

— 2021 - 2023 —

## COMMUNITY HEALTH IMPROVEMENT PLAN

# Queen of the Valley Medical Center

Napa, California



To provide feedback on this CHIP or obtain a printed copy free of charge, please email Teresa Smith, CHI Program Manager at [Teresa.Smith@stjoe.org](mailto:Teresa.Smith@stjoe.org)



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# EXECUTIVE SUMMARY

Providence continues its Mission of service in Napa County through Queen of the Valley Medical Center (QVMC). QVMC is an acute-care hospital with 208 licensed beds, founded in 1958 and located in Napa, California. The hospital's service area is the entirety of Napa County, including 140,394 people.

QVMC dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During the most recent fiscal year, the hospital provided \$33,487,837 in Community Benefit in response to unmet needs.

The Community Health Needs Assessment (CHNA) is an opportunity for Queen of the Valley Medical Center to engage the community every three years with the goal of better understanding community strengths and needs. The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relied on several sources of information: state and national public health data, qualitative data from interviews with community stakeholders and listening sessions with caregivers that serve our most vulnerable residents, and hospital utilization data.

## QVMC Community Health Improvement Plan Priorities

As a result of the findings of our [2020 CHNA](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Queen of the Valley Medical Center will focus on the following areas for its 2021-2023 Community Benefit efforts:

### PRIORITY 1: HEALTH EQUITY – RACIAL & LGBTQ

The disproportionate impact of COVID-19 on Black, Brown, Indigenous, and People of Color (BBIPOC), as well as the national call for racial justice have highlighted the need for additional community conversations around racism and inequities. Health inequities and systemic racism are preventing BBIPOC communities, particularly the Latino/a community, from accessing opportunities, and discrimination prevents the LGBTQ+ community from receiving responsive health care.

### PRIORITY 2: HOUSING & HOMELESSNESS

A major growing community need is around safer and more affordable housing stock, particularly for people with low incomes. The housing crisis in Napa highlights racial and economic inequities in the community, disproportionately affecting the Latino/a community, especially mixed status families. There is additional concern for older adults who have few affordable options in the community, particularly those living on a fixed income.

### PRIORITY 3: MENTAL HEALTH & SUBSTANCE USE SERVICES

There is a general lack of mental health and substance use treatment services in the community. School-age children, older adults, the Latino/a community, and individuals identifying as LGBTQ+ experience barriers to accessing responsive services.

#### PRIORITY 4: ACCESS TO HEALTH SERVICES

There is concern around lack of access to health insurance for mixed status families as well as people losing their insurance due to job loss during the pandemic. A lack of specialists in Napa, transportation, and language barriers prevent individuals from accessing timely and responsive health care services.

# INTRODUCTION

## Who We Are

**Our Mission** As expressions of God’s healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

**Our Vision** Health for a Better World.

**Our Values** Compassion — Dignity — Justice — Excellence — Integrity

Queen of the Valley Medical Center is an acute-care hospital founded in 1958 and located in Napa, California. The hospital has 208 licensed beds, more than 1,687 caregivers (employees), and professional relationships with many local physicians. Major programs and services offered to the community include acute rehabilitation, bariatric surgery, cancer, cardiac, emergency, maternity and infant care, neurosciences, and orthopedics. Synergy Health Club, a Providence owned facility offering fitness and studio classes, is located on the hospital’s campus and Providence Prompt Care, an urgent care clinic, is located about a 10-minute drive from the hospital.

## Our Commitment to Community

Queen of the Valley Medical Center dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During the most recent fiscal year, it provided \$33,487,837 in Community Benefit<sup>1</sup> in response to unmet needs and to improve the health and well-being of those served in Napa County.

## Health Equity

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

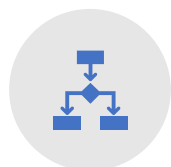
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<sup>1</sup> A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community. To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

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

**Figure 1. Best Practices for Centering Equity in the CHIP**



Address root causes of inequities by utilizing evidence-based and leading practices



Explicitly state goal of reducing health disparities and social inequities



Reflect our values of justice and dignity



Leverage community strengths

## Community Benefit Governance

Queen of the Valley Medical Center demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation, and collaboration with community partners. The Northern California Regional Director of Community Health Investment and the local QVMC Community Health Investment Program Manager are responsible for coordinating implementation of State and Federal 501r requirements.

The Community Benefit Committee (CBC) is the board appointed oversight committee of the Community Outreach department at Queen of the Valley Medical Center. The CBC is composed of Providence Queen of the Valley community board members, internal Providence stakeholders and staff (Chief Executive or designee, mission leader, community health leaders) and external community stakeholders representing subject matter experts and community constituencies (i.e., faith based, FQHC's, mental health, homeless services, education, and Public Health). The CBC reviewed the data collected in the 2020 Community Health Needs Assessment process to identify and prioritize the top health-related needs in Napa County for this 2021-2023 CHIP. The committee also oversees and governs budget, investments, program continuation or discontinuation, populations of focus and community-wide engagement.

## Planning for the Uninsured and Underinsured

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

One way Queen of the Valley Medical Center 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. For information on our Financial Assistance Program go to:

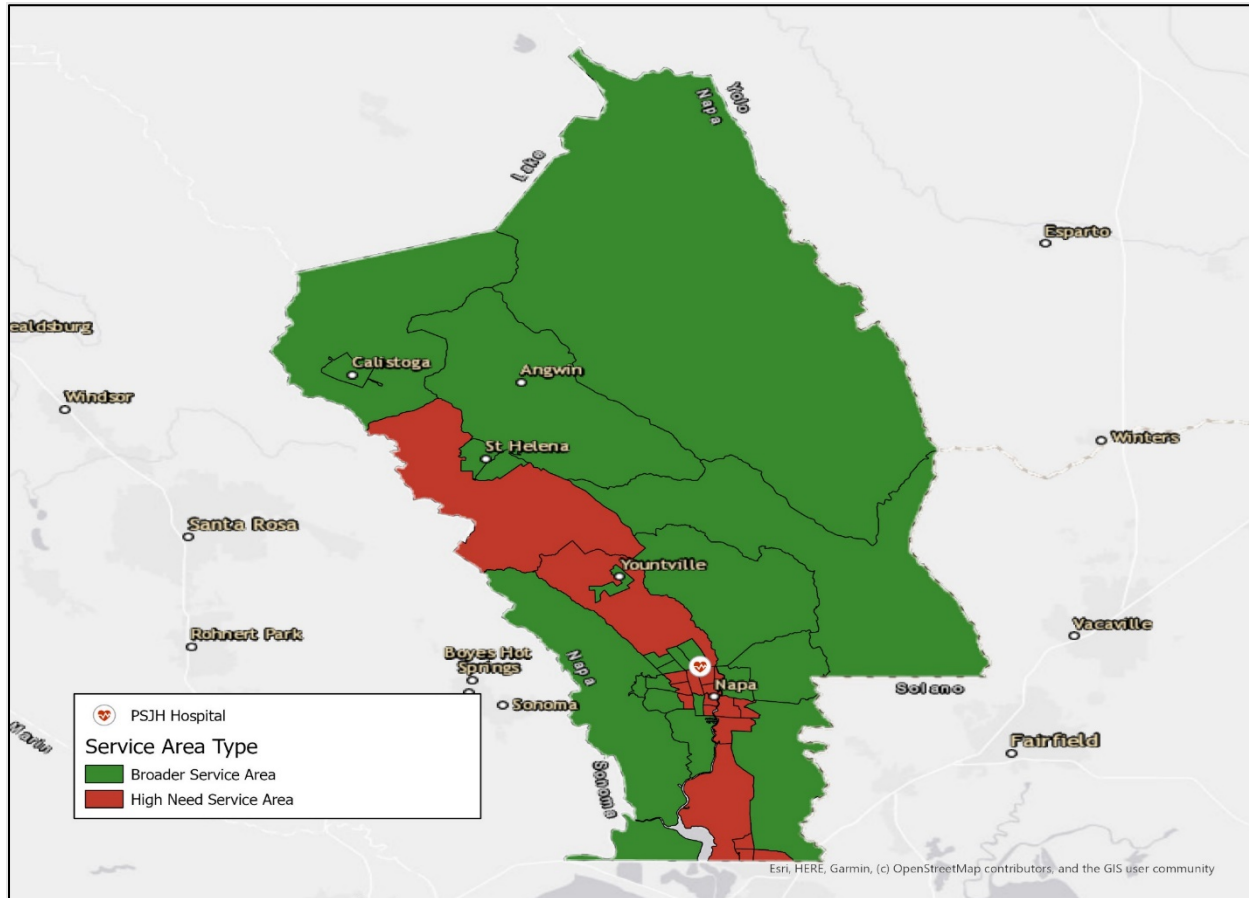
<https://www.stjosephhealth.org/patients-visitors/billing-payment/>.

# OUR COMMUNITY

## Description of Community Served

Queen of the Valley Medical Center’s service area is Napa County and includes a population of approximately 147,000 people.

**Figure 2. Queen of the Valley Medical Center Total Service Area**



Of the over 140,000 permanent residents of Napa County, roughly 48% live in the “high need” area, defined by lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to census tracts across the county. For reference, in 2020, 200% FPL represents an annual household income of \$52,400 or less for a family of four. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.



## Community Demographics

### POPULATION AND AGE DEMOGRAPHICS

Younger age groups are disproportionately represented in the high need communities of Napa County, most likely representing households with young children. Alternatively, age groups 55 and over are less likely to fall into the high need communities or live within those designated census tracts. The male-to-female distribution is roughly equal across Napa County geographies.

In Napa County, approximately 7% of the population are veterans, which is higher than that of the state of California, 5%.

### POPULATION BY RACE AND ETHNICITY

Individuals who identify as Hispanic (below), Asian, or “other race,” are more likely to live in high needs census tracts than their peers of other races.

### SOCIOECONOMIC INDICATORS

**Table 1. Income Indicators for Napa County Service Areas**

Indicator	Broader Service Area	High Need Service Area	Napa County
<b>Median Income</b> Data Source: American Community Survey Year: 2019	\$101,330	\$77,129	\$88,457
<b>Percent of Renter Households with Severe Housing Cost Burden</b> Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	20.8%	25.2%	23.0%

The median income in the high need service area is about \$11,000 lower than Napa County. There is about a \$24,000 difference in median income between the broader service area and the high need service area.

Severe housing cost burden is defined as households that are spending 50% or more of their income on housing costs. On average about 23% of households in Napa County are severely housing cost burdened. In the high need service area, 25.2% of renter households are severely housing cost burdened. Within the total service area there are census tracts in which 30% to 43% of households are experiencing severe housing cost burden.

Full demographic and socioeconomic information for the service area can be found in the [2020 CHNA for Queen of the Valley Medical Center](#).

# COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

## Summary of Community Needs Assessment Process and Results

The Community Health Needs Assessment (CHNA) process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

## Significant Community Health Needs Prioritized

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

### PRIORITY 1: HEALTH EQUITY – RACIAL & LGBTQ

The disproportionate impact of COVID-19 on Black, Brown, Indigenous, and People of Color (BBIPOC), as well as the national call for racial justice have highlighted the need for additional community conversations around racism and inequities. Health inequities and systemic racism are preventing BBIPOC communities, particularly the Latino/a community, from accessing opportunities and living their healthiest lives. Discrimination also prevents the LGBTQ+ community from receiving responsive health care and visibility in the community. A greater commitment to equity in all programs and collaboratives is warranted.

### PRIORITY 2: HOUSING & HOMELESSNESS

A major growing community need is around safer and more affordable housing stock, particularly for people with low incomes. A lack of affordable housing leads to over-crowding and poor living conditions. Housing is foundational to all other needs; once people are housed securely, they can address other needs related to their health and wellbeing. Two groups are of particular concern: the Latino/a community and older adults. The housing crisis in Napa highlights racial and economic inequities in the community, disproportionately affecting the Latino/a community, especially mixed status families. There is additional concern for older adults who have few affordable options in the community, particularly those living on a fixed income.

### PRIORITY 3: MENTAL HEALTH & SUBSTANCE USE SERVICES

There is a general lack of mental health and substance use treatment services in the community. School-age children and older adults need more mental health support in the current environment, increasing the demand for services. The Latino/a community is also underserved, especially mixed status families,

with the following barriers preventing Latino/a individuals from receiving services: stigma, a lack of culturally relevant education and outreach, and a lack of bilingual and bicultural providers. LGBTQ-friendly mental health providers are also difficult to find in the area. There is limited access to mental health services for individuals who do not meet the high-acuity criteria for severe mental illness at Napa County Health and Human Services, as well as limited substance use disorder treatment options. The COVID-19 pandemic is creating a mental health crisis; people are feeling hopeless, afraid, stressed, anxious, and depressed. The stress from the COVID-19 pandemic is compounding trauma related to local fires.

#### PRIORITY 4: ACCESS TO HEALTH SERVICES

There is concern around lack of access to health insurance for mixed status families as well as people losing their insurance due to job loss during the pandemic. A lack of specialists in Napa disproportionately affects individuals on Medi-Cal or without insurance. When individuals are referred to a specialist outside of the area, transportation then becomes a barrier to accessing care. Language barriers prevent Spanish-speaking individuals from receiving responsive care, and virtual interpreters are not nearly as effective as in-person options. Access to care challenges became especially apparent during the COVID-19 pandemic. While telemedicine has improved access to care for some populations, for others this transition has created additional barriers to care, including lack of smart phones or computers, lack of comfort with technology or stable internet access, language barriers, and lack of private space for appointments. Many individuals do not want to talk to their provider on the phone and are not receiving the care they need.

### 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 continuing our Mission through the provision of financial grants and donations to community partners whose work aligns with the mission, vision, and values of the organization.

While Queen of the Valley Medical Center will employ strategies to address each of the four significant health needs that were prioritized during the CHNA process, partnerships with community organizations and government agencies are critical for achieving long-term goals.

Queen of the Valley Medical Center will collaborate with Napa County, the City of Napa, OLE Health, Adventist Health, Mentis, Abode, and a variety of local family resource centers that address the community needs to coordinate care and referrals to address unmet needs.

# COMMUNITY HEALTH IMPROVEMENT PLAN

## Summary of Community Health Improvement Planning Process

The 2021-2023 Community Health Improvement Plan (CHIP) process was impacted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2020 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

Queen of the Valley Medical Center’s CHIP involves a comprehensive approach led by the Community Health Investment Program Manager and Senior Program Coordinator. This process includes both internal and external stakeholders and subject matter experts. Coordinating within the organization and in our community is critical in leveraging the will and the resources required to improve community health. As part of the comprehensive approach, existing initiatives of Queen of the Valley’s community benefit investments are reviewed to ensure alignment with 2020 CHNA priorities. The board appointed Community Benefit Committee is engaged throughout the process, beginning with the development and approval of the CHNA, followed by CHIP development, review and feedback, then final CHIP review and approval.

Queen of the Valley Medical Center 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 Medical Center in the enclosed CHIP.

## Addressing the Needs of the Community: 2021- 2023 Key Community Benefit Initiatives and Evaluation Plan

### COMMUNITY NEED ADDRESSED #1: HEALTH EQUITY – RACIAL & LGBTQ

#### *Population Served*

Populations of focus include Black, Brown, Indigenous, and People of Color (BBIPOC), particularly the Latino/a community, and LGBTQ+ individuals throughout Napa County.

Long-Term Goal(s)

To eliminate social inequities and forms of oppression in our communities, ensuring all people have the opportunities and access to living their fullest, healthiest lives.

**Table 2. Strategies and Strategy Measures for Addressing Health Equity**

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1. Partner with FQHC/OLE Health to ensure timely and adequate follow-up care for vulnerable patients	Individuals with low-income or experiencing vulnerabilities, with special focus on Latino/a patients	# of AED visits for acute upper respiratory infection among Latino/a patients	2020 = 94	10% reduction; 84 instances per year
		# of AED visits for urinary tract infection among Latino/a patients	2020 = 81	10% reduction; 73 instances per year
2. Improve infrastructure to serve LGBTQ+ patients and address disparities through provider training and adequate data collection	LGBTQ+ individuals	# and % of providers trained on LGBTQ+ affirming care and health-related needs	N/A	TBD
		# and % of LGBTQ+ individuals served	N/A	TBD
		# and % of individuals answering SO/GI screening questions	N/A	TBD
3. Continue to provide community health and educational classes, including Parent University classes to increase knowledge around the health and education systems	Low-income and/or Spanish-speaking individuals and families	% of class participants that report learning something new	2019/20 School year: 95%	Maintain
		% of class participants that will do something different as a result of what they learned	2019/20 School year: 93%	95%
4. Partner with FQHCs, other providers and CBOs for COVID-19 outreach, education, testing, vaccination, mitigation of	Latino/a and/or Spanish-speaking individuals and families	% of Latino/a Covid-19 cases	5/2021 = 48.8%	40%
		% of Latino/a Covid-19 hospitalizations	5/2021 = 44%	35%

spread, and mitigation of impacts on Latino/a communities				
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*Evidence Based Sources*

- [Listening to the Voices of Californians - California Health Care Foundation](#)
- [Health Equity | IHI - Institute for Healthcare Improvement](#)
- [Health Equity | CDC](#)

*Resource Commitment*

Queen of the Valley Medical Center will commit staff time from its Community Health Investment department, provide grants to local partners, and help leverage resources from the Providence Population Health Division’s Health Equity Initiative to support efforts that directly address health disparities. In partnership with the Providence Government and Public Affairs Division, local CHI leaders will advocate for policies that address social and economic disparities.

*Key Community Partners*

Queen of the Valley Medical Center values cross-sector collaboration and believes that non-profit organizations and local government organizations must work together to solve community-level problems. We plan to partner with the following organizations to address this need:

- OLE Health
- On The Move – LGBTQ Connection
- UpValley Family Centers
- Napa County Public Health
- Napa County Housing and Homeless Programs
- Providence Medical Group
- Community Organizations Active in Disaster
- Napa Valley Farmworker Foundation

**COMMUNITY NEED ADDRESSED #2: HOUSING & HOMELESSNESS**

*Population Served*

Populations of focus are older adults – especially those living on a fixed income – Latino/a, and undocumented individuals and families.

*Long-Term Goal(s)*

A sufficient supply of safe, affordable housing units to ensure that all people in the community have access to a healthy place to live that meets their needs.

**Table 3. Strategies and Strategy Measures for Addressing Housing & Homelessness**

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1. Support the development of affordable housing stock, including innovative models of permanent supportive housing	Chronically homeless and very-low-income individuals and families; seniors and individuals on a fixed-income	# of units supported through financial contributions	2020 = 0	140
		# of units supported through local advocacy or partnerships	2020 = 104	140
2. Leverage resources through partnerships to expand supportive services for those unstably housed and experiencing homelessness	Individuals experiencing or at risk of experiencing homelessness, including older adults, Latino/a, and undocumented individuals	# of individuals housed	2020 = N/A	TBD
		# of households provided diversion payments to prevent homelessness	2020 = 21	Maintain
		# of diversion payments provided	2020 = 69	Maintain
3. Invest in respite shelter services supported with complex care management	Individuals experiencing homelessness who are being discharged from local hospitals and need respite services	% of individuals who are permanently housed	2020 = 33%	50%

*Evidence Based Sources*

Queen of the Valley Medical Center believes in working upstream to prevent homelessness as well as responding to the immediate needs of individuals and families experiencing housing instability or homelessness, This CHIP includes both prevention and intervention strategies and draws from the following sources:

- [Housing is Health | Providence](#)
- [National Institute for Medical Respite Care \(nimrc.org\)](#)
- [National Health Care for the Homeless Council](#)

- [Reduce poverty by improving housing stability | Urban Institute](#)
- [Housing Instability | Healthy People 2020](#)

#### *Resource Commitment*

Queen of the Valley Medical Center will commit staff time from its Community Health Investment department as well as grants and restricted funding. Approximately \$4,500,000 in Care for the Poor reserve funds are earmarked for reducing housing instability and homelessness in Napa County between 2021 and 2025. Financial support is provided to Nightingale House annually for continuation of respite shelter care. Grant funds through the Housing Opportunities for Persons With AIDS (HOPWA) program will continue to assist with preventing a subset of unstably housed individuals from experiencing homelessness.

Providence Supportive Housing Division and Real Estate and Strategic Operations Division are available to assist with decisions around investments in and support for additional housing units. Additionally, and in partnership with the Providence Government and Public Affairs division, local CHI leaders will support policies that prevent homelessness and increase access to affordable housing.

#### *Key Community Partners*

Queen of the Valley Medical Center values cross-sector collaboration and believes that non-profit organizations and local government organizations must work together to solve community-level problems. We plan to partner with the following organizations to address this need:

- Abode Housing Services
- Burbank Housing
- Housing Authority of the City of Napa
- Napa County Housing and Homeless Programs
- Gasser Foundation
- Napa Valley Community Housing

### **COMMUNITY NEED ADDRESSED #3: MENTAL HEALTH & SUBSTANCE USE SERVICES**

#### *Population Served*

The below strategies are designed to impact all of Napa County, with a special focus on school-aged children, older adults, Latino/a, undocumented, and LGBTQ+ individuals.

#### *Long-Term Goal(s)*

To ensure equitable access to high-quality, culturally responsive, and linguistically appropriate mental health and substance use services, especially for populations with low incomes.



**Table 4. Strategies and Strategy Measures for Addressing Mental Health and Substance Use Services**

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1. Increase local capacity to provide culturally appropriate mental health services when needed	All of Napa County, especially youth and older adults, and Spanish-speaking individuals	# served through CARE Network/Mentis # served through Perinatal MH # therapy sessions provided through Healthy Minds Healthy Aging # served through Cancer Wellness program # served through Partnership HealthPlan # served through Napa County Mental Health	2020 = 106  2020 = 195  2020 = 645  2020 = 30  2020 = 1,717  2020 = 2,262	10% increase
2. Increase local capacity to provide appropriate level of SUD services when needed	All of Napa County, especially youth and older adults, and Spanish-speaking individuals	ED/BHPP: # referred/admitted  Perinatal services: # individuals served  Center Point: # admitted to Residential Services	N/A  2020 = 0  2020 = 76	TBD  10  85
3. Enhance the capacity of our community for prevention, education, and intervention of behavioral health treatment to youth	Teens and preteens	H4L: % of students with increased understanding of mindfulness and physical health  Mentis: % of involved teens and school staff that report improved knowledge of mental health resources  % of youth who complete treatment and show a reduction in their level of anxiety and depression	N/A  2020 = 74%  N/A	TBD  80%  80%

4. Support 24-hour crisis response and crisis stabilization services to ensure immediate mental health needs are met	Napa County residents	Crisis Stabilization Unit: # of individuals served  County Mobile Response Unit: # of individuals served	2020 = 135  2020 = N/A	Maintain  TBD
5. Provide Mental Health First Aid training throughout the community to better address immediate mental health needs	Napa county residents	Number of trainings provided  % improved understanding of different mental health needs	2020 = 0  N/A	9 trainings per year  100%

*Evidence Based Sources*

Queen of the Valley Medical Center believes in working upstream to prevent mental health and substance use concerns as well as responding to immediate needs for crisis interventions. This CHIP includes both primary prevention and crisis intervention strategies and draws from the following sources:

- [SAMHSA - Substance Abuse and Mental Health Services Administration](#)
- [Mental Health & Resilience Support for Teens and Adults \(work2bewell.org\)](#)
- [Prevention Institute](#)
- [Board of Behavioral Sciences \(BBS\)](#)
- [NAMI: National Alliance on Mental Illness](#)

*Resource Commitment*

Queen of the Valley Medical Center will commit staff time across the CARE Network program, provide grants to local partners and facilitate funding from various health system sources. In partnership with the Providence Government and Public Affairs division, local CHI leaders will advocate for increased access to mental health and substance use care with focused community-based solutions.

*Key Community Partners*

Queen of the Valley Medical Center values cross-sector collaboration and believes that non-profit organizations and local government organizations must work together to solve community-level problems. We plan to collaborate with the following organizations to address this need:

- OLE Health
- Mentis
- Collabria
- Alternatives for Better Living

- Center Point
- Aldea Children & Family Services
- Napa County Health & Human Services
- Providence Medical Group
- On The Move – including Innovations
- COPE Family Services

#### COMMUNITY NEED ADDRESSED #4: ACCESS TO HEALTH SERVICES

##### Population Served

Populations of focus include people who are uninsured or those who have recently lost health insurance coverage, Latino/a, and undocumented individuals.

##### Long-Term Goal(s)

To improve access to health care and preventive resources for people with low incomes and those uninsured by deploying programs to assist with navigating the health care system, and to ease the way for people to access the appropriate level of care at the right time.

**Table 5. Strategies and Strategy Measures for Addressing Access to Health Services**

Strategy	Population Served	Strategy Measure	Baseline	2023
1. Partner with FQHC/OLE Health to ensure timely and adequate follow-up care for vulnerable patients	Low income and/or medically vulnerable	TBD in partnership with OLE Health	N/A	TBD
2. Ensure residents are enrolled in health coverage through referrals to Community Health Initiative	Uninsured and under-insured individuals	# of referrals to CHI	N/A	TBD
		# enrolled in coverage from referrals	N/A	TBD
		# new enrollees	2020 = 700 individuals	2,550 individuals
		% of enrollees retaining coverage (Retention rate)	2020 = 80%	85%

		% of enrollees utilizing coverage (Utilization rate)	2020 = 85%	90%
3. Ensure that all Community Outreach clients/patients have seen their medical provider at least once in the past year	Low-income and/or vulnerable individuals	% of clients/patients that have seen their medical provider in the past year  (CARE Network clients; Perinatal clients; Dental patients; Parent University participants)	N/A	90%
4. Increase access to specialty care, diagnostic screening, and procedures through “Operation Access”	Low-income (up to 200% of FPL) and/or uninsured Napa County residents	# of individuals served each year through Operation Access  # of services provided each year through Operation Access	2020 = 65  2020 = 111	70  120
5. Provide early oral health screening, prevention, treatment and education to low-income children; complete dental care delivery, including check-up, treatment, and oral health education for patient/parent	Low-income, uninsured and under-insured individuals age 6 months to 26 years	% of patients returning within 6 months to 1 year  Number of children from families with low incomes provided early oral health screening	2020 = 79%  2020-21 school year = 35	90%  400 each school year by 2022-23

*Evidence Based Sources*

- [Prevention Institute](#)
- [Health People 2020 – Access to Health Services](#)
- [Health Equity | IHI - Institute for Healthcare Improvement](#)
- [Health Equity | CDC](#)

*Resource Commitment*

Queen of the Valley Medical Center will commit staff time from its Community Health Investment department as well as grants and restricted funding from its Care for the Poor account. The CARE Network program will continue to provide complex care management and medical care coordination for some of the most vulnerable individuals in our community.

*Key Community Partners*

Queen of the Valley Medical Center values cross-sector collaboration and believes that non-profit organizations and local government organizations must work together to solve community-level problems. We plan to partner with the following organizations to address this need:

- OLE Health
- Napa County Health & Human Services
- Providence Medical Group
- Community Health Initiative
- Operation Access
- Partnership HealthPlan of CA
- Collabria
- Share the Care

## Other Community Benefit Programs and Evaluation Plan

**Table 6. Other Community Benefit Programs in Response to Community Needs**

Initiative (Community Need Addressed)	Program Name	Description	Population Served (Low Income, Vulnerable or Broader Community)
1. Complex Care Management	CARE Network	This program is integral to addressing all 4 priority need areas. The CARE Network provides socio-economic and medical care coordination to low-income, vulnerable individuals with complex needs serving individuals along with additional caregivers and family members through a continuum of	People with low incomes or experiencing vulnerability

		services and supports linked to community-based services, financial assistance and medical resources.	
2. Health Equity and Access to Health Services	Targeted outreach and education	In partnership with CLC and COAD, develop unified messaging around public health matters and disseminate through partner organizations and trusted messengers throughout the county	People with low incomes or experiencing vulnerability, broader community
3. Health Equity and Mental Health	Healthy for Life	A school-based wellness program at Title 1 schools designed to emphasize lifelong wellness and behavior change among the pediatric population.	People with low incomes or experiencing vulnerability
4. Health Equity	Napa Valley Parent University	In partnership with Napa Valley Unified School District and a local nonprofit, On the Move, Parent University is a learning environment for 1,300 parents annually to gain critical parenting and leadership skills to support their child's academic success. Classes are bilingual.	Low income
5. Access to Healthcare	HIV Clinic	Collaborative with OLE Health to provide HIV clinic services to people who are uninsured and have low incomes	People experiencing vulnerability
6. Access to Healthcare	Farmworker Health Screening	Collaborative effort with OLE Health to screen migrant farmworkers for health concerns	People with low incomes

# 2021- 2023 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Community Benefit Committee of the hospital on May 20, 2021. The final report was made widely available by July 15, 2021



6/22/2021

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Victor Jordan  
Interim Region Chief Executive, Northern California Region

Date

*Rosie Perez*

6/14/2021

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Rosie Perez  
Co-Chair, Community Benefit Committee, Queen of the Valley Medical Center

Date



7/2/2021

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Justin Crowe  
Senior Vice President, Community Partnerships  
Providence

Date

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