St. Joseph Health Queen of the Valley

Fiscal Year 2017 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

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

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

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

INTRODUCTION

Who We Are and Why We Exist

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 208 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 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 2017 Queen of the Valley contributed $12,713,931 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 FY17 totaled $34,631,185.

Overview of Community Health 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

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) Community/ parent education; and, (3) Community and school policy advocacy.
    - This year programs continued at 7 low-income preschool settings (12 classes) and in 18 participating school district sites (44 classrooms). A total of 1,679 unduplicated students participated in fitness and nutrition classes with 18,449 student encounters over the course 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 **2,141** low-income children and providing **5,674** clinic visits. In addition, 16 low income pre-school classes were provided free oral health screenings and fluoride varnish to 439 children. Of these 439 children, 39 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 government burden of healthcare costs.
    - In FY17 CARE Network served 568 clients, of those 261 were newly enrolled. For those newly enrolled clients, emergency room visits decreased by 71% and hospitalizations decreased by 42% as compared to one year prior to enrollment. This year CARE Network launched a pilot project imbedding a community health worker in the emergency department (ED) serving 220 homeless and otherwise vulnerable persons who discharged from our ED.

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. Therapy and services are provided in Spanish and English.
    - 259 unduplicated clients were served by these three mental / behavioral health programs (The CARE Network, Healthy Minds Healthy Aging (HMHA), and the Perinatal Emotional Wellness program) 1,633 therapy sessions provided either in the client's home or in the therapist office.

INTRODUCTION

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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. The Sisters of St. Joseph of Orange trace their roots back to 17th century France and the unique vision of a Jesuit Priest named Jean-Pierre Medaille. Father Medaille sought to organize an order of religious women who, rather than remaining cloistered in a convent, ventured out into the community to seek out "the Dear Neighbors" and minister to their needs. The congregation managed to survive the turbulence of the French Revolution and eventually expanded not only throughout France but also throughout the world. In 1912, a small group of the Sisters of St. Joseph traveled to Eureka, California, at the invitation of the local Bishop, to establish a school. A few years later, the great influenza epidemic of 1918 caused the sisters to temporarily set aside their education efforts to care for the ill. They realized immediately that the small community desperately needed a hospital. Through bold faith, foresight and flexibility, in 1920, the Sisters opened the 28-bed St. Joseph Hospital Eureka and the first St. Joseph Health ministry.

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 59 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, and Imaging Services. 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 2017 Queen of the Valley contributed **$12,713,931** 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 FY17 totaled **$34,631,185.**

ORGANIZATIONAL COMMITMENT

Community Benefit Governance Structure

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

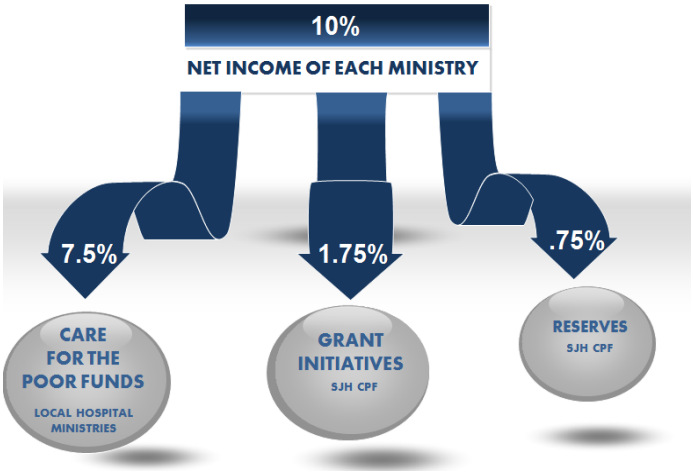


Figure 1. Fund distribution

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 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.

SJH Queen of the Valley further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, community partnerships and an extensive matrix of programs and initiatives addressing identified community health needs. A charter approved in 2007 established the formation of the Queen of the Valley Community Benefit Committee (CBC), a Queen of the Valley Board of Trustee appointed committee integrating community members. The role of the CBC is oversight and championing of community benefit including regulatory compliance as well as integration of mission and values. The CBC makes recommendations regarding policies and programs that address identified community needs, development and implementation of the Community Health Needs Assessment (CHNA) and Community Benefit Implementation Strategy. The Committee acts in accordance with a Board-approved charter.

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, community benefit related provisions of the Affordable Care Act and Section 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 community benefit strategy.

The current CBC membership includes 11 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 at a minimum on a quarterly basis.

PLANNING FOR THE UNINSURED AND UNDERINSURED

Patient Financial Assistance Program

The St. Joseph Health (SJH) Financial Assistance Program helps to make our health care services available to everyone in our community needing emergent or medically necessary care. This includes people who do not have health insurance and are unable to pay their hospital bill, as well as patients who do have insurance but are unable to pay the portion of their bill that

insurance does not cover. In some cases, eligible patients will not be required to pay for services; in others, they may be asked to make partial payment.

At SJH Queen of the Valley, our commitment is to provide quality care to all our patients, regardless of their ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance or are worried about their ability to pay for their care. This is why we have a Financial Assistance Program for eligible patients. In FY17, Queen of the Valley, provided $1,941,223 free (charity care) and discounted care for 2,882 patient encounters.

For information on our Financial Assistance Program click here.

Medi-Cal (Medicaid)

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 FY17, St. Joseph Health Queen of the Valley, provided $2,714,991 in Medicaid shortfall. The Hospital Provider Fee had an impact of $5,914,512 million reducing the net Medicaid benefit from $8,629,503 million to $2,714,991.

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 higher 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 16,000 (12%) of Napa County residents are not U.S. citizens: this can swell during the growing season (Public Policy Institute of California 2011, study based on 2008 population of 134,000). 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, limited access to transportation for those without automobiles and growing academic achievement gap. The

leading causes of death are cancers, coronary heart 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: https://www.thequeen.org/for-community/.

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

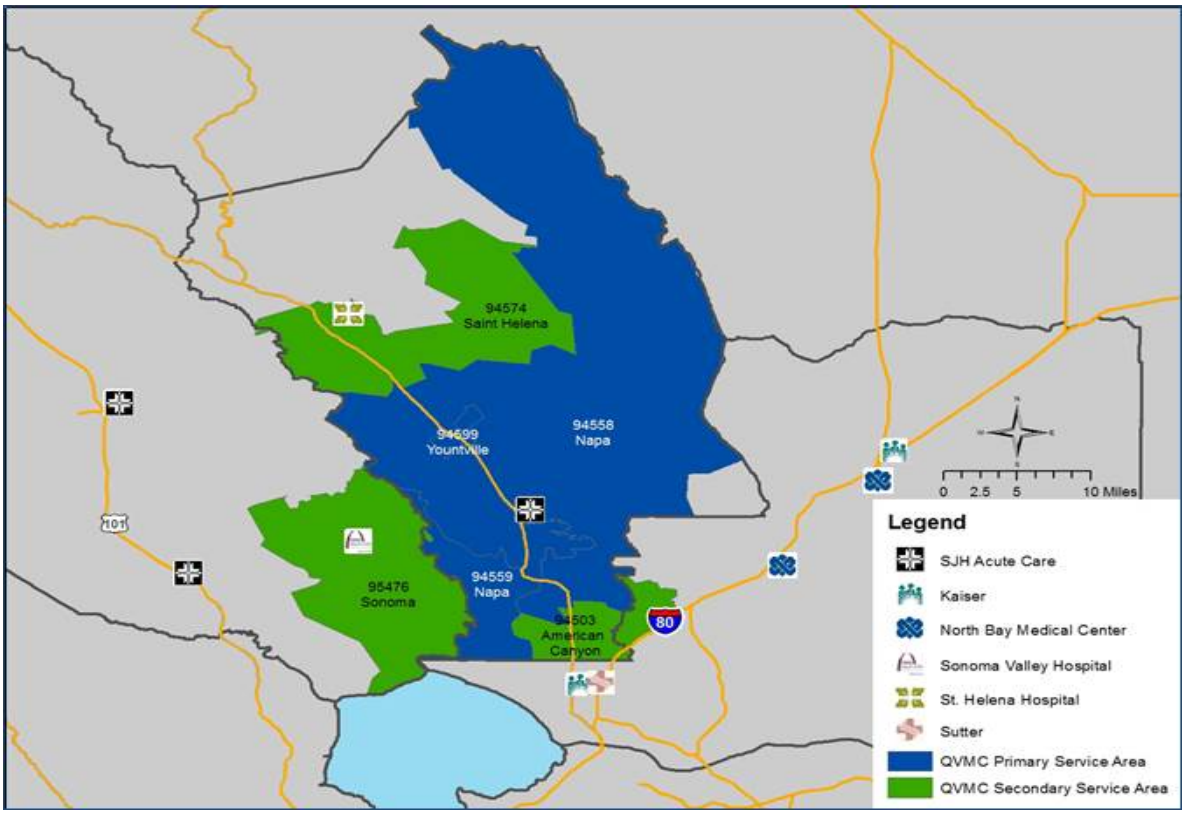
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients resides. The hospital's PSA is comprised of the cities of Napa and Yountville. The hospital's 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 hospital, health care and community benefit ministries located in Sonoma County provide services in the Sonoma 95476 area code, SJH Queen of the Valley community benefit services typically do not extend into Sonoma 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



Source: OSHPD Inpatient Data Set based on Calendar Year 2009, excludes Normal Newborns (MSDRG 795)

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.

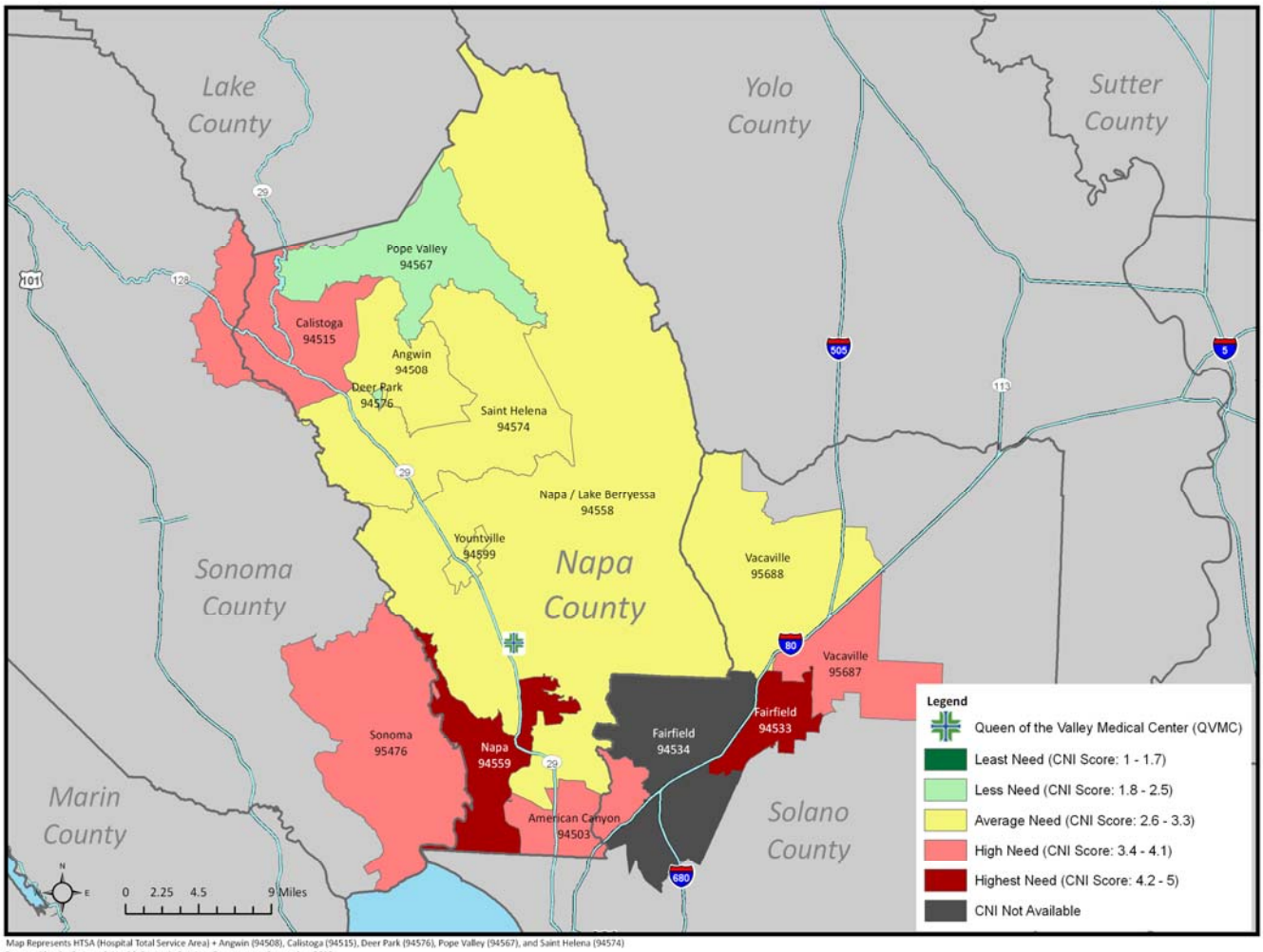
CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers):

- 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)



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**.**

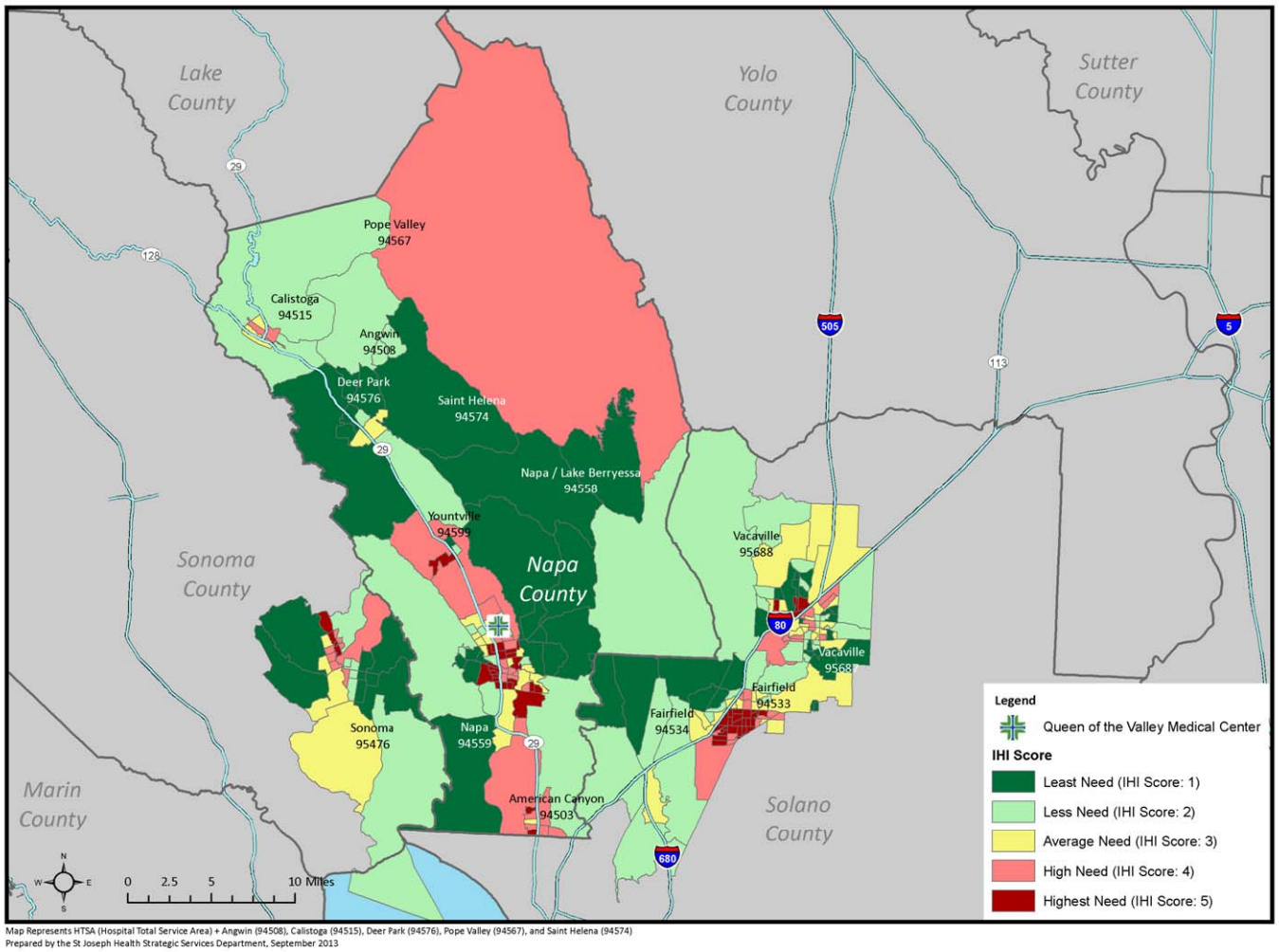
The IHI combines six key social determinants that are often associated with health outcomes:

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)



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 HEALTH NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

SJH Queen of the Valley completed the FY 2014 community needs assessment in partnership with Napa County Public Health, Kaiser Permanente, St. Helena Hospital, Napa Valley Coalition of Nonprofit Agencies and Community Clinic Ole. From this core team developed Live Healthy Napa County (LHNC) which includes 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 (CHSA) 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
  o Physical health improved
  o Mental health improved
  o Prevention resources
• Address Social Determinant of Health
  o Social and physical environments promote good health for all
  o Equitable educational and economic opportunities
• Create and Strengthen Sustainable Partnerships for Collective Impact
  o Public health system collaboration
  o Community engagement and leadership
  o New systems and strategic alliances to focus on policies and practices to address local issues
• Ensure Access High Quality Health Services and Social Support
  o All ages will have access to care to achieve optimal health and reach fullest potential
  o Health services and social supported are integrated
  o Prevention services available to all high risk individuals and families

St. Joseph Health Queen of the Valley anticipates that implementation strategies may change over time and therefore, a flexible approach is best suited for the development of its response to the St. Joseph Health Queen of the Valley 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 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 with DUHN generally meet one of two criteria: *either* there is a high prevalence or severity for a particular health concern to be addressed by a program activity, or there is evidence that community residents are faced with multiple health problems and have limited access to timely, high quality health care. The following table lists the DUHN communities/groups and identified community needs and assets.

DUHN Group and Key Community Needs and Assets Summary Table

DUHN Population Group or Community	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

DUHN Population Group or Community	Key Community Needs	Key Community Assets
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 behavioral health issues	Family Service of Napa Valley Clinic Health Ole County Mental Health Services
	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 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 Priority: 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 Program*** 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, 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 inequality, public transportation system, environmental): 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 $10,000 to Habitat for Humanity, $5,000 to Napa Valley Community Housing, $10,000 to NEWS for a bridge to Housing Program, and $25,000 to local family resource centers and safety-net organizations for food and shelter. In addition, Queen of the Valley addresses basic needs of low-income chronically ill through our CARE Network program. CARE Network provided low income chronically ill clients assistance with transportation on 557 occasions (bus pass, gas card, taxi scrip, volunteer rides), housing on 126 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 301 occasions (health insurance, social security and disability income, veterans (VA) income and benefits, caregiver In Home Supportive Services (IHSS) hours, food stamps, utility assistance and with food access on 465 occasions. In addition, CARE Network provided 22 track phones and 88 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. Queen of the Valley collaborates on this issue through partnering 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.

COMMUNITY BENEFIT PLANNING PROCESS

Summary of Community Benefit Planning Process

Once the CHNA is conducted and needs are identified, strategic planning begins to determine how best to address identified needs. From the community wide needs assessment Queen of the Valley's Community Benefit Committee prioritized needs and 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 identified health priority areas and address unmet needs in the community.

The Planning Committee convened three meetings 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 agreed upon criteria.

The processes included reviewing and discussing:

- The ministry goals
- SB697 guidelines
- ASACB Core Principles
- 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.

The Strategic Planning Committee identified the following health issues under the four LHNC health priorities. Following discussion and review, the health issues were tiered 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 (SDOH)

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.

Based on this review of prioritized significant health needs and a thoughtful priority setting process, Queen of the Valley is addressing 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 18 Title I 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. 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.

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

CARE Network implements intensive community based disease case management, transitional care and brief care coordination services addressing the unique needs of Medi-Cal enrolled, uninsured and underinsured, 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/MFT 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: Children's Mobile Dental**

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. 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: Healthy Minds – Healthy Aging, CARE Network Behavioral Health Integration, Perinatal Mood Disorder**

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.

St. Joseph Health Queen of the Valley
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY17 Accomplishments

Initiative (community needs 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	FY 17 Target	FY17 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%	*FY17 Outcome Measure Change: see page 27

Strategy(ies)	Strategy Measure	FY17 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? 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, and sweetened ice tea)? 4. How many days per week do you eat 5 or more servings of fruits and/or vegetables in a day?	Of the 196 survey responses that had opportunity for improvement, 42% indicated improvement by year – end. All 4 survey categories show improvement: 1. Breakfast = 43% (33 students) 2. Physical Activity = 54%% (48 students) 3. Sugary Beverages = 63% (54 students) 4. Fruits and Veggies = 36% (31 students)
2. Provide onsite nutrition education to parents of low income preschool students on preschool sites (Child Start preschool sites)	FY 17: Number of preschool parent participants in nutrition education classes	In the 7 Child Start preschool locations a total of 12 preschool classes were targeted for parent nutrition education. A total of: • 10 parent nutrition classes taught • 149 parents attended one or more nutrition education classes

Key Community Partners: Napa Valley Unified School District (18 schools), QVMC Wellness Center, Children and Weight Coalition, Child Start Preschools, Healthy Bodies Coalition, School Health Committee

Childhood Obesity

To address childhood obesity in Napa County, in 2009 SJH Queen of the Valley launched 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) Community/ parent education; and, (3) Community and school policy advocacy.

FY17 Accomplishments:

* Change in Outcome Measure: After significant consideration and due diligence it was decided not to conduct the mass screening of students for BMI beginning school year 17. This decision included feedback from participating pediatricians, classroom teachers and Healthy for Life staff. BMI screenings have been conducted since program launch. Although privacy screens are used and care is taken to ensure students do not feel embarrassed to weigh, staff and teachers observed many students uncomfortable with standing on a scale. In addition, a multi-million dollar school district budget gap lead to elementary school budget cuts including reduction of PE teachers. A collaborative decision was made to use the time and resources dedicated toward BMI screenings to increasing the number of children served and enhanced program services.

In FY 17 there was a **77% increase** in number of unduplicated children served compared to FY 16 (from 950 to 1,679), and **over 100% increase** in duplicated encounters (from 9,200 to 18,449) in addition to an increase of classrooms served by 16% (from 38 to 44 classrooms). This year programs continued at 7 low-income preschool settings (12 classes) and in 18 participating school district sites (44 classes).

In FY 17 we continued to focus upstream in obesity prevention, maintaining and enhancing services to low-income preschools (7 preschool sites / 12 classes. Emphasis on preschool teacher education and support included providing two teacher training workshops with 14 attendees, teaching 10 parent nutrition classes with 149 parent attendees, measuring moderate to vigorous physical activity (MVPA) on four different occasions in all 12 classrooms for a total of 48 visits, and providing a fitness coach devoted to one hour per month per school site to work with preschool staff and students to increase the amount of MVPA students receive during the school day. A fourth nutrition class titled **Re-Think Your Drink** was taught to 1025 students in grades K-12.

St. Joseph Health Queen of the Valley
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY17 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	FY17 Target	FY17 Result
Percentage of patients who demonstrate oral health status improvement at recall visit based on a set of clinical criteria	91.5%	92%	92% (Of 478 random chart audits, 92% of children had improved oral health status at follow up visit based on a set of clinical criteria)

Strategy(ies)	Strategy Measure	FY17 Result
Provide early oral health screening and education in preschools and kindergartens	Number of children provided early screening for oral health	439 children received early screening for oral health
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	95% of patients saw a dentist within 6 months to one year following initial examination or last recall exam (Of 478 random chart audits)

Provide patient / parent education on improving and maintaining oral health	Percentage of patient / parents reporting improved oral health behaviors	97.8% of patients /parents reported improved oral health behaviors (136 of 139 parent respondents to Professional Research Consultants, Inc./PRC survey report improved oral health behaviors of their children post dental clinic visit)
Provide Mobile Dental procedures as necessary and indicated	Percentage of those receiving procedures who have reduced caries at follow-up	79% of those receiving dental procedures who have reduced dental caries at follow-up (Of 478 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*

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.

FY17 Accomplishments:

This year our mobile dental clinic spanned 9 locations across Napa County serving **2,141** low-income children and providing **5,674** clinic visits. In addition, 16 low income pre-school classes were provided free oral health screenings and fluoride varnish to over 439 children. Of these 439 children, 39 had no dental home and parents were assisted with referral to a dental home for treatment, education and continued preventive care. This year for the first time 3 Head Start preschool classrooms (60 children) showed no sign of dental caries (cavities).

St. Joseph Health Queen of the Valley
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY17 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	FY17 Target	FY17 Result
Percentage improvement in ED use of new clients at post – enrollment when compared to pre-enrollment	53% reduction (established FY15)	Maintain Baseline	71%

Strategy(ies)	Strategy Measure	FY17 Result
Provide Intensive Case Management Services to individuals at high medical and psychosocial acuity[i] level	Percentage improvement in hospitalizations for new clients enrolled in complex case management post enrollment compared to pre-enrollment	42% reduction in hospitalizations for new clients enrolled in complex case management
Provide 30 day Transitional Care from inpatient to outpatient for vulnerable high risk patients at high risk for readmission	Rate of hospital readmission at 30 days post hospitalization	9.01% hospital re-admission rate. (61 of 742 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	95% (144 of 151 clients served did not require higher level case management services)

Key Community Partners: OLE Health (Formerly Community Health Clinic Ole), Mentis (Formerly Family Services of Napa Valley), Napa County Health and Human Services (Substance Abuse Services, Mental Health Services, Economic Self Sufficiency), Collabria Care (formerly Napa Valley Hospice), and Community Action Napa Valley (Food Bank, Homeless Services, and Smoking Cessation).

Chronic Disease Care Management

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 health 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 government burden of healthcare costs.

FY17 Accomplishments:

In FY17CARE Network served 568 clients, of those 261 were newly enrolled. For those newly enrolled clients, emergency room visits decreased by 71% and hospitalizations decreased by 42% as compared to one year prior to enrollment. To address improved access to critical medical and social supports and provide a community based safety net and continuum of care, in FY 15 Queen of the Valley expanded scope of services of the CARE Network to include transitional care, addressing the unique needs of patients at risk for re-hospitalization, particularly those patients with complex medical conditions as well as difficult socio-economic needs such as housing insecurity and basic needs deficits. The transitional care program served 742 individuals, targeting those most vulnerable regardless of diagnosis or insurance status with a program readmission rate of 9.01 percent.

In August 2017 with a grant from St. Joseph's Community Partnership Fund, Queen of the Valley Community Outreach launched a pilot program, embedding a Community Health Worker (CHW) into the Medical Center emergency department (ED). The program is aimed at providing outreach and follow up services to high risk patients discharging from the ED including the

homeless, uninsured and those with complex medical and socioeconomic needs. The ED-based Community Health Worker engaged patients within the ED setting, provided follow up support after discharge and linkages to critical community-based medical, mental health and substance abuse services in Napa County. Since the program begin in November 2016 through June 2017 the CHW served 220 patients.

St. Joseph Health Queen of the Valley
FY15 – FY17 Community Benefit Plan/Implementation Strategies and Evaluation Plan
FY17 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	FY17 Target	FY17 Result
Percentage of clients who demonstrate a reduction in depression as measured through validated tools appropriate to the target population	90% (FY13)	91%	92.5% of clients (111 of 120)

Strategy(ies)	Strategy Measure	FY17 Result
Identify individuals with risk factors for depression using validated tools	Number of individuals identified with risk factors for depression using validated tools	1,525 individuals were identified at risk for depression
Provide interventions or refer individuals with positive screens to behavioral health services	Percentage of individuals with positive screens provided services or referrals	72% of individuals who have positive screening for mental or emotional health received services or referrals (211 of 293)

Key Community Partners: **Key Community Partners:** Mentis (formerly known as Family Services Napa Valley), Area Agency on Aging, Ole Health (Formerly Community Health Clinic Ole), 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).

FY17 Accomplishments:

92.5% of clients who completed behavioral health services demonstrated improvement in depression symptoms as measured by evidenced based tools. The total number of unduplicated clients served by The CARE Network, Healthy Minds Healthy Aging (HMHA), and the Perinatal Emotional Wellness Program was 211 with 1,633 therapy sessions provided in the client's home or office.

FY17 Other Community Benefit Program Accomplishments

In addition to the preceding priority initiatives, SJH Queen of the Valley also provided the following community benefit programs, activities and support responsive to the health needs identified in the FY 14 CHNA.

Community need being addressed:	Program	Description	FY17 Accomplishments
Addressing Social Determinants Of Health: Studies show health outcomes are directly related to social determinants of health such as poverty, academic success, access to healthy foods, and other environmental factors.	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 creates a learning environment for parents to gain critical parenting and leadership skills to support their child's academic success. Classes are bilingual with a focus on schools with a high percentage of students receiving free and reduced lunch, and those schools with high number of English Second Language (ESL) students.	NVPU offered 100 different class topics at 6 elementary school sites including 3 Napa Valley Early Learning Initiative (NVELI) locations with over 1,492 unduplicated parent participants. Altogether 200 classes were offered with over 10,565 parent participants (parents take multiple classes). Class topics include: 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.
Improve Wellness And Healthy Lifestyles through perinatal community health education	Perinatal Education	Educational classes for pre and postnatal mothers, partners, and siblings including birth preparation, infant care, breastfeeding and infant safety.	Queen of the Valley community benefit offers a wide variety of perinatal classes to all in our community, regardless of income or area hospital birthing choice. This year 131 classes were presented in English and 30 classes were presented in Spanish with 2,426 class participants (duplicated). Free perinatal exercise classes at Queen of the Valley's Medical Fitness Center are offered to low income women. This year perinatal

Community need being addressed:	Program	Description	FY17 Accomplishments
			exercise classes including aqua and yoga were provided to 168 low income women.
Improve Wellness And Healthy Lifestyles through nutrition community health education	Cooking Matters	Cooking Matters is a series of cooking classes that empowers families with the skills to stretch their food budgets and cook healthy meals at home for their children. As part of the No Kid Hungry campaign to end childhood hunger in America, Share Our Strength's Cooking Matters teaches participants to shop smarter, use nutrition information to make healthier choices and cook delicious, affordable meals.	This year QVMC offered a total of 18 classes to 26 unduplicated individuals totaling 131 encounters (participants take several classes). Three of the six week series classes were offered in Spanish. Cooking Matters Pop-Up tours were provided at three Title 1 schools in the NVUSD and provided tours to 58 participants in Spanish. One additional pop-up tour was provided at a local community center providing education to 19 participants.
Access To Health Services And Supports through ensuring access to diagnostic, treatments and procedures for Napa's uninsured population.	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 Permanente) and Ole Health (FQHC), OA continues in Napa this year linking 84 unique lives to 209 specialty appointments and 112 surgical procedures and or diagnostic services.
Address Social Determinants Of Health through ensuring food and	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	A community benefit contribution totaling $52,063 provided to eight safety-net non-profit agencies in Napa County helped to secure food and housing for the poor. In addition, a community benefit

Community need being addressed:	Program	Description	FY17 Accomplishments
shelter.		such as food and shelter.	contribution in total of $150,000.00 was provided to Catholic Charities in support of a medical respite for the homeless (Nightingale House).
Access To Health Services And Supports	Access to specialty care (HIV, Hepatitis C) for the uninsured and under- insured	Uninsured and underinsured persons have difficulty accessing specialty care for complicated chronic conditions such as HIV and Hepatitis C.	This year Queen of the Valley provided a community benefit donation of $36,000 to Ole Health to bring HIV/Hepatitis C specialty clinics directly to the FQHC site. Patients of these specialty clinics are then followed by Queen of the Valley's CARE Network team for care coordination and case management. Clinics provided services to over 86 unduplicated patients for a total of 192 office visits.
Create and Strengthen Sustainable Partnerships: Services for Older Adults	Healthy Aging Population Initiative (HAPI)	HAPI is a coalition of over 40 organizations serving older adults in Napa County. HAPI conducts needs assessments specific to older adults, develops collaborative strategies to address needs and advocates for policy change to improve the health and quality of life for older adults.	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, strategic activities and evaluation. In FY 17, based on a comprehensive 2016 survey of Napa County older adults, HAPI focused on understanding the increasing housing needs of older adults and determined that a more expansive, community-wide lens would be most effective in both understanding the issues and also driving change. HAPI invited the County of Napa and the Commission on Aging to plan and convene a community-wide summit to look at the housing crisis from the perspectives of families, workforce, business, older adults and homeless. More than 280 individuals representing these sectors attended to learn about the challenges related to lack of housing for various sectors and the impact on the

Community need being addressed:	Program	Description	FY17 Accomplishments
			health, economy, community life and diversity of the county. A second convening identified several key opportunities for improving access to housing in Napa Valley including public education, advocacy, and innovative programs such as Whole Person Care. Sub-committees continue these efforts. In addition, HAPI spearheaded the implementation of a new web portal proving access to information about programs and services for older adults in the community. HAPI continues to promote the mental health, transportation and information and assistance strategies begun more than 10 years ago. The Committee has grown from 20 members to more than 40 organizations and has forged close relationships with both the County and policymakers.
Access to Health Services and Supports through a community wide collaborative to reduce death from sudden cardiac arrest	Heart Safe Program	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, Napa County Health and Human Services, and community members have joined forces to ensure existing Automatic External Defibrillators (AEDs) are maintained and registered to a database, and that new AEDs are placed in high risk areas. Free AED	In FY 17 a community benefit donation in the amount of $35,000 supported the placement of an additional 30 AEDs and 21 CPR/AED training events for a total of 2,446 persons trained. There are now a total of 103 AEDs in the Heart Safe Program throughout Napa county. Leveraged support from the Heart Safe Program assisted the City of American Canyon and the City of Calistoga to become designated as HeartSafe Communities in October of 2016.

Community need being addressed:	Program	Description	FY17 Accomplishments
		training along with hand only CPR available to all Napa County residents.	
Access to Health Service and Supports through community health screenings	Health screening for migrant farmworkers and the homeless	An ongoing partnership with Ole Health to provide health screenings to migrant farmworkers and the under-insured. Screenings include cholesterol and blood sugar testing in addition to health education in prevention of diabetes, hypertension, heart disease and obesity. Participants with no medical home are linked to primary care at Ole Health.	A total of 4 health screenings were provided, three for farmworkers at vineyard management sites and one supporting Amen ministries health screening by providing medical interpreting services for all the medical providers. In total, 686 uninsured and under-insured individuals were provided health screens and linked to care. Toward this effort, Queen of the Valley contributed a community benefit of $4,298.00 toward health fair supplies as well as in kind staffing including RN, Social Work, and Community Health Workers.

FY17 Community Benefit Investment

In FY17 St. Joseph Health Queen of the Valley invested a total of $12,713,931 Care for the Poor dollars in key community benefit programs.

FY17 COMMUNITY BENEFIT INVESTMENT
St. Joseph Health Queen of the Valley
(ending June 30, 2017)

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)	$1,941,223
	Unpaid cost of Medicaid[4]	$2,714,991
	Unpaid cost of other means-tested government programs	$3,519,737
Other benefits for Vulnerable Populations	Community Benefit Operations	$772,381
	Community Health Improvements Services	$1,669,324
	Cash and in-kind contributions for community benefit	$728,934
	Community Building	$0
	Subsidized Health Services	$342,160
	Total Community Benefit for the Vulnerable	***$11,688,750***
Other benefits for the Broader Community	Community Benefit Operations	$161,819
	Community Health Improvements Services	$676,563
	Cash and in-kind contributions for community benefit	$102,057
	Community Building	$0
	Subsidized Health Services	$79,742
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	$5,000
	Total Community Benefit for the Broader Community	***$1,025,181***
	TOTAL COMMUNITY BENEFIT *(excluding Medicare)*	$12,713,931
Medical Care Services for the Broader Community	Unpaid cost to Medicare[5] ***(not included in CB total)***	$34,631,185

[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. The pledge/grant (separate from the quality assurance fee) is reported in Cash and In-kind Contributions for other vulnerable populations.
[5] Unpaid cost of Medicare is calculated using our cost accounting system. In IRS Form 990, Schedule H, we use the Medicare cost report.
[6] Non-financial summary of accomplishments are referred to in CA Senate Bill 697 as non-quantifiable benefits.

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.

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 address this identified need, Queen of the Valley continues to convene representatives from homeless services, Napa County HHS, Adventist Health St. Helena Hospital and the Ole Health. This collaborative engaged Project Nightingale, a program of Catholic Charities that provides short term medical respite including shelter, meals, and care coordination for the homeless. This year Nightingale opened its doors in April of 2017 and through June 30th 2017 has provided medical respite to 18 unduplicated clients referred from partner healthcare agencies. Of the 18 enrolled in Nightingale, 11 had experience with chronic homelessness and 4 had Veterans' status, two clients were transitional aged youth between ages of 18-24, and five were older adults over the age of sixty two.

Alcohol and Drug Services
Substance use disorder (SUD) continues to be an identified health need in Napa County. In response to this need, 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 the community at large as well as provide a warm hand off for patients hospitalized and interested in engaging in services upon hospital discharge. As part of this effort, a Napa County ADS counselor is provided in kind space at Queen of the Valley community outreach department providing services to the community at large as well as inpatients as needed.

Further efforts to address substance abuse include offering health care professional's education and inviting community wide collaboration in the use of two nationally recognized models.

- **SBIRT**: Queen of the Valley provided SBIRT training (Screening, Brief intervention, Referral to Treatment) on two separate full day sessions for a total of 34 health care professionals from throughout the community. In conjunction with SBIRT training, in a separate daylong session, Motivational Interviewing (MI) training was provided to a total of 39 health care professionals from across the community.
- **4 P's Plus**: The second nationally recognized model addresses the perinatal population. The term perinatal relates to the time, usually a number of weeks, immediately before pregnancy, during pregnancy and after childbirth. The perinatal population in Napa County is an identified at-risk population for SUD and one that may falsely screen negative using the SBIRT method. In FY 16, Queen of the Valley entered into an agreement with Dr. Ira Chasnoff and NTI Upstream, to use the evidence based screening model specifically developed for women of childbearing age, the 4 P's Plus screening program. Since program inception October 2015; 1,094 women have been screened using 4 P's protocol, 369 had positive screens, 183 had brief intervention, 264 referrals were made to additional alcohol and drug services with 121 women accepting those services.

The Table:

The Table is a safety net food program providing a warm dinner Monday through Friday at The First Presbyterian Church. Since 1999, Queen of the Valley has provided an annual donation and sponsored a meal the second Tuesday of each 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 is the second year we have invited local musicians and singer-songwriters to provide live music during meal time. The music is uplifting and provides a therapeutic calming environment for all. The two greatest benefits from The Table are relief from hunger and relief from social isolation. This FY17, Queen of the Valley volunteers served 1,821 meals and countless smiles to vulnerable community members.

Quit Smoking Program

Smoking is still the most preventable cause of disease and death in the United States and in World History. Tobacco use is associated with cancer, heart disease, stroke and lung cancer, which were identified as the leading causes of death in the 2014 CHNA.

According to a 2015 California Health Interview Survey (CHIS) Smoking Report for Napa County, 8.6% of the adult population still smokes daily. Approximately 6.5% of Napa youth smoke, compared to the 4.8% state average. Almost 70% of smokers want to quit, and many smokers have made numerous quit attempts and are highly frustrated and anxious about their ability to ever quit. The anxiety associated with quitting often prohibits smokers from making any more quit attempts. California survey data show that it takes an average of 12 to 14 attempts to quit. In an effort to address tobacco use in Napa County, Queen of the Valley collaborates with Community Action Napa Valley's (CANV) Quit Smoking program which uses an evidence based curriculum in the provision of education, outreach and support. In addition to providing CANV's Quit Smoking program in kind conference room space for free Quit Smoking Classes; we also continue to offer the CANV Quit Smoking Referral Service, a component of the County wide CHIP. The Quit Smoking Referral Service establishes a process for a warm hand off for inpatient and outpatient referrals during the time a patient may be most motivated to quit smoking. With this program model, 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 post hospital discharge. There were a total of 115 patients referred by 31 different physicians. Six persons attended the community classes, 91% of the participants made at least one quit attempt, and 50% of the participants completely quit by the end of class series. At the end of the class series, 80% felt they were fully prepared to continue quitting and 20% were focusing on remaining smoke free with added support.

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. Throughout the year, staff time is contributed toward coalition meetings, coordination and reporting of LHNC related activities.

Volunteerism:
Queen of the Valley leadership and staff contributed 130.5 reported hours of community service and volunteerism for efforts toward feeding the hungry, advocating for the vulnerable at town hall meetings and serving on local non-profit Boards, City Commissions and coalitions in an effort to impact identified community health needs.

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 FY17 BCP conducted 3 blood drives at Queen of the Valley with a total of 96 registered donors and 63 units of blood donated.

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 throughout the year with major shipments coordinated for Christmas 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 cards written by school children along with an issue folded pocket flag with prayers prepared by women veterans residing at the California 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 2,234 care packages were lovingly prepared and shipped to troops in harm's way.

Over the years, OWLFH has developed into a strong community wide organization. This year Queen of the Valley supported Operation: With Love from Home to file and become a separate tax exempt corporation ensuring the ongoing effort of this care package ministry.

In addition to sending care packages, OWLFH volunteers identified a need to support the mental health needs of local military families. Napa County has over 9,410 veterans with more than 100 new recruits enlisting each year. The U.S. Department of Veterans Affairs estimates that PTSD afflicts 31% of Vietnam Veterans, 20 % of Iraq Veterans and 11% of Afghanistan Veterans with 22 Veterans committing suicide each day in the U.S.

Family members and friends play a large role in supporting veterans and active duty service members, including the pressure of transitioning from military culture to civilian life, struggling with post traumatic combat stress, living with a traumatic brain injury and self-medicating with alcohol and drugs. In response to this mental health need, OWLFH has partnered with Mentis, a local non-profit behavioral health agency, to create a monthly support group facilitated by a licensed psychologist to provide peer to peer support, tools and self-care strategies. This group is called Homefront and receives referrals from local non-profits, public health and the Veterans Administration Care Give Program.

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Governance Approval

This FY17 Community Benefit Report was approved at the September 21, 2017 meeting of the St. Joseph Health Queen of the Valley Community Benefit Committee of the Board of Trustees.

Sister Christine Schleich, CSJ

Chair's Signature confirming approval of the FY17 Community Benefit Annual Report

9/21/2017

Date

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