St. Joseph Health, Queen of the Valley Medical Center
Fiscal Year 2015 COMMUNITY BENEFIT REPORT
PROGRESS ON FY15 - FY17 CB PLAN/IMPLEMENTATION STRATEGY REPORT

St. Joseph Health
Queen of the Valley

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

EXECUTIVE SUMMARY

INTRODUCTION

Who We Are and Why We Exist

As a ministry founded by the Sisters of St. Joseph of Orange, St. Joseph Health Queen of the Valley Medical Center (Queen of the Valley) lives out the tradition and vision of community engagement set out hundreds of years ago. Queen of the Valley is an acute-care hospital founded in 1958, located within City of Napa and County of Napa, California. The facility has 211 licensed beds and a campus that is approximately 12.3 acres in size. Queen of the Valley has a staff of more than 1,300 and professional relationships with more than 300 local physicians. Queen of the Valley 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. Key programs and services include cardiac care, critical care, cancer care, diagnostic imaging, emergency medicine, obstetrics, and a community medical fitness center. With no county hospital, Queen of the Valley provides vital hospital and community services and addresses the needs of the uninsured and underinsured through its financial assistance program providing free and discounted care (traditional charity care).

In the tradition of 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 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, Queen of the Valley 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

In total, for fiscal year 2015 Queen of the Valley contributed $**26,031,325** in community benefit, excluding unreimbursed costs of Medicare. This investment helped care for, vulnerable, low-income persons, the uninsured and underinsured and the broader community. In addition, the unreimbursed cost of Medicare in FY15 totaled **$30,822,643**

Overview of Community Needs and Assets Assessment

Community Benefit programs and services 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 has participated in a collaborative approach to the triennial CHNA. Our FY14 CHNA is in partnership with Napa County Public Health, Kaiser Permanente, St. Helena Hospital, Napa Valley Coalition of Nonprofit Agencies, and Community Health Clinic Ole. From this core team, the collaborative cast an even wider net to include a larger and more diverse stakeholder representative group. This larger group known as Live Healthy Napa County (LHNC) is a public-private partnership bringing together 80 agencies to collaboratively conduct Napa's CHNA and develop a comprehensive Community Health Improvement Plan (CHIP).

In addition, the FY14 CHNA process included three different community assessment strategies: 1) an extensive review of existing data from government, public, and private institutions, 2) English and Spanish language community surveys, 28 community workshops in English and Spanish, 16 stakeholder interviews, and 3) convening 55 representatives from diverse community organizations for a day long local public health system assessment (LPHSA).

Community Plan Priorities/Implementation Strategies

In response to identified unmet health-related needs identified in the FY14 Community Health Needs Assessment St. Joseph Health Queen of the Valley's FY15-FY17 community benefit plan focuses on four priority areas: Childhood Obesity, Access to Dental Care, Continuum of Care, and Access to Behavioral Health Services.

Childhood Obesity

- To address childhood obesity in Napa County, SJH Queen of the Valley continues the **Healthy for Life** program (H4L), a school-based obesity prevention program designed to emphasize lifelong fitness and healthy eating behaviors among children and adolescents. The program incorporates the following strategies: (1) School-based obesity prevention; (2) Intervention with at-risk children; (3) Community/ parent education; and, (4) Community and school policy advocacy.
    - This year program expansion targeted low-income preschool settings, adding 7 preschool sites (13 classes) to our existing 17 participating district school sites (37 classes), increasing the total classrooms served by 47% (from 30 to 44 classrooms). Over 1,000 unduplicated students participated in program fitness classes and nutrition classes with over 9,000 student encounters overall. Of the 496 elementary students captured for physical assessments, **20%** (45 of 224 children) classified as overweight and obese at the beginning of the school year re-classified to a **lower weight** category by the end of the school year.

Access to Dental Care

- To address the identified community need of oral health, Queen of the Valley launched a **Children's Mobile Dental Clinic** in 2005. Currently as one of only two providers of

dental care for low income or Medi-Cal eligible children in Napa County, Queen of the Valley strives to meet this continued community need.

- This year our mobile dental clinic spanned 9 locations across Napa County serving **2,129** low-income children and providing **5,067** clinic visits. In addition, 37 low income pre-school classes were provided free oral health screenings and fluoride varnish to over 640 children. Of these 640 children, 115 had no dental home and parents were assisted with referral to a dental home for treatment, education and continued preventive care.

Continuum of Care

- **CARE** (Case Management, Advocacy, Resources, and Education) **Network** is a nationally recognized, award winning community based program that promotes chronic disease self-management utilizing an interdisciplinary RN, social work, behavioral and spiritual approach. Services are provided in the clients' home or as needed in a health provider office or other community service location. The program is aimed at care coordination and improving disease management and quality of life while reducing overall healthcare costs.
  - In FY15 CARE Network served over 400 clients, of those 236 were newly enrolled. For those newly enrolled clients, emergency room visits decreased by **53%** and hospitalizations decreased by **53%** as compared to one year prior to enrollment. To address improved access to critical medical and social supports and provide a continuum of care from hospital to outpatient settings, SJH Queen of the Valley expanded scope of services of the CARE Network to include transitional care, addressing the unique needs of patients recently discharged from inpatient care or at risk for hospitalization, particularly those patients with complex medical conditions as well as difficult socio-economic needs such as housing insecurity and basic needs deficits.

Access to Behavioral Health Services

- Access to low cost mental health services continues to rank as a priority in the FY14 CHNA. To address this need, Queen of the Valley took a multipronged approach with three integrated mental health programs that promote screening of targeted populations for depression, offer brief therapeutic interventions (1-10 sessions) and/or referrals to more intensive services and navigate clients to other community support services and groups. Program beneficiaries include postpartum mothers, CARE Network intensive case management clients and underserved older adults at risk for behavioral or cognitive

health issues. Services are bilingual Spanish/English and link clients to community resources and services.

- The total number of unduplicated clients served by these three mental / behavioral health programs (The CARE Network, Healthy Minds Healthy Aging (HMHA), and the Perinatal Emotional Wellness program) was 232 with 1,127 therapy sessions provided in the client's home or office. 90% of clients completing services demonstrated improvement in depression symptoms. In addition, HMHA conducted trauma debriefing sessions with 20 older adults who had been affected by the 2014 earthquake, thereby mitigating post traumatic reactions.

INTRODUCTION

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Mission, Vision and Values and Strategic Direction

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.

St. Joseph Health, Queen of the Valley Medical Center (also known as Queen of the Valley) has been meeting the health and quality of life needs of the local community for over 50 years. Serving communities including American Canyon, Napa, Yountville, St. Helena, Calistoga, Angwin, Pope Valley and Lake Berryessa, SJH Queen of the Valley is an acute care hospital that provides quality care as the county's only Level III Trauma Center and neonatal intensive care unit. Queen of the Valley 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, a Cancer Center, Heart Center, Maternity/Infant Care, Neurosciences, Orthopedics, Rehabilitation Services, Women's Services, Imaging Services, and Wound Care Clinic. With over 1,300 employees committed to realizing the mission, Queen of the Valley is one of the largest employers in the region.

Strategic Direction

As we move into the future, Queen of the Valley is committed to furthering our mission and vision while transforming healthcare to a system that is health-promoting and preventive, accountable in its inevitable rationing decisions, integrated across a balanced network of care and financed according to its ability to pay. To make this a reality, over the next five years (FY14-18) St. Joseph Health and Queen of the Valley are strategically focused on two key areas to which the Community Benefit (CB) Plan strongly align: population health management and network of care.

Community Benefit Investment

In total, for fiscal year 2015 Queen of the Valley contributed **$26,031,325** in community benefit, excluding unreimbursed costs of Medicare. This investment helped care for, vulnerable, low-income persons, the uninsured and underinsured and the broader community. In addition, the unreimbursed cost of Medicare in FY15 totaled **$30,822,643**

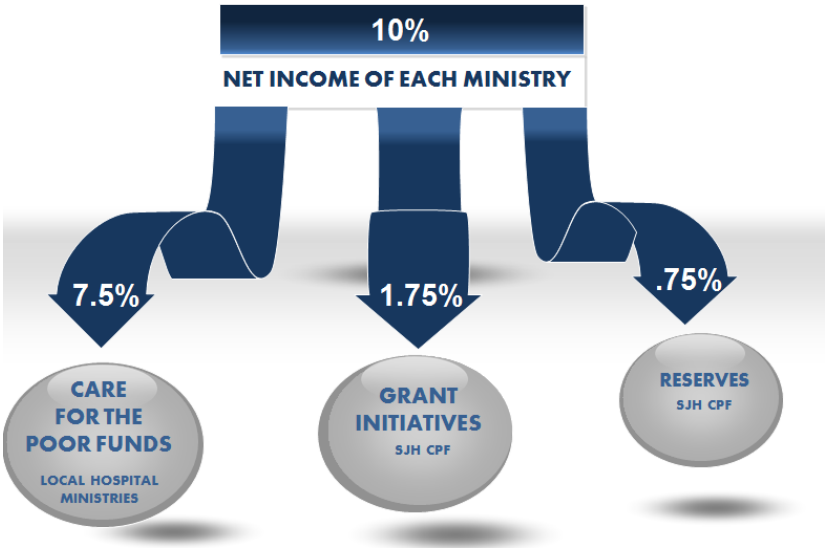
ORGANIZATIONAL COMMITMENT

St. Joseph Hospital dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and underserved.

In 1986, St. Joseph Health created the St. Joseph Health Community Partnership Fund (SJH CPF) (formerly known as the St. Joseph Health System Foundation) to improve the health of low-income individuals residing in local communities served by SJH hospitals.

Each year, St. Joseph Health, Queen of the Valley allocates 10% of its net income (excluding unrealized gains and losses) to the St. Joseph Health Community Partnership Fund. (See Figure 1). 7.5% of the contributions are used to support

Figure 1. Fund distribution



local hospital Care for the Poor programs. 1.75% is used to support SJH Community Partnership Fund grant initiatives. The remaining .75% is designated toward reserves, which helps ensure the Fund's ability to sustain programs into the future that assist low-income and underserved populations.

Furthermore, Queen of the Valley will endorse local non-profit organization partners to apply for funding through the St. Joseph Health Community Partnership Fund. Local non-profits that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout St. Joseph Health hospitals' service areas.

Community Benefit Governance Structure

SJH Queen of the Valley further 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, Community Outreach Queen of the Valley are responsible for coordinating implementation of California Senate Bill 697 (provisions and Federal 501r requirements) as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the Community Benefit Plan.

The Community Benefit (CB) Management Team provides orientation for all new Hospital employees on Community Benefit programs and activities, including opportunities for community participation.

A charter approved in 2007 establishes the formulation of the 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 Health Needs Assessment and Community Benefit Plan/Implementation Strategy Reports, and overseeing and directing the Community Benefit activities.

The Community Benefit Committee has a minimum of eight members including three members of the Board of Trustees. Current membership includes 10 Board of Trustees, 9 community members, and 3 St. Joseph Health Queen of the Valley staff members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Benefit Committee generally meets monthly.

Roles and Responsibilities

Senior Leadership

- CEO and other senior leaders are directly accountable for CB performance.

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 *Advancing the State of the Art of Community Benefit (ASACB) Five 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 (CB) Department

- Manages CB efforts and coordination between CB and Finance departments on reporting and planning.
- Manages data collection, program tracking tools and evaluation.
- Develops specific outreach strategies to access identified Disproportionate Unmet Health Needs (DUHN) populations.
- Coordinates with clinical departments to reduce inappropriate ER utilization.
- Advocates for CB to senior leadership and invests in programs to reduce health disparities.

Local Community

- Partnership to implement and sustain collaborative activities.
- Formal links with community partners.
- Provide community input to identify community health issues.
- 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

Patient Financial Assistance Program

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 FY15, St. Joseph Health Queen of the Valley, provided **$1,706,699** in financial assistance (free and discounted care) for 3,708 encounters.

One way 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.

Medicaid and Other Means-Tested Government Programs

Queen of the Valley provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California, and other means-tested government programs. In FY15, St. Joseph Health Queen of the Valley, provided **$16,940,030** in Medicaid shortfall and **$3,488,782** in other means-tested government programs.

COMMUNITY

Defining the Community

Located 50 miles northeast of the San Francisco Bay Area, Napa is one of the most renowned agricultural as well as premium wine-producing regions in the world with a population of approximately 136,484 people (2010 Census), an increase of 9.8 percent from the 2000 Census. Napa County's Latino population grew by 50 percent from 2000 to 2010. The wine, agricultural, and hospitality industries are the county's largest and responsible for nearly 40,000 jobs. Immigrants have worked in Napa's vineyards, wineries, and hospitality sector for decades and are overrepresented in the County's workforce; however, Latino men have relatively low earnings compared to other county workers, mostly as a result of lower educational attainment and limited English proficiency. Latinos have become the largest demographic group of school children. Close to half (45 percent) of all children enrolled in Napa County's public schools were English Language Learners (ELL's) in 2008-09. In some areas of the county 30-50 percent of those over 25 years of age do not have a high school diploma. The academic achievement gap is high among children who are economically disadvantaged and/ children who are not.

The cost of living in Napa County is high with a family of four needing between $65,000 and $77,000 to meet their family's basic needs for food, shelter, childcare and healthcare (Insight Center for Community Economic Development). Among Latinos, 51 percent live below the self-sufficiency level. Forty-one percent of Latino immigrant households in the county that rented were living in crowded conditions (Profile of Immigrants in Napa County, 2012).

While Napa is not considered a "poor" county relative to other counties, including those with large agricultural areas, about 12 percent of children (3,670) and 7.2 percent of seniors age 65+ live below the poverty level and 26.4 percent live below 200 percent of poverty including 10,000 children. Due to the high cost of living in Napa County, 43 percent of families with children live below the family self-sufficiency level. (Source: Insight Center for Community Economic Development) Thirty-five percent of households speak a language other than English at home; 25 percent speak Spanish.

An estimated 15,246 residents are not U.S. citizens; this can swell during the growing season. With 15 percent of the population 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. Twenty-two percent of the population is 17 years of age and younger. According to the 2010 US Census, 56.4 percent of the population is White, 32.2 percent are Latino, 6.8 percent are

Asian, 4.2 percent are two or more races, 2 percent are African American, 1.1 percent are other. (American Community Survey, US Census 2010) Other social factors affecting Napa residents are lack of affordable housing, high cost of food and limited access to transportation for those without automobiles and growing academic achievement gap. The leading causes of death are cancers, coronary health disease, Alzheimer's disease and cerebrovascular disease. Chronic diseases such as heart disease and diabetes are on the rise as are correlating factors such as obesity and overweight. A complete copy of SJH Queen of the Valley's FY14 CHNA is located here: http://www.thequeen.org.

Hospital Total Service Area

The community served by the Hospital is defined based on the geographic origins of the Hospital's inpatients. The Hospital Total Service Area is the comprised of both the Primary Service Area (PSA) as well as the Secondary Service Area (SSA) and is established based on the following criteria:

- PSA: 70 percent of discharges (excluding normal newborns)
- SSA: 71 percent-85 percent of discharges (draw rates per ZIP code are considered and PSA/SSA are modified accordingly)
- Includes ZIP codes for continuity
- Natural boundaries are considered (i.e., freeways, mountain ranges, etc.)
- Cities are placed in PSA or SSA, but not both

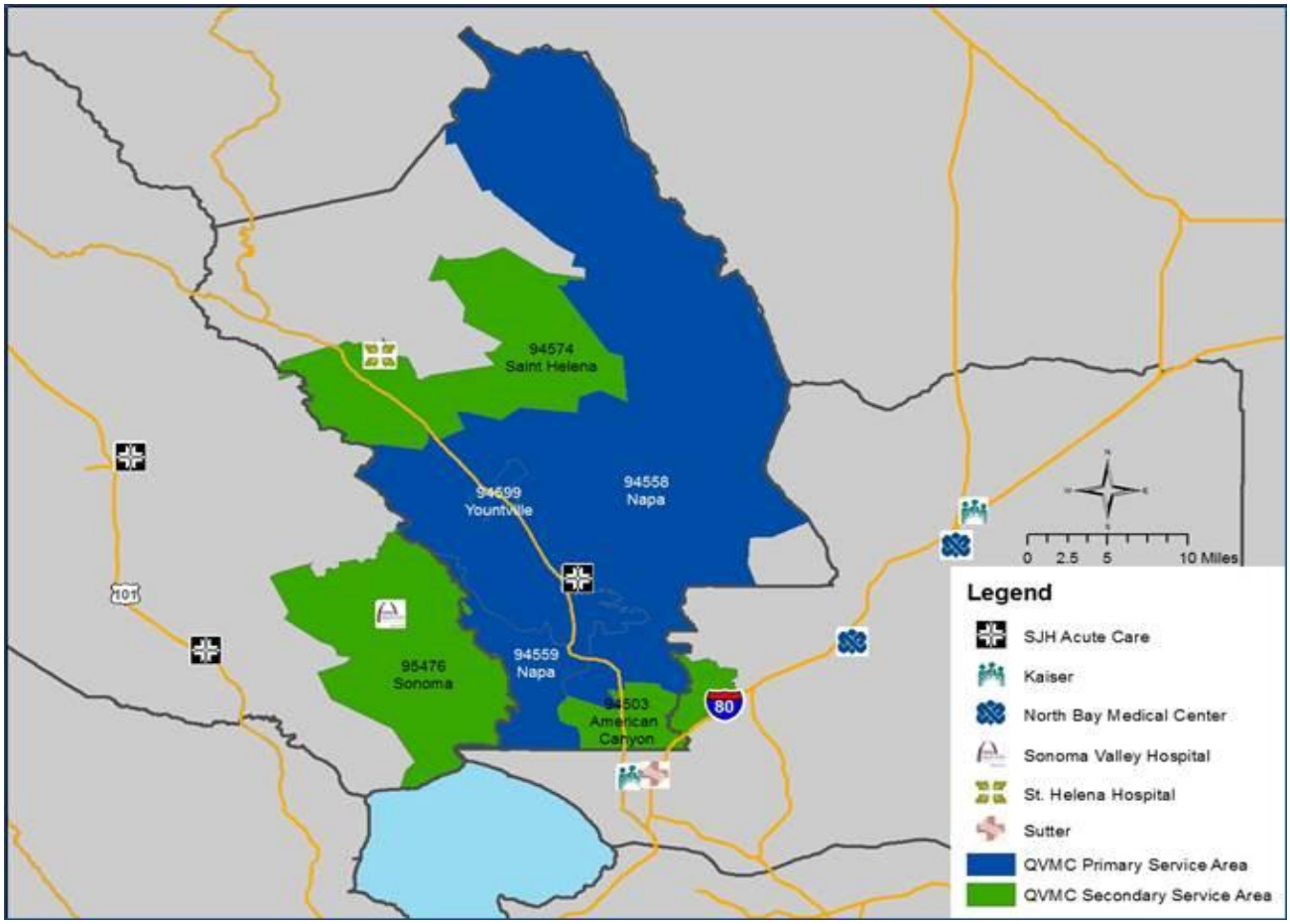
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients resides. The hospital's PSA is comprised of the cities of Napa and Yountville. The hospital's SSA is comprised of the cities of American Canyon, St. Helena, and the city of Sonoma. With the exception of the city of Sonoma, all PSA and SSA fall within the geographic boundary of Napa County. The city of Sonoma has Sonoma Valley Hospital and falls within Sonoma County, a county with two SJH hospitals, urgent care clinics, and community benefit outreach including mobile health and mobile dentistry. Given SJH regional collaborative efforts, SJH Queen of the Valley community benefit service area does not extend into Sonoma County, and provides outreach and services within Napa County.

Table 1. Cities and ZIP codes

Cities	ZIP Codes	Hospital PSA/SSA
Napa	94558, 94559	PSA
Yountville	94599	PSA
American Canyon	94503	SSA
St Helena	94574	SSA
Sonoma	95476	SSA

Figure 1 (below) depicts the Hospital's PSA and SSA. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

Figure 1. SJH Queen of the Valley Medical Center Total Service Area



Community Need Index (Zip Code Level) Based on National Need

Dignity Health (formerly known as Catholic Healthcare West (CHW)) and Truven Health Analytics developed the Community Need Index (CNI). The Community Needs Index (CNI) identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations.

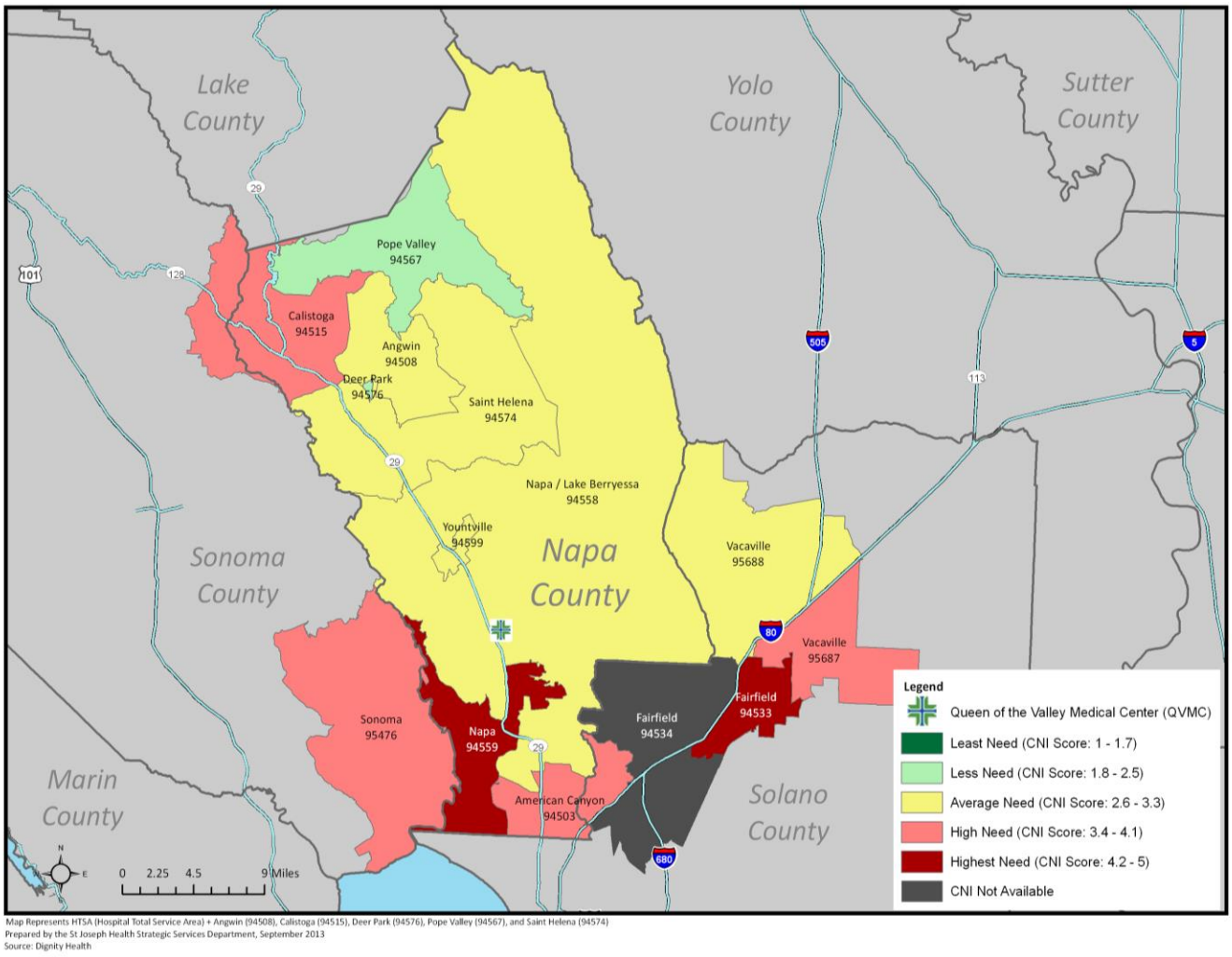
CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers):

- Income Barriers (Elder poverty, child poverty and single parent poverty)
- Culture Barriers (non-Caucasian limited English);
- Educational Barriers (percent population without HS diploma);
- Insurance Barriers (Insurance, unemployed and uninsured);
- Housing Barriers (Housing, renting percentage).

This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalizations for manageable conditions such as ear infections, pneumonia or congestive heart failure compared to communities with the lowest CNI scores. (*Ref (Roth R, Barsi E. Health Prog. 2005 Jul-Aug; 86(4):32-8.)* The CNI is used to a draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources. For example, the ZIP code 94559 on the CNI map is scored 4.2 - 5, making it a High Need community.

Figure 2 (below) depicts the Community Need Index for the ***hospital's geographic service area based on national need***. It also shows the location of the Hospital.

Figure 2. SJH Queen of the Valley Community Need Index (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, September 2013
Source: Dignity Health

Intercity Hardship Index (Block group level) Based Geographic Need

The Intercity Hardship Index (IHI) was developed in 1976 by the Urban and Metropolitan Studies Program of the Nelson A. Rockefeller Institute of Government to reflect the economic condition of cities and allow comparison across cities and across time. The IHI ranges from 0-100, with a higher number indicating greater hardship. The IHI was used by St. Joseph Health to identify block groups with the greatest need**.**

The IHI combines six key social determinants that are often associated with health outcomes:

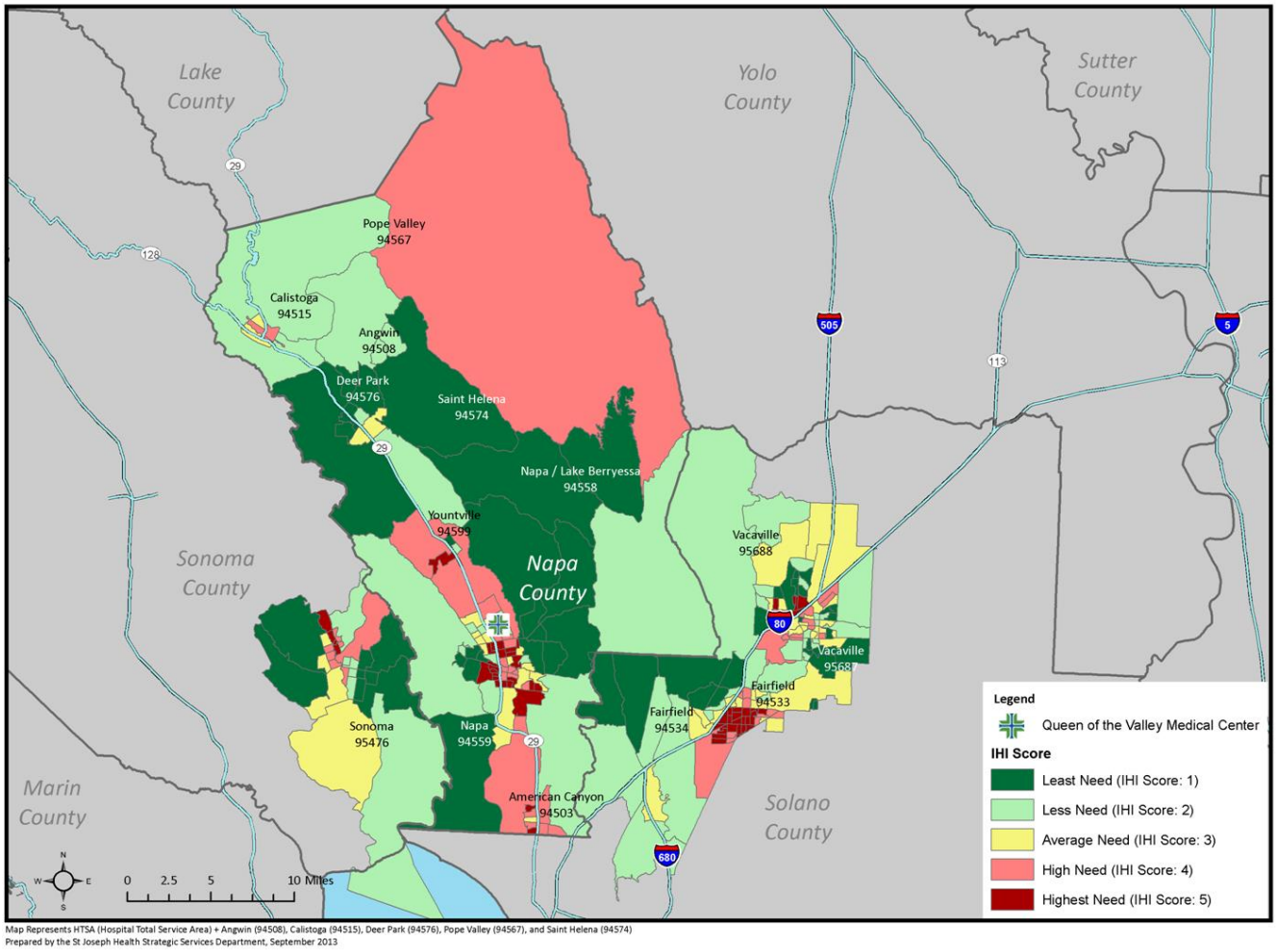
1) Unemployment (the percent of the population over age 16 that is unemployed)
2) Dependency (the percent of the population under the age of 18 or over the age of 64)

3) Education (the percent of the population over age 25 who have less than a high school education)
4) Income level (per capita income)
5) Crowded housing (percent of households with seven or more people)
6) Poverty (the percent of people living below the federal poverty level)

Based on the IHI, each block group was assigned a score from 1 (lowest IHI, lowest level of hardship/need) to 5 (highest IHI, highest level of hardship/need). The IHI is based on ***relative need within a geographic area***, allowing for comparison across areas. Similar to what is seen with the Community Need Index; the highest need areas in Napa County are in the cities of Napa and Yountville.

Figure 3 (below) depicts the **Intercity Hardship Index** for the hospital's geographic service area and demonstrates *relative need*.

Figure 3. SJH Queen of the Valley Intercity Hardship Index (Block group Level)



COMMUNITY NEEDS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

SJH Queen of the Valley completed this needs assessment in partnership with Napa County Public Health, Kaiser Permanente, St. Helena Hospital, Napa Valley Coalition of Nonprofit Agencies and Community Clinic Ole. This new collaborative, Live Healthy Napa County (LHNC) is composed of a public-private partnership bringing together, among others, representatives not just from health and healthcare organizations, but also from business, public safety, education, government and the general public to develop a shared understanding and vision of a healthier Napa County. The collaborative process cast a wide net to include three different comprehensive needs assessments and a larger and more diverse stakeholder representative group to reach further into the community.

As part of this comprehensive CHNA, three community assessments strategies were employed.

1. The Community Themes, Strengths, and Forces of Change Assessment included the following qualitative information gathering processes:
   a) An online and paper survey of 2,383 residents (356 in Spanish) included a series of 28 multiple-choice questions that asked respondents to consider quality of life in Napa County, which health issues they felt were most pressing for County residents, how and where they accessed health care and social services, what barriers they faced in accessing services, how they viewed economic and housing conditions in the County, and types of recreational and volunteer activities.
   b) In addition to the survey, 300 residents and other stakeholders participated in 28 workshops. Workshop participants mapped community assets, prioritized key challenges and developed a vision for a healthy Napa County.
   c) In 16 stakeholder interviews leaders were asked to describe a healthy Napa County; identify the most important health factors and issues; identify populations that are adversely affected by health problems; and identify assets, strengths, and challenges that affect health throughout Napa County.
2. A Local Public Health System Assessment collected data for the Local Public Health System (the system) using the National Public Health Performance Standards Program's (NPHPSP) local instrument. The instrument reviews the "10 Essential Public Health Services (EPHS)" - core public health functions that should be undertaken in every community - as a framework to evaluate the system's performance and environmental and individual factors to create conditions for improved health and wellbeing in a community.
3. The Community Health Status Assessment included a comprehensive review of secondary data sources to obtain the most current and reliable data for the CHSA. Secondary data sources and resources included, but were not limited to, the U.S.

Census, the American Community Survey, the California Department of Public Health (CDPH), the California Department of Education (CDE), the California Health Interview Survey (CHIS), the California Healthy Kids Survey (CHKS), the Behavioral Risk Factor Surveillance System (BRFSS), the CDC National Center for Health Statistics, the California Department of Justice, Healthy People 2020 (HP 2020), and the 2012 County Health Rankings and Roadmaps. Data collected through the Napa County Public Health Vital Statistics Office and the Public Health Communicable Disease Control programs are also utilized.

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 four priority areas in no particular ranked order:

COMMUNITY HEALTH PRIORITIES

• Improve Wellness and Healthy Lifestyles
  ○ Physical health improved
  ○ Mental health improved
  ○ Prevention resources
• Address Social Determinant of Health
  ○ Social and physical environments promote good health for all
  ○ Equitable educational and economic opportunities
• Create and Strengthen Sustainable Partnerships for Collective Impact
  ○ Public health system collaboration
  ○ Community engagement and leadership
  ○ New systems and strategic alliances to focus on policies and practices to address local issues
• Ensure Access High Quality Health Services and Social Support
  ○ All ages will have access to care to achieve optimal health and reach fullest potential
  ○ Health services and social supported are integrated
  ○ Prevention services available to all high risk individuals and families

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, certain community health needs may become more pronounced and require changes to the initiatives identified by Queen of the Valley 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. The following table lists the DUHN communities/groups and identified community needs and 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	Queen of the Valley Mobile Dental Clinic Sister Anne's Dental Clinic Head Start WIC
	Prevention and early intervention to improve nutrition, physical activity and prevent obesity	Children& Weight Coalition Queen of the Valley Healthy 4 Life Program Schools Queen of the Valley Wellness Center Parent University Family Resource Centers
	Reduce educational opportunity gap (social determinant of health): Increase parental involvement in schools	Title I schools - NVUSD 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	Queen of the Valley bilingual perinatal education classes Healthy Moms and Babies Linkage to clinical care programs for pregnant women Breastfeeding Coalition
	Access to screening and early intervention for perinatal depression	Queen of the Valley Perinatal Mood Disorders program Prenatal providers
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	Queen of the Valley CARE Network Queen of the Valley (hospital) Community Health Clinic Ole Family Service of Napa Valley Queen Of The Valley Wellness Center Adult Day Services
	Access to affordable, community-based behavioral health services for depression and other	Family Service of Napa Valley Clinic Health Ole County Mental Health Services

	behavioral health issues	
	Access to affordable dental care	Sister Anne's Dental Clinic
	Access to affordable health care	Community Health Clinic Ole Queen of the Valley Napa County HHS
Low income seniors	Access to affordable, quality dental care	Sister Anne's Dental Clinic; FQHC
	Access to affordable mental health services including preventive programs	Family Services of Napa valley Area Agency on Aging Adult Day Services County Services for Older Adults
	Chronic disease management	Queen of the Valley CARE Network Adult Day Services SJH-QV Community Health Clinic Ole Family Service of Napa Valley Queen of the Valley Wellness Center
	Access to community-based supports for independent living	Area Agency on Aging Community Action Napa Valley County Services for Older Adults In Home Supportive Services Senior Centers Home Health care agencies

PRIORITY COMMUNITY HEALTH NEEDS

The FY15-17 CB Plan was developed in response to findings from the Queen of the Valley FY14 Community Health Needs Assessment and is guided by the following five ASACB Core Principles:

- **Disproportionate Unmet Health-Related Needs:** Seek to accommodate the needs to communities with disproportionate unmet health-related needs.
- **Primary Prevention:** Address the underlying causes of persistent health problem.
- **Seamless Continuum of Care:** Emphasis evidence-based approaches by establishing operational between clinical services and community health improvement activities.
- **Build Community Capacity:** Target charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance:** Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

The Queen of the Valley Community Benefit Committee (a cross section of community leaders, nonprofit sector providers, community members and Queen of the Valley leadership) discussed and agreed upon specific criteria to be used in ranking health priorities as follows:

CRITERIA
• Builds upon and aligns current programs with identified priority community health needs (Live Healthy Napa Valley) and Queen of the Valley strategic priorities particularly related to population health and networks of care. • Focuses on most vulnerable and addresses health disparities • Has potential for high impact on issue/individuals • Works upstream: prevention and early intervention • Committed partners and opportunities for linkages with other organizations, institutions and stakeholders • Competency • Engages and empowers those to be served • Important to the community to be served • Is feasible with sufficient resources available to address adequately • Measurable • Align with ASACB Core Principles

Ranking Health Priorities

The Queen of the Valley Community Benefit Committee had a lengthy discussion of the findings from the Community Health Needs Assessment and the strategic initiatives of the hospital. Following this discussion, members of the SJH Queen of the Valley Community Benefit Committee rank ordered the four health priorities developed by the LHNC CHNA Steering Committee. Each member of the committee ranked each priority area as #1 through #4

with #1 as the highest priority. Items ranked #1 received 4 points, #2 equaled 3 points, #3 equaled 2 points and #4 equaled 1 point. Weighted scores for each need were calculated by adding the number of points received. The result of this ranking process is as follows:

PRIORITY HEALTH NEED	POINTS
#1 Priority: Improve Wellness and Healthy Lifestyles	61
#2 Priority: Ensure Access to High Quality Health Services and Supports	55
#3 Priority: Address Social Determinants of Health	54
#4 Create and Strengthen Sustainable Partnerships for Collective Impact	35

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 community benefit programs and by funding other non-profits through our Care for the Poor Program managed by the St. Joseph Health Community Partnership Fund.

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, resources to meet the identified needs of underserved communities through St. Joseph Health communities.

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

Basic Needs (specifically housing, income equality, public transportation system, environmental): While the hospital does not directly address affordable housing, living wage, public transportation, and public environmental issues, Queen of the Valley recognizes addressing these social determinants of health as integral to overall health and quality of life. This year Queen of the Valley provided cash donations in the amount of $5,000 to Napa Valley Community Housing, $5,000 to Legal Aid of Napa Valley for legal advocacy around basic needs, and $3,000 to Molly's Angels for volunteer drivers for persons without transportation, particularly the chronically ill. In addition, Queen of the Valley addresses basic needs of low-income chronically ill through our CARE Network program. CARE Network provided clients assistance with transportation on 389 occasions (bus pass, gas card, taxi scrip, volunteer rides), housing 144 occasions (into homeless shelter, section 8 application, Season of Sharing, housing authority, homeless prevention rapid re-housing program, emergency funds, general housing application assistance), with benefits on 306 occasions (health insurance, social security and disability income, veterans (VA) income and benefits, caregiver In Home Supportive Services (IHSS) hours, food stamps, and utility assistance) and with food on 444 occasions (food cards).

In addition, CARE Network provided 48 track phone cards to persons without phones, particularly the homeless population enabling case management and care coordination.

Countywide Communication/Data Systems: The LHNC collaborative identified that the overarching Local Public Health System (includes the network of organizations and entities throughout Napa County that contribute to the public's health and wellbeing) has challenges coordinating communication and data systems, such as health management technology and technology related to coordinating care and services. Although the hospital does not directly address this need, we partner with LHNC as a key Core Support Team member in seeking resources to further LHNC efforts of a coordinated continuum of care for the Napa community.

Dental Services for Older Adults: Although we did not directly provide dental services for older adults, we have established a formal agreement with Napa's FQHC dental clinic to share the expertise of Queen of the Valley's dental director. In order to cover the hours our dental director would be dedicating to the FQHC, Queen of the Valley hired an additional dentist. The result of shared leadership at both clinics is enhanced coordination of dental services for the low-income and uninsured population across the lifespan.

COMMUNITY BENEFIT PLANNING PROCESS

Summary of Community Benefit Planning Process

Following the full Community Benefit Committee ranking of priority areas, the Community Benefit Committee convened a representative Planning Committee including staff, community members, professionals and hospital trustees to review the findings and determine how best to align the community benefits efforts of the Queen of the Valley over the next three years with the health priority areas above and address unmet needs in the community.

The Planning Committee convened in three meeting over eight hours to develop a recommended implementation framework (initiatives and programs) for the FY15-17 Community Benefit plan in alignment with the health priorities and the criteria above.

The processes included reviewing and discussing: SB697 guidelines and ASACB 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
- Criteria for selection of priority initiatives for SJH Queen of the Valley investment.

To determine priority initiatives and programs 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
- Opportunities, challenges and barriers to addressing issues
- Specific opportunities for SJH 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 evaluation of current programs in order to assess alignment with needs identified in the current CHNA, effectiveness and efficiency of the services provided, and leveraging of community resources. Following staff evaluation, the Planning Committee also reviewed these existing community benefit programs and evaluated the value of these programs in addressing DUHN communities and identified health priorities.

The Strategic Planning Committee identified the following health issues under the four health priorities. The issues were placed in two categories: ongoing health issues and emerging issues. Following discussion and review, the health issues were ranked them using a scaled ranking process. Scores were aggregated for each health issue and rank ordered by score. Items are listed in rank order:

Ongoing Health Needs	Emerging Issues
1. Chronic Diseases (Healthcare Access) 2. Mental and Emotional Health (Healthcare Access) 3. Childhood Obesity (Wellness) 4. Dental Care (Healthcare Access) 5. Community Health Partnerships (Sustainable Partnerships) 6. Perinatal Education (Wellness) 7. Educational Opportunity Gap (SDoH)* 8. Safety Net (SDoH)	1. Continuum of Care for uninsured (Healthcare Access) 2. Living Wage; Family Self-sufficiency (SDoH) 3. Accessibility to social supports and services (SDoH) 4. Immigration (SDoH)

* Social determinants of health

Building upon and leveraging existing programs and partnerships and critical gaps, the Planning Committee identified key initiatives, programs and strategies to address the specific health needs above to design a framework for the Community Benefit efforts in FY15-FY17. The Community Benefit Committee reviewed and approved the implementation framework.

Based on this review of prioritized significant health needs and a thoughtful priority setting process, Queen of the Valley will address the following four priority areas with specific initiatives or programs as part of its FY15-FY17 CB Plan:

1. Improve Wellness and Healthy Lifestyles/Childhood Obesity: <u>Healthy for Life Program</u>

Queen of the Valley will continue to implement the Healthy for Life Program, currently at 17 local schools. Healthy for Life (H4L) is a school-based obesity prevention program designed to emphasize lifelong fitness and healthy eating behaviors among children and adolescents. The program incorporates the following strategies: (1) School-based obesity prevention; (2) Intervention with at-risk children; (3) Community/ parent education, and, (4) Community and school policy advocacy. Curriculum components depending on age level appropriateness may include nutrition, aerobic exercise, and resistance training. The Queen of the Valley Healthy for Life Program focuses on children at risk for obesity and their families in Napa County, particularly those in low-income neighborhoods and schools. H4L will focus risk assessments, nutrition programming and physical activity training at elementary schools with a preponderance of children from low income or diverse families. Three nutrition sessions and a summer teacher training that would emphasize lifelong fitness will be provided for all levels (elementary, middle and high schools). Additionally, a dietician will provide individualized family counseling for elementary students identified as obese (95 percentile or above).

2. Improve Access to Quality Health Services and Supports/Continuum of Care: <u>CARE Network</u>

CARE Network implements intensive disease case management, transitional care and brief care coordination services addressing the unique needs of Medi-Cal enrolled and uninsured patients recently discharged from inpatient care or at risk for hospitalization, particularly those patients with complex medical conditions as well as difficult socio-economic needs such as housing insecurity and basic needs deficits. The program is aimed at improving disease management and quality of life while reducing overall healthcare costs. Upon referral from the hospital, primary care or other partners, a multi-disciplinary team comprised of an SW intake specialist, an RN case manager, an MSW case manager, an LCSW behavioral health specialist, and a community care aide develop and implement an individualized care plan with the client based on level and type of care requited. Intensive case management clients receive a comprehensive assessment of medical, psychosocial, economic needs. Case managers work directly with hospital social work, health care providers, community resources staff and Napa County Social Services, Mental Health and Alcohol and Drug Services to address each client's unique needs.

3. Improve Access to Quality Health Services and Supports/Dental Care: <u>Children's Mobile Dental</u>

QVMC's Mobile Dental Clinic provides a comprehensive array of dental services targeted toward children living at or below 200 percent of the Federal Poverty level. Services are provided regardless of ability to pay. The program is a primary provider of services to low-income Napa County children serving more than 2200 children annually at 8 school and neighborhood sites and up to 1000 preschool and kindergarten children at their school sites. Queen of the Valley Mobile Dental Program Strategies includes (1) Oral health screening in preschools and kindergartens serving low income children; (2) Mobile Dental Clinic 6-month examinations and cleaning; (3) Patient and parent/caregiver education at examinations and, (4) Mobile Dental clinical procedures as determined by patient guidelines and needs including fillings, extractions, pulpotomy, root canals, crowns, scaling and root planning, and space maintainers. In addition, for children requiring sedation, the Mobile Dental Clinic director may provide surgical procedures at the medical center.

4. **Improve Access to Quality Health Services and Supports/Behavioral Health: <u>Healthy Aging-Healthy Minds, CARE Network Behavioral Health Integration, Perinatal Mood Disorder</u>**

Access to low cost mental health services ranked as a top priority in the past three community health needs assessments for Napa County. To address this ongoing need, Queen of the Valley will continue to implement a multipronged approach with three mental health programs that promote screening of targeted populations for depression, offer brief therapeutic interventions (1-10 sessions) and/or referrals to more intensive services and navigate clients to other community support services and groups. These programs target postpartum mothers, CARE Network intensive case management clients and underserved older adults at risk for behavioral or cognitive health issues. Services are bilingual Spanish/English. The perinatal emotional wellness program provides free counseling and referral services for pregnant and postpartum women experiencing depression and other behavioral health concerns. CARE Network Integrated Behavioral Health provides free mental health services to low-income chronically ill clients. Services include cognitive and behavioral health assessments, case management, therapy sessions, as well as community presentations, provider education and caregiver training and support.

Queen of the Valley Medical Center
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY15 Accomplishments

Initiative (community need being addressed): Level of childhood obesity among Napa children is very high, particularly among Latino children. According to the California Department of Education prevalence in overweight and obesity among 5th, 7th, and 9th grade students in Napa is 40 percent, up 6.1 percent from 2005 to 2010; this is the largest increase among Bay Area counties. Nearly 50 percent of economically disadvantaged students were overweight or obese.

Goal (anticipated impact): Reduce risk factors of obesity among at risk children participating in Healthy for Life Program

Outcome Measure	Baseline	FY15 Target	FY15 Result
Percentage of children participating in the program assessed as overweight and obese re-classifying to a lower weight category by the end of the school year	9.5% (average of FY12 and FY13)	10%	Elementary = 20.1% (45 of 224 students) Preschool = 38.5% (37 of 96 preschoolers)

Strategy(ies)	Strategy Measure	Baseline	FY15 Target	FY15 Result
1. Implement school based physical activity and healthy eating program.	Number and Percent of children participating in H4L program that improve healthy lifestyle choices. Survey questions: 1. How many days per week do you eat breakfast?	Baseline established FY15 at 38% (423 of the 1,106 survey respondents).	Not applicable	Of the 1,106 survey responses that had opportunity for improvement, 423 (38%) indicated improvement by year-end. All 4 survey categories show

	2. How many days per week do you participate for 60 minutes or more of physical activity (walking, biking, running, sports)? 3. How many times per day do you drink sugary beverages (sodas, fruit juice, sports drinks, sweetened ice tea)? 4. How many days per week do you eat 5 or more servings of fruits and/or vegetables in a day?			improvement: 1. Breakfast = 46.8% improvement (73 students) 2. Physical activity 40.9% improvement (119 students) 3. Sugary beverages 28.1% improvement (121 students) 4. Fruits and veggies 48% (110 students)
2. Refer children at the 95 percent or above BMI percentile and their families to nutrition counseling. (*Plan to shift strategy of how to provide family nutrition counseling from individual family counseling sessions to onsite nutrition education at schools)	Number of children referred for interventions	FY 15 Baseline: 163 families referred, 4 families (children) completed counseling sessions.	Plan to shift strategy of how to provide nutrition counseling to families due to very low participation rate in individual family nutrition counseling sessions, even	163 families referred 85 families expressed an interest 13 families attended one session 5 families attended two sessions 4 families attended all three sessions

			with flexible scheduling and reminder calls.	

Key Community Partners: Napa Valley Unified School District (17 schools), QVMC Wellness Center, Community Clinic Ole, pediatricians, Children and Weight Coalition, Kaiser Permanente, Child Start Preschools, Healthy Bodies Coalition

FY15 Accomplishments:

This year we embarked on moving upstream in obesity prevention, expanding services to low-income preschools (7 preschool sites / 13 classes) to our existing 17 participating district school sites (37 classes), increasing the total classrooms served by 47% (from 30 to 44 classrooms). Emphasis on preschool teacher education and support included providing two teacher training workshops with 24 attendees, teaching parent nutrition classes with 165 parent attendees, measuring moderate to vigorous physical activity (MVPA) on eight different occasions at all 7 sites (58 visits), and providing a fitness coach devoted to one hour per month per school site to working with preschool staff and students to increase the amount of MVPA students receive during the school day.

Queen of the Valley Medical Center
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY15 Accomplishments

Initiative (community need being addressed): QVMC Children's Mobile Dental is one of two providers of oral health services available to children from low-income families with Denti-Cal, no insurance or other low reimbursement insurance.

Goal (anticipated impact): To improve oral health status of 2200 children 6 months to 26 years of age in Napa County, particularly those who are uninsured or underinsured

Outcome Measure	Baseline	FY15 Target	FY15 Result
Percentage of patients who demonstrate oral health status improvement at recall visit based on a set of clinical criteria	91.5%	92%	94% (Of 480 random chart audits, 94% of children had improved oral health status at follow up visit)

Strategy(ies)	Strategy Measure	Baseline	FY15 Target	FY15 Result
Provide early oral health screening and education in preschools and kindergartens	Number of children provided early screening for oral health	600	600	644
Provide 6-month examinations and cleanings	Percentage of patients having seen a dentist within 6 months to one year following initial or last recall exam	81%	82%	94% (Of 480 random chart audits)
Provide patient / parent education on improving and maintaining oral health	Percentage of patient / parents reporting improved oral health behaviors	97 %	98%	100% (Of 164 parent survey respondents)

Provide Mobile Dental procedures as necessary and indicated	Percentage of those receiving procedures who have reduced caries at follow-up	Baseline established FY15 at 80%	Not Applicable	80% (Of 480 random chart audits)

Key Community Partners: Child Start/Head Start, First Five of Napa County, Community Health Clinic Ole Sister Ann Dental Clinic, Napa Unified School District, St. Helena Unified School District, City of American Canyon, Puertas Abiertas Family Center

FY15 Accomplishments:

Our mobile dental clinic spanned 9 locations across Napa County serving 2,129 low-income children and providing 5,067 clinic visits. In addition, 37 low income pre-school classes were provided free oral health screenings and fluoride varnish to over 640 children. Of these 640 children, 115 were referred to a dental home due to detected oral health problems. As one of two main providers of oral health for low income children in Napa County, to meet demand and community need we have added clinic days and are exploring opportunities to partner with Sr. Anne Dental Clinic FQHC to leverage resources and expand capacity. Prevention efforts include a focus on parent and child education. In alignment with ACA health insurance age ranges, this year we increased our age range from 6 months up to 21 years to 6 months up to 26 years.

Queen of the Valley Medical Center
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY15 Accomplishments

Initiative (community need being addressed): FY13 Community health needs assessment showed access to health services and supports for underserved communities as a key community need along with high rates of chronic conditions including heart disease and diabetes.

Goal (anticipated impact): Improve disease management and quality of life of low-income adults and older adults with acute to moderate medical conditions, chronic diseases and /or comorbidities, and complex socio-economic needs

Outcome Measure	Baseline	FY15 Target	FY15 Result
Percentage improvement in ED use of new clients at post – enrollment when compared to pre-enrollment	53% reduction (established FY15)	Not applicable	53%

Strategy(ies)	Strategy Measure	Baseline	FY15 Target	FY15 Result
Provide Intensive Case Management Services to individuals at high medical and psychosocial acuity level	Percentage improvement in hospitalizations for new clients post enrollment compared to pre-enrollment	36% (established FY15)	Not applicable	36%
Provide 30 day Transitional Care from inpatient to outpatient for patients at high risk for readmission	Rate of hospital readmission at 30 days post hospitalization	14.8% Based on 5 months of data after program launched February 2015, representing 54	Not applicable	14.8%

		clients served.		
Provide Brief Care Coordination for individuals at moderate to low acuity level needing brief support	Percentage of clients not requiring higher level case management services	90% (established FY15)	Not applicable	90%

Key Community Partners: Community Health Clinic Ole, Family Services of Napa Valley, Napa County Health and Human Services (Substance Abuse Services, Mental Health Services, eligibility), QVMC Case Management and Social Services, QVMC Patient Financial Services, Community Action Napa Valley-Food Bank, Homeless Services, Smoking Cessation.

FY15 Accomplishments:

The CARE Network served 419 unduplicated clients in FY15 of those 236 were newly enrolled. For those newly enrolled the emergency department (ED) visits decreased by 53% and the in-patient hospitalizations decreased by 53% as compared to one year prior to enrollment.

Partnership Health Plan of California (PHC): Partnership HealthPlan of California (PHC) is a non-profit community based health care organization that contracts with the State to administer Medi-Cal benefits through local care providers to ensure Medi-Cal recipients have access to high-quality comprehensive cost-effective health care. PHC provides quality health care to over 510,100 members in 14 Northern California counties. Given CARE Network's history of successful care management and care coordination we have established two formal agreements with Partnership Health plan of California, providing hospital to home Care Transitions services and an Intensive Outpatient Case Management Program (IOPCM) for specified PHC members in Napa County.

Transitional Care: Evidence shows that providing assistance to patients bridging hospital discharge to home reduces health care costs associated with avoidable readmissions and other complications. In February of 2015 CARE Network, in collaboration with Queen of the Valley inpatient case management and Sonoma State University school of nursing, launched a formal transitional care program. This program provides transitional care to any patient, regardless of health insurance status and income.

Brief Care Coordination: We recognized that not all our clients require the high intensity of services of the CARE Network model which has an average length of service of six to nine months and includes RN, social work, community health worker, behavioral health and spiritual health. This year we launched a brief care coordination program model with a length of service of 30 days. Clients may require application assistance or health care navigation with a social work and community health worker focus. This new streamlined process allows for increased efficiencies and capacity to accept new clients.

CARE Network Maintenance Program: Research demonstrates a link between weak social support systems and poor health outcomes. With over 20 years of experience, CARE Network has many anecdotal scenarios of stable clients with poor social supports who revisit the emergency department or re-hospitalize shortly after discharge from the program. One elderly client stated "I feel better just knowing someone is there for me if I need help". This year CARE Network launched a Maintenance Program for clients ready for discharge from intensive services, yet remain at risk due to poor social supports. These clients are informed they will receive a phone call or home visit on a quarterly basis, and that they may contact us at any time as needed.

Queen of the Valley Medical Center
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY15 Accomplishments

Initiative (community needs being addressed): Mental and emotional health services, particularly for low income, Spanish-speakers and uninsured adults, older adults and pregnant women was identified in FY13 Needs Assessment as a critical gap in access to health services and support.

Goal (anticipated impact): Reduce depression among low-income older adults, individuals with chronic disease and pregnant and postpartum women.

Outcome Measure	Baseline	FY15 Target	FY15 Result
Percentage of clients that improve depression as measured through validated tools appropriate to the target population	90% (FY13)	91%	90%

Strategy(ies)	Strategy Measure	Baseline	FY15 Target	FY15 Result
Identify individuals with risk factors for depression using validated tools	Number of individuals identified with risk factors for depression using validated tools	1,380 (FY13)	1,385	1,650
Provide interventions or refer individuals with positive screens to behavioral health services	Percentage of individuals with positive screens provided services or referrals	Baseline established FY15 at 89%	Not applicable	89%

Key Community Partners: Family Services Napa Valley, Area Agency on Aging, Community Health Clinic Ole, Queen of the Valley Medical Associates, St. Helena Women's Center, Adult Day Services, Napa County Mental Health, Napa County Alcohol

and Drug Services, Napa County Public Health, and Comprehensive Services for Older Adults (CSOA).

FY15 Accomplishments: Access to low cost mental health services ranked as a top priority in the past three community health needs assessments for Napa County. To address this ongoing need, Queen of the Valley offers a multipronged approach with three mental health programs that promote screening of targeted populations for depression, offer brief therapeutic interventions (1-10 sessions) and/or referrals to more intensive services and navigate clients to other community support services and groups. These programs target postpartum mothers, CARE Network intensive case management clients and underserved older adults at risk for behavioral or cognitive health issues. Services are bilingual Spanish/English. The perinatal emotional wellness program provides free counseling and referral services for pregnant and postpartum women experiencing depression and other behavioral health concerns. CARE Network Integrated Behavioral Health provides free mental health services to low-income chronically ill clients. Services include cognitive and behavioral health assessments, case management, therapy sessions, as well as community presentations, provider education and caregiver training and support. Community benefit investment in these behavioral health programs is over $200,000.

This year 90% of clients completing behavioral health services demonstrated improvement in depression symptoms as measured by evidenced based tools. The total number of unduplicated clients receiving behavioral health services through The CARE Network, Healthy Minds Healthy Aging (HMHA), and the Perinatal Emotional Wellness Program was 232 with 1,127 therapy sessions provided in the client's home or at Queen of the Valley behavioral health office. The number of clients completing a minimum of 2 depression screens (PHQ9) increased by 52% as compared to the prior year.

August 2014 Napa Earthquake: The 6.0 earthquake experienced by the Napa community in August of 2014 created a new community need for trauma related behavioral health. In response, HMHA conducted trauma debriefing sessions with 20 older adults who had been affected by the 2014 earthquake, thereby mitigating post traumatic reactions. Also, through our partnership with Family Service of Napa Valley, a nonprofit behavioral health provider, Trauma Resiliency Trainings (TRM) were offered to clinicians in the community.

Neonatal Intensive Care Unit: The stress and emotional toll for a parent whose infant is admitted to the neonatal intensive care unit (NICU) is undeniable. This year the perinatal emotional wellness program therapist began attending weekly rounds in the NICU to partner with NICU staff in serving the needs of these parents.

Other Community Benefit

Initiative (community need being addressed):	Program	Description	FY15 Accomplishments
1. Social Determinants Of Health: Academic Achievement	Napa Valley Parent University (NVPU)	**Napa Valley 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. Classes are bilingual with a focus on Spanish speaking parents.	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. NVPU offered **95 different class** curriculums at 5 elementary school sites with over 1,600 unduplicated parent participants. Altogether 239 classes were offered with over 10,000 parents participating (duplicated). Class topics included: becoming an effective school consumer, helping children with homework, computer literacy, becoming a school and community leader, becoming an effective volunteer in the school, raising a healthy child and accessing health services
2. Improve Wellness And	Perinatal Education	Educational classes for pre and postnatal	QUEEN OF THE VALLEY community benefit offers perinatal classes to all in our community,

Healthy Lifestyles: Community Health Education		mothers, partners, and siblings including birth preparation, infant care, breastfeeding and infant safety	regardless of income or area hospital birthing choice. 200 classes were presented for 475 (unduplicated) women. With women taking multiple classes, altogether there were 2,340 class participants (duplicated). An additional 622 class participants (duplicated) were provided specific to breast feeding support. In addition, 152 low income women (Medi-Cal) were provided access to perinatal exercise classes at Synergy Medical Fitness Center free of charge.
3. Address Social Determinants Of Health: Food and Shelter	Food and Shelter Safety Net for the Poor	Food and shelter are essential basic needs. Queen of the Valley provides cash in kind donations to community partners who provide for basic needs such as food and shelter.	A community benefit contribution totaling $15,000 provided to three safety-net non-profit agencies in Napa County helped to secure food and housing for the poor: Community Action Napa Valley (Meals on Wheels, Napa Valley Food Bank), The Table, and Napa Valley Community Housing. To assure we are informed of these needs on an ongoing basis, community benefit designates a staff member to sit on the Napa Safety-Net Food Committee.
4. Access To Health Services And Supports: Access to diagnostic, treatments and procedures for Napa's	Operation Access (OA)	Operation Access is a nonprofit organization that coordinates volunteer medical services for the uninsured.	Through a collaborative effort of area hospitals (Queen of the Valley, St. Helena Hospital, Kaiser Permanents) and the FQHC Ole Health, OA was launched in Napa this year serving 33 unique lives with 45 encounters and 95 specialty appointments.

uninsured population.			
5. Access To Health Services And Supports	Cancer, HIV and Hepatitis C specialty services for uninsured and underinsured	An ongoing partnership with FQHC Ole Health..	Uninsured and underinsured persons have difficulty accessing specialty care for complicated chronic conditions This year Queen of the Valley provided a community benefit donation of $36,000 for HIV/Hepatitis C specialty services, and $5,000 for specialty oncology services to Ole Health. In addition, these patients are followed by Queen of the Valley's CARE Network for care coordination and case management. The HIV clinic provided services to a total of 68 unduplicated patients for a total of 158 office visits. Cancer clinic provided services to 11 unduplicated, uninsured patients for a total of 26 office visits.
6. Create & strengthen Sustainable Partnerships: Services for Older Adults	Healthy Aging Population Initiative (HAPI)	HAPI is a coalition of 40-50 organizations serving older adults in Napa County. HAPI assesses older adult needs and advocates policy and develops collaborative strategies to address needs	Queen of the Valley contributed a community benefit donation in the amount of $32,400 to Area Agency on Aging in support of HAPI facilitation and activities. This year HAPI developed and conducted a broad-based survey of more than 1,000 older adults in Napa Valley. It covered issues on a variety of topics, and will be used to inform the general public and public officials about the needs and priorities of older adults and guide planning and policy program development and policy advocacy.

FY15 Community Benefit Investment

In total, for fiscal year 2015 Queen of the Valley Medical Center contributed **$26,031,325** in community benefit, excluding unreimbursed costs of Medicare. This amount helped care for the poor, vulnerable, low-income persons, the uninsured and underinsured. In addition the unreimbursed cost of Medicare totaled an additional **$30,822,643.**

FY15 COMMUNITY BENEFIT INVESTMENT
St. Joseph Health Queen of the Valley Medical Center
(ending June 30, 2015)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services[2]	Net Benefit
Medical Care Services for Vulnerable[3] Populations	Financial Assistance Program (FAP) (Traditional Charity Care-at cost)	$1,706,699
	Unpaid cost of Medicaid[4]	$16,940,030
	Unpaid cost of other means-tested government programs	$3,488,782
Other benefits for Vulnerable Populations	Community Benefit Operations	$741,100
	Community Health Improvements Services	$1,255,765
	Cash and in-kind contributions for community benefit	$637,852
	Community Building	$0
	Subsidized Health Services	$295,939
	Total Community Benefit for the Vulnerable	***$25,066,167***
Other benefits for the Broader Community	Community Benefit Operations	$274,104
	Community Health Improvements Services	$543,793
	Cash and in-kind contributions for community benefit	$61,017
	Community Building	$0
	Subsidized Health Services	$79,744
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	$6,500
	Total Community Benefit for the Broader Community	***$965,158***
	TOTAL COMMUNITY BENEFIT *(excluding Medicare)*	$26,031,325
Medical Care Services for the Broader Community	Unpaid cost to Medicare[5] ***(not included in CB total)***	$30,822,643

[2] Catholic Health Association-USA Community Benefit Content Categories, including Community Building.
[3] 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 (referred to as Medi-Cal in California), Medicare, California Children's Services Program, or county indigent programs. For SJH, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.
[4] Accounts for Hospital Fee.
[5] Unpaid cost of Medicare is calculated using our cost accounting system. In Schedule H, we use the Medicare cost report.

Telling Our Community Benefit Story: Non-Financial[6] Summary of Accomplishments

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

Live Healthy Napa County's Community Health Improvement Plan (CHIP)
In FY 2014, an enhanced community health needs assessment collaborative called "Live Healthy Napa County" consisting of a public-private partnership to improve the wellbeing of all in Napa County was championed by Napa County Public Health, Queen of the Valley, Kaiser Permanente, St. Helena Hospital, local non-profit agencies, among others, to bring together representatives not just from health and healthcare organizations, but also business, public safety, education, government and the general public to build strategies in a shared vision and effort to create a healthier Napa County. This effort is based on the Collective Impact model, forming cross sector coalitions in order to create lasting solutions for large scale issues. Queen of the Valley has accountability for 13 performance measures within LHNC that include a community wide Breast Feeding plan, healthy nutrition plan for children and families (Cooking Matters), increasing activity for children in schools (H4L), reducing barriers and increasing access to services through improved health care provider collaboration and integration (CARE Network), improve access to dental services for low income children and young adults up to age 21 (Mobile Dental Clinic). Throughout the year, staff time are contributed toward coordination and reporting of LHNC related activities.

Quit Smoking Concierge at Queen of the Valley
Smoking is still the most preventable cause of disease and death in the United States and in World History. In Napa County 16% of the adult population continues to smoke (17,000 people), compared to the 12% State rate and 6.5% of Napa youth smoke, compared to the 4.8% State average. Although 70% of all smokers want to quit, most

[6] Non-financial summary of accomplishments are referred to in CA Senate Bill 697 as non-quantifiable benefits.

smokers have made numerous quit attempts without success. In FY15, as part of the County wide CHIP, Queen of the Valley saw an opportunity to partner with Napa Quit Smoking Program by developing a process for a warm hand off for inpatient and outpatient referrals during the time a patient may most be motivated to quit smoking. The process involved policy development, physician buy in, establishment of a referral process, and collaborative monitoring and reporting. Napa Quit Smoking Program staff receive referrals from Queen of the Valley and visit the patient in the hospital before discharge to introduce them to the program and offer education and encourage participation. This type of warm hand off increases the likelihood of program participation. There were a total of 43 referrals in this first year to this cost free smoking cessation program for underserved or underinsured Napa County residents.

Alcohol and Drug Services

Alcohol and drug services (ADS) are an identified a community need in Napa. Queen of the Valley and Napa County Alcohol and Drug Services (ADS) entered into a formal agreement in September of 2014, partnering to provide screening and outreach services to our community at large as well as provide a warm hand off for patients hospitalized and interested in engaging in services upon hospital discharge. To facilitate this effort, a Napa County ADS counselor is on site at Queen of the Valley community outreach department for community members and with direct access for inpatient visits as needed. Based on need, this year we increased the onsite Napa County ADS counselor form one day a week to five days a week. Further efforts include Queen of the Valley hosting a training by UCLA on Motivational Interviewing and SBIRT (Screening, Brief Intervention and Referral to Treatment), an evidence based program which trains staff in techniques to approach patients during the "teachable moment" of their visit to their provider or trauma center. This program has shown through research studies to reduce DUI arrests and healthcare costs, in addition to reducing alcohol related trauma recidivism by up to 50%. Immediately following the training Queen of the Valley convened a group of community stakeholders to develop a plan for community wide implementation of this program. In the months that followed Napa was well represented on monthly Virtual SBIRT Learning Collaborative calls lead by UCLA, helping California agencies with program implementation. The Perinatal population was identified as an at risk group and one that may falsely screen negative using this method. In April of 2015, Queen of the Valley entered into contract with Dr. Ira Chasnoff, to use his 4 P's screening program, an evidence base tool specific developed to screen this perinatal population.

Amigas Del Alma (Spanish Speaking Breast Cancer Support Group)

A new addition to the 19 support groups offered at Queen of the Valley is "Amigas Del Alma". Beginning in January of this year is the first bilingual bicultural support group

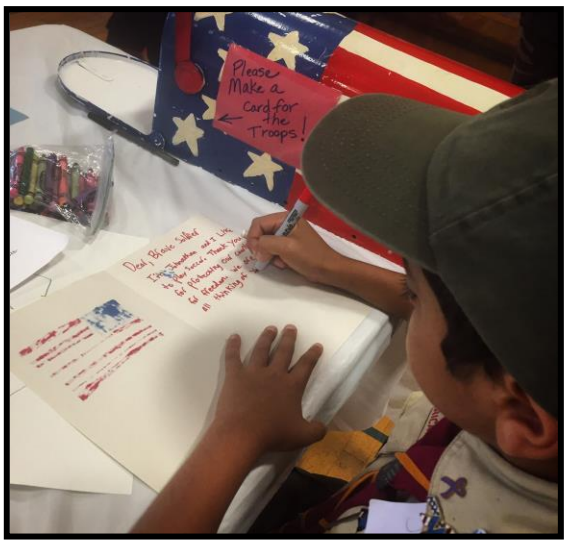
in Napa County for Spanish speaking women confronting breast cancer. Outreach includes distributing flyers to local hospitals, clinics, physician offices, churches and other non-profit agencies. Participants are encouraged to share their feelings and experiences even on culturally sensitive topics with a safe confidential environment led by two Queen of the Valley facilitators, an oncology certified RN and a Social Worker. Topics are based on participant's interest and needs. This support and education extends to the family and caregivers.

Volunteerism:

On August 24th, 2014 Napa Valley experienced a 6.0 earthquake at 3:20 a.m. that had devastating impacts throughout the County. Queen of the Valley immediately began to see injured and almost as immediately began to see staff and physicians report to assist. After the earthquake, there emerged enhanced community needs including mental health. Mental health program staff with Queen of the Valley community benefit provided trauma resiliency training to community nonprofit organizations and directly to earthquake victims. Aside from earthquake response and recovery, Queen of the Valley leadership contributed 672 reported hours of community service and volunteerism for efforts toward feeding the hungry at The Table, helping the homeless at the HOPE Center and advocating on their behalf at town hall meetings, participating in local community fundraising events such as the American Cancer Society Relay For Life, donating at Blood Drives, offering bereavement support, providing coordination for Napa County Holiday Assistance, supporting care packages for troops abroad, helping at migrant farm worker health fairs, participating in the Latino Elder Coalition, and supporting Latino women through Puertas Abiertas.

Operation with Love from Home (OWLFH):

Founded and supported by Queen of the Valley since 2007, this community-wide effort ships care packages to deployed troops primarily to the Middle East throughout the year with major shipments coordinated for Christmas, Valentine's Day, and the 4th of July. Hospital and community volunteers assist with planning, collection of needed items from a variety of sources including schools, banks, grocery stores, doctor offices, service organizations, health clubs and from Queen of the Valley. Enclosed in every care package are healthy snacks, boot socks, playing cards, toiletries and thank you card written by school children along with an issue



folded pocket flags with prayers prepared by women veterans residing at the Yountville Veterans Home. Twice a year at a local gymnasium OWLFH hosts a large coordinated care package assembly event bringing the community together to fill care packages while honoring our veterans, active duty service personnel and family members toward this healing ministry. This year 1,689 care packages were lovingly prepared and shipped to troops in harm's way.

Blood Drives:
Another form of non-profit collaboration is partnering with Blood Centers of the Pacific (BCP) blood drives. We create awareness while inviting the community to join Queen of the Valley employees, physicians and volunteers to meet the chronic shortage of lifesaving blood products. In FY15 BCP conducted 3 blood drives at Queen of the Valley with a total of 133 registered donors and 104 units of blood donated.

Board Membership:
Queen of the Valley leaders serve other nonprofit organizations by participating as board of directors. Organizations with Queen of the Valley representation on their board include Alpha Pregnancy Clinic, Justin Sienna High School Board, Napa Valley Tobacco Board, Parents CAN, Work Force Investment Board, Napa Valley Hospice and Adult Day Services, The Table, and Rianda House.

Heart Safe Program:
Approximately 350,000 Americans die from sudden cardiac arrest (SCA) each year — more than lung cancer, breast cancer, prostate cancer, and AIDS combined. Access to an automated external defibrillator (AED) and hands on CPR can mean the difference between life and death for a victim of sudden cardiac arrest. Queen of the Valley and The Via Heart Project 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, and community members have joined forces to ensure existing AED's are maintained and registered to a database, that AED's are placed in high risk areas at a low cost or through scholarship funding, and there is free AED training along with hands on CPR to all in Napa County residents. In FY15, there were 27 CPR/AED training events for a total of 1,590 individuals trained. Queen of the Valley contributed a community benefit donation and champions efforts in support of this program that now has a total of 50 AED's in Heart Safe Program throughout Napa County.

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, Queen of the Valley has sponsored and provides one warm "home cooked" meal on the second Tuesday of the month. For this meal, Queen of the Valley 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 FY15, Queen of the Valley volunteers served 1,696 meals to vulnerable community members.

Project Nightingale:

When a patient is ready to be released from a hospital or emergency department, the assumption is that they have a home and safe environment in which to recuperate; however, many individuals have no home, and Napa's homeless shelters are not equipped to provide medical respite. To further define this identified need, Queen of the Valley convened representatives from homeless services, Napa County HHS, St. Helena Hospital, Kaiser Permanente, and the Ole Health. This collaborative engaged Project Nightingale, a Catholic Charities Program currently providing short term services allowing bed rest and recuperation for homeless individuals discharged from hospitals. Collaboration continues with key organizations and funders to establish this service in Napa County.