access to screening and early intervention for perinatal depression</p>	<p>Perinatal Spanish Workshops (SJH – QV)</p> <p>Healthy Moms and Babies</p> <p>Linkage to clinical care programs for pregnant women</p> <p>Perinatal Mood Disorders program (SJH – QV)</p>
Low income adults, including Spanish speaking adults	<p>Chronic disease management: access to care, support, education and mental health services to improve quality of life and disease management</p> <p>Access to affordable, community based behavioral health services for depression and other behavioral health issues</p> <p>Access to affordable dental care</p> <p>Access to affordable health care</p>	<p>CARE Network, SJH-QV</p> <p>SJH-QV Medical Center</p> <p>Community Health Clinic Ole</p> <p>Family Service of Napa Valley</p> <p>Wellness Center, SJH-QV</p> <p>Family Service of Napa Valley</p> <p>Community Health Clinic Ole</p> <p>County Mental health Services</p> <p>Family Resource Centers</p> <p>Sr. Anne’s Dental Clinic</p> <p>Community Health Clinic Ole</p> <p>SJH-QV</p>

DUHN Group and Key Community Needs and Assets Summary Table

DUHN Population Group or Community	Key Community Needs	Key Community Assets
Low income seniors	<p>Access to affordable, quality dental care</p> <p>Access to affordable mental health services including preventive programs</p> <p>Chronic disease management</p> <p>Access to community based supports for independent living</p>	<p>Sr. Anne’s Dental Clinic</p> <p>Family Services of Napa Valley</p> <p>Area Agency on Aging</p> <p>Adult Day Services</p> <p>County Services for Older Adults</p> <p>CARE Network SJH-QV</p> <p>SJH-QV Medical Center</p> <p>Community Health Clinic Ole</p> <p>Family Service of Napa Valley</p> <p>Wellness Center</p> <p>Area Agency on Aging</p> <p>Community Action Napa Valley</p> <p>County Services for Older Adults</p> <p>In Home Supportive Services</p> <p>Senior Centers</p> <p>Home Health care agencies</p>

PRIORITY COMMUNITY HEALTH NEEDS

Community benefit activities addressing identified needs for these populations include:

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

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community. We are committed to continue our Mission through our community benefit programs, in kind collaborative efforts such as contribution of staff time and resources and - as resources allow, by funding other non-profits through our Community Benefit funding streams managed by St. Joseph Health, Queen of the Valley.

Furthermore, St. Joseph Health, Queen of the Valley will endorse local non-profit organization partners to apply for funding through the [St. Joseph Health, Community Partnership Fund](#). Organizations that receive funding provide specific services or resources to meet the identified needs of underserved communities served by St. Joseph Health ministries.

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The following community health needs identified in the ministry CHNA will not be directly addressed as a primary area of focus by SJH-QV and an explanation is provided below:

- **Substance Abuse:** Napa County Health and Human Services (HHS) Drug and Alcohol division confirmed desire to champion this effort for Napa County. In collaboration, this year SJH-QV contributed \$5,000 funding support to Napa County's inpatient substance abuse treatment program, McAllister Institute, and over \$14,000 to the Wolfe Center which provides services for youth. For those we serve through SJH-QV, as indicated, coordinated care and referral to these services is provided.
- **Housing:** Napa offers subsidized housing and nonprofit organizations supporting assistance with housing. To support these efforts SJH-QV contributed \$5,000 to Napa Valley Community Housing, \$5,000 to Legal Aid of Napa, and through community benefit program services assisted 148 low-income persons obtain affordable housing.
- **Jobs:** Napa County HHS, Self Sufficiency division offers "Workforce Napa Business and Career Center" with free job search workshops, access to computers, resume assistance, job application assistance, and hiring events. For those we serve, as indicated, coordinated care and referral to these services is provided.
- **Transportation:** Napa County Transportation & Planning Agency (NCTPA) provides transportation policy and planning for the County as well as transit services including bus, shuttle, trolley and the taxi scrip program which serves persons 65 or over or those with disabilities. To support community members with transportation, SJH-QV community benefit staff assisted low-income clients with transportation on 345 occasions, through the provision of bus passes, taxi scrip, ferry tickets, and arranging transportation through volunteer services.
- **Environmental:** Napa County Environmental Division provides services targeting environmental health, consumer protection, Land Use and Pollution to name a few. Through our community benefit programs, SJH-QV works individually with clients, providing assistance, support, advocacy and resources should environmental issues impair health or quality of life.

The following figure describes in more detail the Community Health Needs identified through the SJH, Queen of the Valley CHNA as priorities. Those needs that the hospital did not plan to address through direct priority programming are noted in the aforementioned explanation.

Health Needs Identified through CHNA	Plan to Address
Lack of Affordable Accessible Care	Yes
Lack of Affordable Dental Care	Yes
Community Collaborative Identified Priority Areas:	
• Strategies that address obesity	Yes
• Senior Support Services	Yes

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

COMMUNITY BENEFIT 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 benefit efforts of SJH-QV over the three years (FY 12-14) to address the unmet needs in the community.

The Planning Committee convened in two meetings 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 SJH-QV 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

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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 St. Joseph Health, Queen of the Valley Community Benefit 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 health o Community health planning is collaborative o We are preventing health problems upstream o We are meeting Healthy People 2020 objectives o 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
<p>The Initiative should:</p> <ul style="list-style-type: none"> • Align with Core Principles of Advancing the State of the Art in Community Benefit (ASACB) • 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

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- 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, SJH-QV 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.

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 a template format (3W template) for the Community Benefit committee to review and discuss. This Community Benefits plan framework was approved prior to the development of the plan.

Community Outreach Department staff developed logic models (4E template) 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 SJH-QV Board of Trustees.

St. Joseph Health, Queen of the Valley

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FY14 Accomplishments

Initiative: Disease Management for Low-Income Chronically Ill

Description: 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, a nationally recognized, 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: Community Health Clinic Ole (a Federally Qualified Health Center), County Medical Services Program (CMSP), Adult Day Services of Napa Valley, 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

Goal (Anticipated Impact²): Improve the quality of life of low-income adults with chronic diseases and/or co-morbidities and complex socio-economic needs.

Target Population (Scope): All CARE Network clients

² **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)

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How will we measure success? Outcome Measure: 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 administered 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.

FY 14 Progress: Median change score of the 56 patients completing second quality of life survey (SFv2) was 4, with 66% of patients showing improvement in their quality of life score. Approximately 25% of the clients that we serve are enrolled in our cancer case management program and some nearing end of life. This can impact the result of the quality of life survey as their life is impacted by many decisions that come with end of life. The 3 year median change score for 206 patients completing the second quality of life survey was 7.42 with 68% of patients showing an improvement in their quality of life.

Strategy 1: Deliver necessary medical resources.

Strategy Measure 1: 100% of CARE Network clients and their caregivers receive nursing assessment, education, coaching and support regarding their chronic disease and management. Of the 344 clients served in FY14, 165 were newly enrolled. For the 165 clients newly enrolled to services a total of **404 referrals to medical services** such as primary care physicians, specialists, pharmacy, hospice, outpatient palliative care program, cardiac rehabilitation, cancer rehabilitation, and/or adult day services were provided.

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

Strategy Measure 2: Measured by the number of benefits applied for compared to the number of benefits granted within a six month period. Benefits include health insurance (County, State, or Federal), income benefits (State or Federal), veteran's benefits, and caregiving (IHSS). In FY14, social workers assisted application for **benefits** on **112** occasions of which 72% (77) were granted. In addition to benefits, referrals and applications for basic needs were provided for housing (106 occasions), food (414 occasions), transportation (306 occasions), and other (270). Altogether **1,261 referrals for benefits and basic needs** were provided and **obtained**.

Strategy 3: Enhance disease self-management

Strategy Measure 3: Measured by the reduction in emergency room visits and hospitalizations, CARE Network clients demonstrated an average **64% reduction in ED visits** when compared to pre-enrollment (from 21.76 average monthly visits to 7.79 average monthly visits), and a **66% reduction in hospitalizations** (from 19.92 average monthly to 6.75 average monthly).



Because self-assessed health status is a valid and useful indicator of health, another disease management indicator relates to our client survey administered by PRC in which clients are asked to rate *“their ability to take care of their health without professional medical help, due to the care they received.”* This new survey was implemented in November of 2013 and of the 37 survey respondents, **95% rated their ability to take care of their health**, as a result of CARE Network services, as excellent, very good, or good.

FY14 Accomplishments:

Winner of the Premier Cares Award 2014, The Monroe E. Trout Premier Cares Award is given each year to community agencies and health organizations that support people excluded from, or underserved by, the mainstream health delivery system: farm workers, homeless children, pregnant teens, low-income mothers and infants, individuals who don't have the strength or means to reach a clinic or hospital.

<https://www.premierinc.com/wps/portal/premierinc/public/aboutpremier/socialresponsibility/caresaward>

Premier Inc. Breakthroughs Conference and Exhibition: “Community-based approach to reducing re-admissions for high-risk patients” presentation, San Antonio Texas June 2014.

Additional Services: CARE Network services assist the caregiver and/or family as well as the client. For example, financial assistance to purchase food or pay utilities provides support to the entire household. In FY14 comprehensive community-based disease management services were provided to 344 clients, and to 687 household members for a total of **1031 individuals served**. Aside from these enrolled clients and non-enrolled household members, CARE Network serves our community members who are referred seeking social service counseling and brief case management services. For these community members served and not enrolled into CARE Network program, an additional **959 encounters** were provided.

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Care Transitions Pilot: The CARE Network Care Transitions program provides 30 day telephonic or face to face weekly follow up by RN's for patients discharging from medical center to home. The services include: ensuring the correct medications are obtained and that the client understands when to take them, review of key warning signs related to their disease/medications and actions to take, ensuring linkage to primary or specialty care and timely follow-up, and advanced care planning. In FY 14 **378** patients were served in this pilot with a total of **1020** patient contacts.

Medical Fitness Monitored Exercise Program: Recognizing the physical and mental health benefits of exercise, SJH-QV's Care Network staff partnered with SJH-QV's medical fitness center to sponsor low-income chronically ill clients through a specialized monitored exercise program. This year 38 clients received medical fitness membership services with a total of **857 monitored exercise visits**.

Community Care Conferencing: In an effort to build shared accountability toward community-based, quality care for these most vulnerable individuals, CARE Network developed and implemented a coordination of care conference for complex cases that involves a specific client's network of care outside the hospital and hospital programs. For example, an emergency room physician may request a conference for a patient and request representation from EMS, county drug and alcohol, mental health, homeless shelter, and CARE Network. This process is reserved for the most complex cases, building and strengthening sustainable local care management by improving identification and timely referral, intake and coordination and monitoring of high risk and vulnerable individuals. This past year, **four** complex community care conferences were conducted.

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FY14 Accomplishments

Initiative: Dental Care for Low-Income Children

Description: 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 oral pain can lead to serious infection and other medical problems. In light of findings from the Napa County that pointed to 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: Child Development Programs, *Dos Mundos*, Harvest Middle School, Los Niños, Menlo, Napa County Child Start Programs, Napa County Health and Human Services (WIC), Napa County Office of Education, Napa Valley Language Academy, Napa Valley Unified School District, Phillips Elementary School, St. John's the Baptist Catholic Primary School, *Puertas Abiertas* Family Resource Center, Shearer Elementary School, St. Helena High School, Therapeutic Child Care Center, Valley Oak Alternative High School, SJH - Community Partnership Fund.

Goal (Anticipated Impact³): To improve the oral health of children 6 months to 21 years of age in Napa County, particularly those who are uninsured or underinsured.

Target Population (Scope): Mobile Dental Clinic Patients

How will we measure success? Outcome Measure: 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%
Baseline is 90% with a 10% gap. A 10% gap reduction represents a 1% increase from baseline.

³ **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)

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FY 14 Progress: 90% of 473 patients (randomly audited patient records) demonstrate oral health improvement at recall visit. The three year percent improvement (FY 12-14) for 1,262 patients is **91** percent.

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

Strategy Measure 1: In 2006, the State of California passed legislation (Assembly Bill 1433 (Emmerson/Laird)) requiring that children have a dental check-up by May 31 of their first year in public school, at kindergarten or first grade. This year we provided oral health screenings and fluoride application at 35 different low-income preschool sites to a total of **818 children**. Also, of these 818 children, 126 were referred to a dental home.

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

Strategy Measure 2: In FY14 the clinic spanned nine locations across Napa County serving 2,040 children (including 339 new patients), providing 4,682 clinic visits. A total of 3,070 clinic visits involved exams and cleanings, and 84% of patients returned for regular checkups between 6 to 9 months post treatment.

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

Strategy Measure 3: A routine component of every exam, 100% of patients (2,040) received oral health instruction in FY14. Additionally, based on satisfaction survey given to parents of dental patients, 98% of 147 parent respondents report improved oral health behaviors their children (such as brushing longer or more often) since coming to the mobile dental clinic.

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

Strategy Measure 4: Of the 2,040 children served in FY14, **2,688 procedures** were required (fillings, extractions, pulpotomy, root canals, crowns, scaling and root planning, space maintainer). Of 473 random chart audits performed, 72% of children who received treatment had reduced caries at follow up.

FY14 Accomplishments:

Prevention: Preventing oral health problems is a key priority for our mobile dental team. Parent education begins when the child is 6 months of age and continues with every follow up visit for exams and cleanings. Dental sealants are one strategy to decrease the incidence of cavities. In addition to an increase in parent knowledge, improved oral health behaviors of the child, and the extensive number of exams and

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cleanings performed for low-income children, the mobile dental team applied dental sealants to 1,135 teeth.

Community Continuum of Care: In an effort to engage like-minded community partners and create a seamless continuum of care for dental services for the low-income, SJH-QV and Community Health Clinic Ole, a Federally Qualified Health Center (FQHC) explored and applied a shared leadership structure for dental services for both organizations. Implemented in the last quarter of FY13, performance improvement activities are underway to identify opportunities for enhanced processes to meet the dental needs of low-income older adults, adults, and children in Napa County.

St. Joseph Health, Queen of the Valley

FY12 – FY14 Community Benefit Plan/Implementation Strategies and Evaluation Plan FY14 Accomplishments

Initiative: Reducing Prevalence of Childhood Obesity in Napa County

Description: SJH-QV takes a three pronged approach - Healthy for Life, Breastfeeding Education, Community Health Education

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 their 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, more than 40% of fifth, seventh, and ninth graders are overweight or obese, and nearly 50% of economically disadvantaged students were overweight or obese (Napa Needs Assessment 2013). Obesity is also a growing concern among low-income preschoolers (ages 2-4); the U.S.DA reports that 18.3% of Napa County preschoolers are considered to be obese, which is twice as high as the Healthy People 2020 objective. In an effort to address this critical health issue, SJH-QV 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 provides training to teachers and exercise equipment to schools, as well as guest instructors for nutrition and a variety of P.E. classes designed to be non-competitive, fun, safe and comfortable for all students.



Breastfeeding Education

Breastfed babies have a reduced risk for obesity and type II diabetes later in life. Approximately 83% of newborns in Napa County were exclusively breastfed in the hospital in 2011 (Napa County Needs Assessment 2013). To promote and support breastfeeding in the community, SJH-QV supports the development of a community **breastfeeding coalition**, providing \$5,000 in community benefit to fund health care professional education in addition to in-kind staff time toward coalition development and implementation. At the end of FY 13 The Napa Valley Breastfeeding Coalition established as a 501(c)3 and had its first Board of Directors and Community Partners Annual Meeting in FY 14.

Community Nutrition Education

Coordinated through SJH-QV community benefit is “**Cooking Matters,**” a program offering free, six-week-long series of cooking and nutrition classes to low-income individuals and families. Classes are taught by volunteer culinary and nutrition instructors working in teams. This year we were able to offer “Cooking Matters’ in Spanish. In addition to Cooking Matters, SJH-QV offers bilingual community health education specific to nutrition and healthy lifestyle behaviors in underserved locations throughout Napa County.

Key Community Partners: Children and Weight Treatment Coalition, Community Health Clinic Ole (FQHC), family resource centers, Kaiser Permanente, Napa Breastfeeding Coalition, Napa County Health and Human Services, Napa Valley Pediatrics, Napa Valley Unified School District, School Health Committee, Synergy Medical Fitness Center, Napa County WIC, First 5, 18 Reasons, Apple Lane Foundation, Napa County Public Health, Silverado Cooking School, Share Our Strength, Napa Community Housing

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Goal (Anticipated Impact⁴): Increase knowledge on topics related to childhood obesity among populations in Napa who are most at risk.

Target Population (Scope): Low-income, underserved, perinatal population, and children at risk for obesity.

How will we measure success?

Outcome Measure: Percentage of pregnant women, children and families that increase knowledge or healthy behaviors to prevent or reduce childhood obesity.

Three-Year Target: By FY14 increase percentage by 10% of baseline (baseline is 62%).

FY 14 Progress: Of 494 survey respondents from two programs; breastfeeding education (228 respondents) and Cooking Matters (268 respondents), 86% report increased knowledge.

In addition to the above surveys showing increase knowledge, of the 469 student respondents from Healthy for Life in FY 14, over ten survey categories show improvement including; 23% reduction in screen time per day, 24% increase in physical activity for 60 minutes, 23% increase in consumption of 5 fruits and/or vegetables per day, and a 15% improvement eating breakfast.

Strategy 1: Implement school based obesity prevention program – Healthy for Life

Strategy Measure 1: Implemented in Napa County in FY 09, FY14 marks our sixth year expanding the Healthy for Life program, now in 18 schools. This year targeted expansion into the lower elementary classes (grades K-2) **increased** the number of classrooms served by **30%** (from 23 to 30 classrooms). Over **1,000 students** participated in some portion of the program's exercise and fitness classes and 469 students were captured for physical assessments.

Strategy 2: Provide interventions for children at risk for obesity- Healthy for Life

⁴ **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)

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Strategy Measure 2: Among the 469 students assessed, 194 were classified as overweight or obese (BMI greater than 85th percentile). Of these overweight or obese students 38 (18%) **improved their weight** status by yearend. Of the 469 students 102 were identified as obese (BMI greater than 95th percentile). For these high risk students identified as obese, physician follow-up was provided to educate parents, notify the child's primary care provider and ensure further follow up care. In addition, new this year, these high risk students and their parents were offered a series of three family nutrition counseling sessions with a registered dietician - in English or Spanish - at no cost to the families.

Strategy 3: Community Based Education - Provide community and parent education, including breastfeeding, healthy lifestyles, and nutrition.

Strategy Measure 3: Bilingual community health education is provided at all Healthy for Life school sites, all Parent University school sites, plus 8 additional underserved locations throughout Napa County. In addition to Healthy for Life and Parent University programs;

- Four classes specific to nutrition were offered in underserved locations in the community with a total of 40 participants. Of these 40 persons, 76% reported increase in knowledge and 82% an increase in confidence to adopt topic behaviors.
- 12 classes specific to breastfeeding were offered with 228 participant contacts, 88% of participants reported increase in knowledge and 89% an increase in confidence to adopt topic behaviors.
- Four sessions (28) "Cooking Matters" classes were offered with 268 participant contacts, 84% reported an increase in knowledge and 95% an increased confidence to adopt the topic behaviors.

Strategy 4: Healthcare Professional Breastfeeding Education - Provide breastfeeding education for providers (physicians, mid-wives, nurse practitioners, nurses, lactation consultants, lactation educators, health educators and other members of the breast feeding support team).

Strategy Measure 4: In FY14 four (4) community-wide breastfeeding trainings offering continuing education credit for healthcare professionals were conducted with a total of 128 participants.

FY14 Accomplishments:

Healthy for Life School Engagement

To accomplish program expansion, SJH-QV provided 20 lower grade teachers (grades K-2) and 12 upper grade teachers (grades 3-5) a full day of Healthy for Life training to

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incorporate Sports Play and Active Recreation for Kids (SPARKS) curriculum into PE classes. SJH-QV funds the training and the teacher's time to participate in the training. Participating schools also receive a community benefit donation of fitness equipment and physical education curriculum for student use in teacher-directed education classes. In addition, SJH-QV's medical fitness center contributes a rich variety of resources to the Healthy for Life program including a Registered Dietician and exercise instructors. This year, through specific grant funding, we were able to provide a series of 3 individualized nutrition counseling sessions to the entire family for highest risk children (>95% BMI), at no out of pocket fee for the family.

Cooking Matters

"Cooking Matters" offers specialized curricula that cover nutrition and healthy eating, food preparation, budgeting and shopping. This year we were able to recruit a bilingual chef and support staff and offer "Cooking Matters" in Spanish for the first time with 88 Spanish speaking participant encounters.



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FY14 Accomplishments

Initiative: Behavioral Health

Description: SJH-QV takes a three pronged approach – 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 three 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

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integrated behavioral health into the chronic disease management program, **CARE Network**, providing free mental health services to low-income chronically ill clients. Most recently, in FY 12 SJH-QV partnered in the launch of “**Healthy Minds, Healthy Aging**”, a community-based behavioral health initiative for underserved older adults at risk for behavioral or cognitive health issues. Services are bilingual Spanish/English and include cognitive and behavioral health assessments, case management, behavioral health sessions/therapy sessions, as well as community presentations, caregiver training and support, and health care provider outreach and training.

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

Goal (Anticipated Impact⁵): Reduce depression for low-income older adults, those with chronic disease and pregnant and postpartum women.

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

How will we measure success? Outcome Measure: 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%).

FY 14 Progress: 98% (of 53 clients completing two PHQ9 surveys) improved depression score.

Strategy 1: Provide universal screening for depression

Strategy Measure 1: Referrals to behavioral health are identified through a variety of processes including the Edinburg Depression Scale (EPDS) for perinatal wellness, the SF12v2 screen for CARE Network, and the PHQ2 for the Healthy Aging program. For all 3 programs, a total of 1272 universal screenings for depression were conducted.

Strategy 2: Conduct assessment of needs

⁵ **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)

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Strategy Measure 2: Once clients are enrolled in a behavioral health program, clinicians use the PHQ9 depression scale to assess progress. For all 3 programs, 192 clients were assessed for depression by behavioral health clinicians using the PHQ9. Of these, **96%** (183) had PHQ9 scores of 5 or above indicating **depressive symptoms** appropriate for treatment. In addition to depression assessment, clients were assessed and warm hand offs were provided on over **666** occasions to community resources and services including food, housing, and drug and alcohol services.

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

Strategy Measure 3: For all three programs, **244 individuals** were served, including those older adults served through the Healthy Minds Healthy Aging program who were provided brief case management without behavioral health intervention. For these 244, a total of 1,026 face to face sessions were provided and 1,882 telephonic contacts for a total of **2,908** encounters. For all, **39** clients required and were referred for more intensive behavioral health services, and with advocacy and warm hand off strategies, **98% (38)** of these clients received these additional services.

FY14 Accomplishments

Community Benefit Investment for Mental Health

St. Joseph Health, Queen of the Valley takes a collaborative capacity building approach to increasing access to behavioral health services within the community. A community benefit contribution in the amount of **\$110,000** to Family Service of Napa Valley provides for an onsite therapist integrated into services for the chronically ill (CARE Network). Another multi-agency program, “Healthy Minds, Healthy Aging” is a partnership between Area Agency on Aging, Family Service of Napa Valley, Napa Valley Hospice & Adult Day Services, Napa County Comprehensive Services for Older Adults and SJH-QV. Launched in 2012, the program is funded through the Napa County Mental Health Services Act Prevention and Early Intervention (PEI) funds and through SJH-QV community benefit, with community benefit contribution from SJH-QV totaling over **\$71,000** not including in kind space for program staff and operations.

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FY12 – FY14 Community Benefit Plan/Implementation Strategies and Evaluation Plan

FY14 Accomplishments

Initiative: Community Education and Empowerment

Description: Napa Valley Parent University

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/CSU system, as compared to 31.6% of their White peers. Additionally, the 2013 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.

St. Joseph Health Queen of the Valley has implemented three initiatives facilitating community education and empowerment: Parent University, perinatal education series (pre and postnatal classes for parents and siblings), and a bilingual community health education curriculum with a variety of topics.

Key Community Partners: On the Move, Napa Valley Unified School District, Adult Education, McPherson Elementary School, Salvador Elementary School, Shearer Elementary School, Phillips Elementary School, Napa Junction Elementary School, Parents CAN, Napa County Office of



Education, Healthy Moms and Babies

Goal (Anticipated Impact⁶): To improve self-efficacy of participants that can contribute to lifelong health and wellbeing.

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

How will we measure success? Outcome Measure: 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. A three month baseline measure is 88% with a 12% gap. A 10% gap reduction represents 1.2% gain in self-efficacy.

FY 14 Progress: 80% of 745 surveys report improved self-efficacy. The three year average increase in reported self-efficacy from 2,167 surveys is 88.5 percent. Of note; baseline consisted of a 3 month data analysis from a small sampling of classes.

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

Strategy Measure 1: 100% of classes utilize culturally appropriate tools (curricula, materials, and visuals). 100% of classes are provided in the language of the participants, either English or Spanish. Of the 1,307 **Parent University** survey respondents, 99% report programs as culturally appropriate. Of the 751 survey respondents for **Perinatal** and other **Bilingual community health education**, 98% report programs as culturally appropriate.

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

Strategy Measure 2: Parent University consists of 84 different class curriculums and is conducted at 5 different underserved elementary schools with a total of 1,176 parent participants, 7,436 parent encounters (duplicated – same parent's participated in multiple classes), 63% of parents reporting improved knowledge, and 67% reporting improved confidence on topic application (applying knowledge in daily life). **Bilingual Community Health Education** classes are provided at 8 underserved community

⁶ **Anticipated Impact** is equivalent to **Goal**. Language is used for clarity with regard to IRS Proposed Rule (2013)

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locations utilizing 19 different class curriculums with a total of 103 participants, 69% reporting improved knowledge and 75% reporting improved confidence on topic application. This year 397 **Perinatal Education** workshops were offered to the broader community. Workshops covered 17 different topics including: childbirth education, post-partum yoga, breastfeeding, infant care, sibling classes, and infant massage. There were a total of 3,829 participant encounters, with 87% of class participants reporting improved knowledge and 85% reporting improved confidence on topic application.

FY14 Accomplishments:

Parent University – program expansion to 2 additional schools including a new focus into preschools reaching parents of children ages 3-5, more specifically those with no prior schooling experience. Also, this year Parent University enhanced and developed a curriculum specific to leadership development. This new parent leadership curriculum was implemented and 36 parents successfully completed the course which includes a leadership project for each. Last, with the support and collaboration of Napa Valley Parent University, Parent University was successfully replicated at one elementary school in Fresno County, with plans for expansion in other Fresno schools.

Community Navigator Trainings - SJH-QV recognizes the value of a strong community safety net for the poor and vulnerable. To strengthen the community-based continuum of care and enhance a sense of shared accountability for Napa's vulnerable; SJH-QV conducts trainings for frontline staff from other organizations that provide community resource information and referral assistance. In FY14 we conducted three trainings free to community navigators focused on women's services, services for persons with disabilities, on men's health and wellbeing. Representatives from five local agencies presented on these topics with nearly 30 attendees including staff from family resource centers, Community Housing, Health and Human Services, Napa Valley Unified School District, Migrant Education, VOICES (emancipated foster youth), Even Start, and Children's Health Initiative to name a few.

Other Community Benefit Programs and Evaluation Plan

Community Partnerships for Community Health

Our mission calls us to improve the health and quality of life of our community and we realize the need to partner with others to make this a reality. To this end SJH-QV provided over **\$448,000** in cash and in kind support to local nonprofit organizations offering critical safety net resources to Napa's most vulnerable including mental health, food security programs, housing programs, domestic violence shelter, teen pregnancy program, gang tattoo removal program, Boys & Girls Club nutrition program, Operation with Love from Home (providing care packages to U.S. troops abroad), Birth Choice Health Clinic, senior services, and Napa County family resource centers. Reports from these partnerships demonstrate that thousands of lives were touched and provided critical services through this support from SJH-QV.

The following highlight a few key community partnerships.

Community Health Clinic Ole

SJH-QV is dedicated to improving the health and quality of life for our entire community, including our community's most vulnerable. To this end, we partner with Napa's Federally Qualified Health Center, Community Health Clinic Ole (CHCO) to support a variety of programs and services totaling over **\$61,000** in community benefit. FY14, funded efforts to Community Health Clinic Ole included:



Cancer Screening and Oncology Clinic: As the result of an identified community need, in FY11 SJH-QV, CHCO, and Redwood Oncology developed an **oncology clinic for the uninsured**. This clinic is staffed with an in-kind SJH-QV CARE Network RN, an oncologist from Redwood Regional Oncology Group and is conducted and operationally supported through CHCO. Uninsured cancer patients seen in cancer clinic are case managed by SJH-QV CARE Network. In FY13, **12** oncology clinic visits were provided for **5** uninsured cancer patients. In support of cancer care and prevention services for low-income, SJH-QV provides a cash donation to CHCO supporting the oncologist's services, CHCO's women's cancer screening program and colon cancer screening program for a total **\$25,000** cash donation for cancer detection and care.

HIV Clinic: In FY14 a community benefit in the amount of **\$36,000** to CHCO provides an HIV physician specialist to conduct **HIV clinic** for Napa County HIV positive individuals. This year, in response to an identified need for specialized care for patients with Hepatitis C, HIV clinic has expanded to serve CHCO patients with this complex

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diagnosis. HIV/Hepatitis C clinic is staffed with SJH-QV CARE Network in kind RN and social worker, and HIV patients seen are case management by this RN/social worker team. This year **163** clinic visits were provided for 75 patients.

Migrant Farm Worker Health Screenings: This year SJH-QV partnered with CHCO to provide 2 health screenings. SJH-QV contributed a community benefit of **\$1,789** toward health fair supplies as well as in kind RN staffing. Services include cholesterol and blood sugar screenings. Participants are assisted for ongoing care through CHCO establishing a medical home. A total of **117 individuals** were served.

Napa Valley Adult Day Services: Alzheimer's Care

Adult Day Services provides professional care and respite for families and caregivers of individuals with Alzheimer's disease and other cognitive and mental health issues. Without Adult Day Services, these individuals are at high risk for institutionalization. With changes in reimbursement and diminishing resources toward Adult Day Services, SJH-QV provided a community benefit in the amount of **\$44,200** to sustain this critical community program.



Area Agency on Aging/Healthy Aging Planning Initiative (HAPI)

With 15.1 % of all residents over the age of 65, Napa County has a higher proportion of older residents than California as a whole (2013 Napa Community Health Needs Assessment). Queen of the Valley recognizes the importance of a community benefit focus on the needs of older adults. A total of **\$32,400** was invested in FY14 to support the county wide collaborative Healthy Aging Planning Initiative (HAPI), which brings together senior-serving organizations throughout Napa Valley to network, coordinate services and outreach to older adults, address service gaps, and advocate for supportive community-based services that protect and enhance the independence of Napa's seniors.

"Queens Heart Safe" Program/Via Foundation

Access to an automated external defibrillator (AED) can mean the difference between life and death for a victim of sudden cardiac arrest. That's



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why St. Joseph Health, Queen of the Valley, in collaboration with The Via Foundation, established “The Queen’s Heart Safe Program”: to make AEDs commonplace at businesses, organizations, and schools throughout Napa County. In FY14 SJH-QV contributed a community benefit donation of **\$20,000** in support of this program as well as in kind staff time to conduct nine (9) CPR/AED training events, a total of 960 individuals, organized throughout Napa County in FY14. As of fiscal 14 year-end, **35 AED’s** have been installed across the county. This collaborative program between the Via Foundation and SJH-QV is also made possible through a cooperative effort with the Napa Fire Department, EMS/911, Napa County Office of Education, American Medical Response (local ambulance company), Napa County Health and Human Services, PTA representatives, among others.

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FY14 COMMUNITY BENEFIT INVESTMENT
St. Joseph Health Queen of the Valley Medical Center
(Ending June 30, 2014)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services ⁷	Net Benefit
Medical Care Services for Vulnerable⁸ Populations	Financial Assistance Program (FAP) (Charity Care-at cost)	1,976,026
	Unpaid cost of Medicaid ⁹	13,063,243
	Unpaid cost of other means-tested government programs	2,752,323
Other benefits for Vulnerable Populations	Community Benefit Operations	760,488
	Community Health Improvements Services	1,852,605
	Cash and in-kind contributions for community benefit	68,000
	Community Building	0
	Subsidized Health Services	402,948
Totals Community Benefit for the Vulnerable		20,875,633
Other benefits for the Broader Community	Community Benefit Operations	253,496
	Community Health Improvements Services	571,376
	Cash and in-kind contributions for community benefit	380,044
	Community Building	137,428
	Subsidized Health Services	71,222
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	5,000
	Total Community Benefit for the Broader Community	
TOTAL COMMUNITY BENEFIT (excluding Medicare)		22,294,199
Medical Care Services for the Broader Community	Unpaid cost to Medicare <i>(not¹⁰ included in CB total)</i>	29,952,201

⁷ Catholic Health Association-USA Community Benefit Content Categories, including Community Building.

⁸ CA SB697: "Vulnerable Populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medicaid, Medicare, California Children's Services Program, or county indigent programs. For SJHS, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.

⁹ Accounts for Hospital Fee. The pledge/grant (separate from the quality assurance fee) is reported in Cash and In-kind Contributions for other vulnerable populations.

¹⁰ Unpaid cost of Medicare is calculated using our cost accounting system. In Schedule H, we use the Medicare cost report.

Telling Our Community Benefit Story: Non-Financial¹¹ Summary of Accomplishments

Dating back to the 1650's the founding Sisters of St. Joseph Health, the Sisters of St. Joseph of Orange, divided their city into four quadrants and sought out the needs that existed. When the sisters could meet those needs, they did so in their discreet way. When they could not, they invited other people of good will to help alleviate suffering.

In the tradition of the Sisters of St. Joseph of Orange, SJH-QV community benefit efforts are integral to our heritage and mission as a Catholic Health Ministry. Collaborative relationships with others in the community are a key strategy to meeting identified needs and improving the health and quality of life of people in the community we serve.

Live Health Napa County: Live Healthy Napa County (LHNC) is a public-private-community partnership to improve health and wellbeing of everyone in Napa County. Launched in 2013 by representatives from County of Napa, Kaiser Permanente, St.



Helena Hospital, Queen of the Valley Medical Center, and the Napa Valley Coalition of Nonprofit Agencies, and championed by Napa County Public Health, LHNC includes a broad representation of approximately 40 Napa County stakeholders and offers a powerful venue for collective action to improve the health and quality of life for those in our community. Throughout FY 14 SJH-QV provided over 5 key department staff toward the development of the CHNA and of the Community Health Improvement Plan (CHIP).

Dental Services for Low-Income: In an effort to engage like-minded community partners and create a seamless continuum of care for dental services for the low-income, SJH-QV Community Benefit and Community Health Clinic Ole (Federally Qualified Health Center / FQHC) explored and applied a shared leadership structure for dental services for both organizations. Implemented in the last quarter of FY13, performance improvement activities are underway to identify opportunities for enhanced processes to meet the dental needs of low-income older adults, adults, and children in Napa County.

¹¹ Non-financial summary of accomplishments are referred to in SB 697 as non-quantifiable benefits.

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Volunteerism: In FY14 SJH-QV leadership staff contributed 353 hours of community service and volunteer hours for efforts toward feeding the hungry, bereavement support, Birth Choice Health Clinic, holiday assistance, care packages for troops abroad, migrant farm worker health fairs, Latino elder Coalition, Napa Valley Adult School, support groups, and Stop Falls Napa Valley home assessments. In addition to volunteerism, SJH-QV offers in kind use of conference room space for 18 community support groups and a variety of community coalition meetings.



Operation with Love from Home (OWLFH): Founded and supported by SJH-QV, this community-wide effort ships care packages to deployed troops throughout the year with major shipments coordinated for Christmas, Valentine's Day, and the 4th of July. Volunteers assist with collection of needed items from a variety of sources including schools, banks, service organizations, grocery stores, and health clubs and from SJH-QV. Enclosed in every care package is a thank you card written by school children and issue folded pocket flags with prayers inside prepared by Korean War women veterans residing at the Yountville Veterans Home. Large coordinated care package assembly days bring the community together toward this healing ministry. This year 1,579 care packages were shipped.

The Table: The Table is a "soup kitchen" safety net food program providing a warm dinner Monday through Friday at The First Presbyterian Church. Since 1999, SJH-QV has sponsored and provides one warm "home cooked" meal on the second Tuesday of the month. For this meal, SJH-QV volunteers and their families create the menu, shop, prepare the meal, and decorate the dining hall to create a welcoming environment, serve the meal and clean up. This FY14, SJH-QV volunteers served 1,942 meals to vulnerable community members.

Holiday Assistance: SJH-QV is one of the lead organizations coordinating a county-wide holiday assistance program. Staff volunteers for program registration, toy drive, and distribution of holiday packages. For Christmas 2013; **1,432 low-income families** were provided **food** and 2,805 children between ages 0-11 were provided toys and 379 tweens/teens from ages 12-15 were provided gifts.

Blood Drives: Another form of volunteerism is the Blood Centers of the Pacific (BCP) blood drive targeting SJH-QV employees, physicians and volunteers. In FY14 BCP conducted 3 blood drives at SJH-QV with a total of 104 registered donors and 85 units of blood donated.

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Board Membership: SJH-QV leaders serve other nonprofit organizations by participating as board of directors. Organizations with SJH-QV representation on their board include Birth Choice Health Clinic, Napa Valley Coalition of Nonprofit Agencies, Napa Valley Community Foundation, American Red Cross, Napa Valley Tobacco Board, Work Investment Board, City Council Member's Latino Advisory Council and Napa Valley Hospice and Adult Day Services.