



*ST. JOSEPH HEALTH QUEEN OF THE VALLEY*

*FY18 - FY20 Community Benefit Plan/Implementation Strategy Report*



To provide feedback about this *Community Benefit Plan/Implementation Strategy Report*, email [Dana.Codron@stjoe.org](mailto:Dana.Codron@stjoe.org)

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## **EXECUTIVE SUMMARY**

St. Joseph Health, Queen of the Valley Medical Center (Queen of the Valley) is an acute-care hospital founded by the sisters of St. Joseph of Orange in 1958, located at 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 1,280 professional relationships and more than 300 local physicians. Major programs and services include cardiac care, cancer care, critical care, diagnostic imaging, neurosciences, orthopedics, rehabilitation services, urgent care, emergency medicine, obstetrics, a mobile dental clinic 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.

The Total Service Area (TSA) of Queen of the Valley Medical Center includes approximately 167,000 people and includes zip codes for the cities of Napa, Yountville, American Canyon, St. Helena and Sonoma. The city of Calistoga is the only incorporated city in Napa County that is not within the service area. Over 75% of the population of the TSA is in Napa County, and approximately 90% of Napa County's population is within the TSA. Compared to the state, the TSA (and Napa County) has higher percentages of elderly and non- Latino Whites, and lower percentages of Asian Americans. Median income of the TSA is somewhat higher than California and there is less reported poverty.

Immigrants have worked in the vineyards, wineries and hospitality sector for decades and are overrepresented in the workforce; however, Latino men have relatively low earnings compared to other workers, mostly as a result of lower educational attainment and limited English proficiency. Within the TSA approximately 34% of the population speaks a language other than English at home and 16% do not speak English well. Those under the age of 18 constitute 21.6% of the population, and those with household income below 200% of the Federal Poverty Level constitute approximately 30% of the population. Approximately 15% of children live in poverty. Ethnic breakdown of the primary service area is 56.9% white, 36.6% Latino and 3% Asian.

Each year Queen of the Valley demonstrates organizational commitment to the community benefit process through the allocation of human resources and financial resources that currently supports over 45 employees and an extensive matrix of well-organized and coordinated community benefit programs including a mobile dental clinic for children, complex care coordination for vulnerable individuals with medical and psychosocial needs, and bilingual critical parenting and leadership skills to support the academic success of their children. In addition to administration of programs and services, Queen of the Valley serves as an anchor institution in Napa providing financial contributions to nonprofit community partner organizations to collaboratively leverage resources to meet community health needs.

## **FY18-FY20 CB Plan Priorities/Implementation Strategies**

As a result of the findings of our FY17 Community Health Needs Assessment (CHNA) and through a prioritization process aligned with our mission, resources and hospital strategic plan, St. Joseph Health Queen of the Valley will focus on the following areas for its FY18-FY20 Community Benefit efforts:

- **Mental Health:** Access to low cost mental health services was ranked as a top priority in the past several needs assessments for Napa County. To address this need, SJH Queen of the Valley will continue to implement a multi-pronged 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. Program beneficiaries include postpartum mothers, CARE Network intensive case management clients and underserved older adults at risk for behavioral or cognitive health issues. Services are bilingual Spanish/English and link clients to community resources and services.
- **Substance Abuse:** Perinatal substance abuse can have significant health impacts on the health pregnant women and lifelong issues for children. SJH Queen of the Valley will engage in a broad-based collaborative effort with healthcare, public health and community-based organizations to prevent, screen, educate and intervene in perinatal substance abuse. Work on this issue has begun. A screening pilot indicated nearly 34% of women screened had used alcohol, tobacco other drugs increasing risks for poor pregnancy and birth outcomes and lifelong child health.
- **Social Determinants of Health: Housing Concerns, Economic Issues and Access to Care:** To address social determinants of health that impact health equity, SJH Queen of the Valley will focus on housing issues, economic stability for the highly vulnerable and access to critical health care that reduces economic burden on families. This will include investments in community partnerships to stabilize housing for very low-income homeless individuals and innovations to increase access to affordable housing for low-income individuals and families. CARE Network social services care coordination will address basic needs and improve economic stability of those with complex socio-economic concerns as well as medical and psychosocial issues. A mobile dental clinic will provide access to dental care for children and youth from low-income families.

## **MISSION, VISION, AND VALUES**

### ***Our Mission***

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

### ***Our Vision***

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

### ***Our Values***

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

## **INTRODUCTION – WHO WE ARE AND WHY WE EXIST**

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 17<sup>th</sup> 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.

Established in Napa California nearly 60 years ago, St. Joseph Health Queen of the Valley Medical Center is an acute-care hospital with a campus that is approximately 12.3 acres in size. The facility has 208 licensed beds and is the major diagnostic and therapeutic medical center for Napa County and the surrounding region. Queen of the Valley has a caregiver staff of more than 1,280 and professional relationships with more than 300 physicians. Services include 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

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campus. Other medical specialties include: state of the art robotic surgery, an accredited cancer center, a regional heart center, maternity/infant care, neurosciences, orthopedics, rehabilitation services, women’s services, and imaging services.

Deeply rooted in the heritage of the founding Sisters, what is now Queen of the Valley’s Community Benefit (CB) Department began decades ago without regulatory mandates but rather as a community health ministry for the poor and vulnerable. 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.

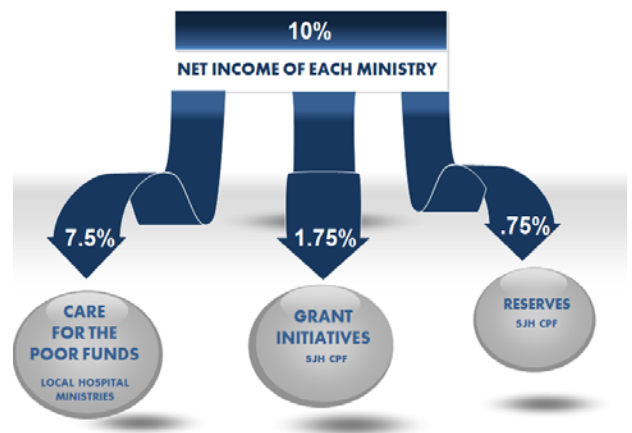
## **ORGANIZATIONAL COMMITMENT**

St. Joseph Health Queen of the Valley 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 lives of low-income individuals residing in local communities served by SJH Hospitals.

Each year St. Joseph Health Queen of the Valley allocates 10 percent of its net income (net unrealized gains and losses) to the St. Joseph Health Community Partnership Fund. 75 percent of these contributions are used to support local hospital Care for the Poor programs. 17.5 percent is used to support SJH Community Partnership Fund grant initiatives. The remaining 7.5 percent 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, 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. Local non-profits that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout St. Joseph Health hospitals’ service areas.



## **Community Benefit Governance and Management Structure**

St. Joseph Health 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.

Queen of the Valley 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 that integrates 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 of Outreach for 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 the hospital CEO, 11 Board of Trustees, 9 community members, and 3 St. Joseph Health Queen of the Valley staff members. The CBC is actively engaged in the planning and oversight of the 2017 community health needs assessment (CHNA) as well as the FY 2018 – 2020 implementation strategy planning process.

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, St. Joseph Health and Queen of the Valley are strategically focused on two key areas to which the Community Benefit Plan strongly align: population health management and network of care.

## **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 St. Joseph Health Queen of the Valley has a **Patient Financial Assistance Program** that provides free or discounted services to eligible patients.

One way St. Joseph Health Queen of the Valley informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible.

## **COMMUNITY**

### **Definition of Community Served**

Queen of the Valley provides Napa County communities with access to advanced care and advanced caring. The hospital's service area extends from St. Helena in the north, American Canyon in the south, Lake Berryessa in the east and the city of Sonoma in the west. Our Hospital Total Service Area includes the cities of American Canyon, Napa, Yountville, St. Helena, and Sonoma. This includes a population of approximately 167,087 people, an increase of 22% from the prior assessment.

### **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 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% of discharges (excluding normal newborns)
- SSA: 71%-85% 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



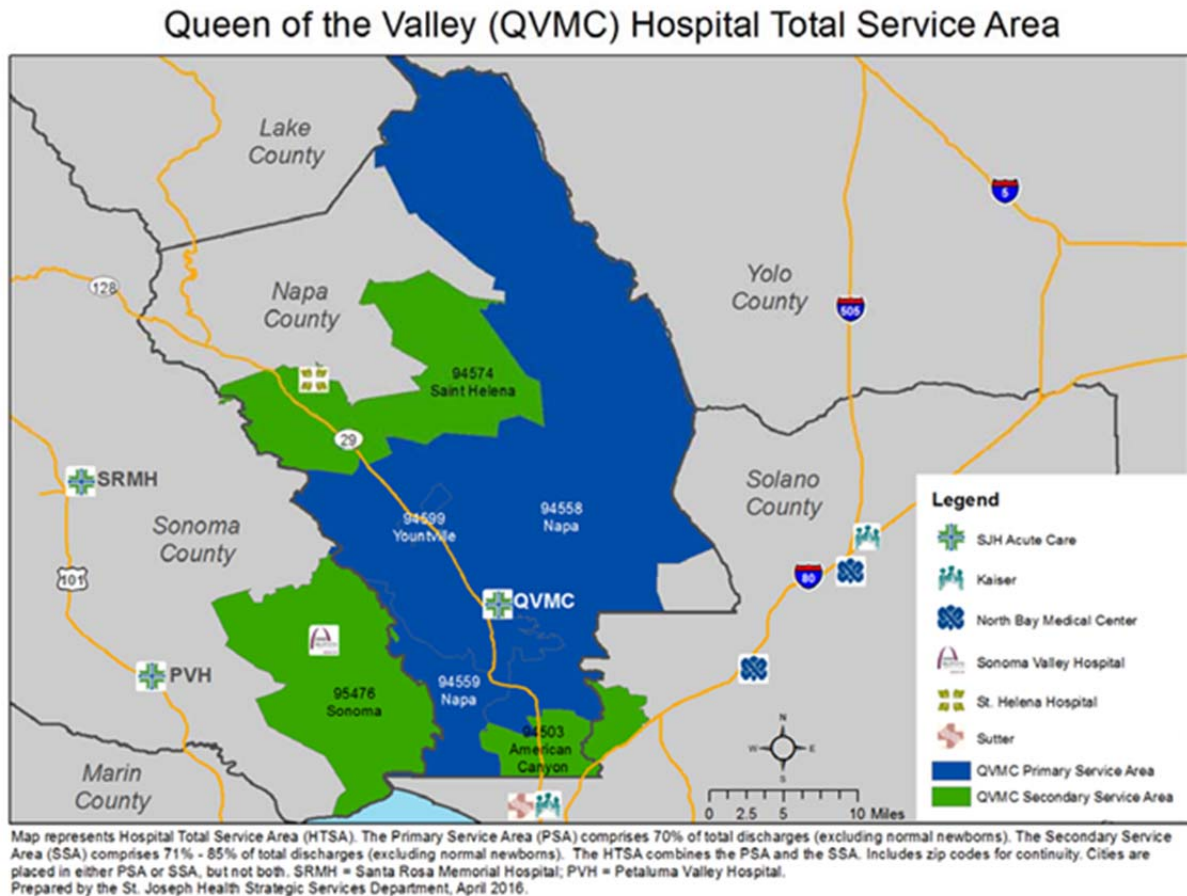
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The Primary Service Area (“PSA”) is the geographic area from which the majority of the Hospital’s patients originate. The Secondary Service Area (“SSA”) is where an additional population of the Hospital’s inpatients resides. The PSA is comprised of the cities of Napa and Yountville. The SSA is comprised of the cities of American Canyon, St. Helena, and Sonoma/Boyes Hot Springs.

**Table 1. Cities and ZIP codes**

Cities/ Communities	ZIP Codes	PSA or SSA
Napa	94558, 94559	PSA
Yountville	94599	PSA
American Canyon	94503	SSA
St. Helena	94574	SSA
Sonoma/Boyes Hot Springs	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.



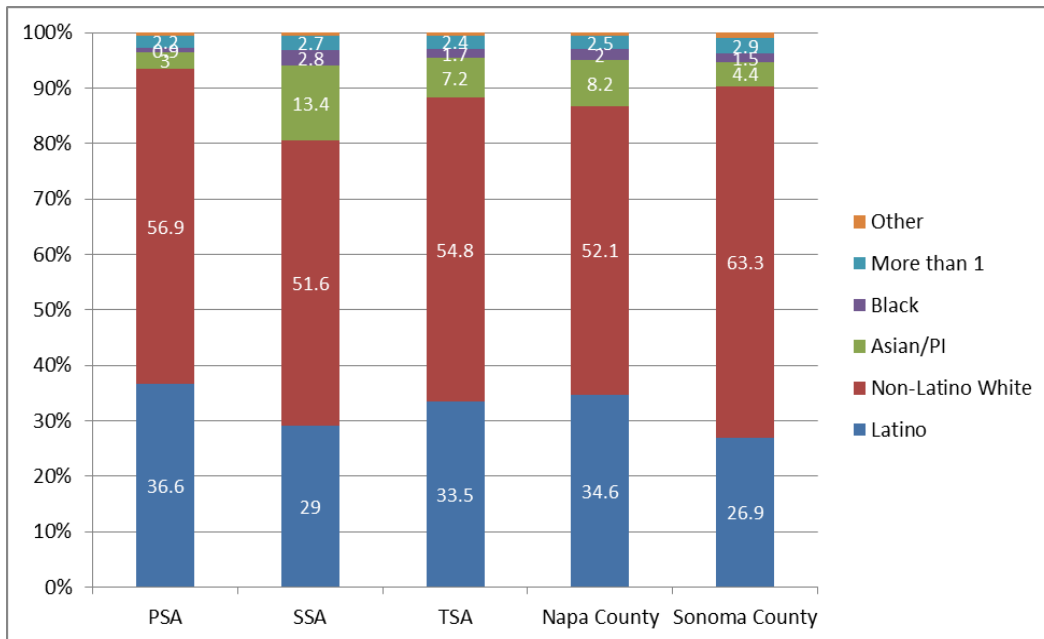
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The table and graph below provide basic demographic and socioeconomic information about the Queen of the Valley Medical Center Service Area and how it compares to Napa and Sonoma Counties and the state of California. The Total Service Area (TSA) of Queen of the Valley Medical Center includes approximately 167,000 people. Over 75% of the population of the TSA is in Napa County, and approximately 90% of Napa County’s population is within the TSA. The city of Calistoga is the only incorporated city in Napa County that is not within the service area. The Primary Service Area (PSA) consists of the zip codes for the cities of Napa and Yountville. Compared to the state, the TSA (and Napa County) has higher percentages of elderly and non- Latino Whites, and lower percentages of Asian-Americans. Median income of the TSA is somewhat higher than California and there is less reported poverty.

**Service Area Demographic Overview**

Indicator	PSA	SSA	TSA	Napa County	Sonoma County	CA
Total Population	99,520	67,567	167,087	141,203	503,284	38,986,171
Under Age 18	21.6%	21.6%	21.6%	21.8%	20.6%	23.6%
Age 65+	17.8%	19.5%	18.5%	17.3%	16.9%	13.2%
Speak only English at home	66.7%	63.7%	65.5%	64.6%	74.3%	56.2%
Do not speak English “very well”	16.2%	16.1%	16.2%	16.3%	10.9%	19.1%
Median Household Income	\$66,687	\$71,096	\$68,468	\$69,936	\$63,910	\$62,554
Households below 100% of FPL	7.3%	8.1%	7.6%	7.3%	7.6%	12.3%
Households below 200% FPL	22.4%	21.7%	22.1%	21.7%	21.6%	29.8%
Children living below 100% FPL	14.9%	16.1%	15.4%	14.0%	15.1%	22.7%
Older adults living below 100% FPL	7.6%	6.4%	7.1%	7.1%	6.8%	10.2%

**Race/Ethnicity**



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

The Community Need Index (CNI) was developed by Dignity Health (formerly known as Catholic Healthcare West (CHW)) and Truven Health Analytics. 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 (% 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

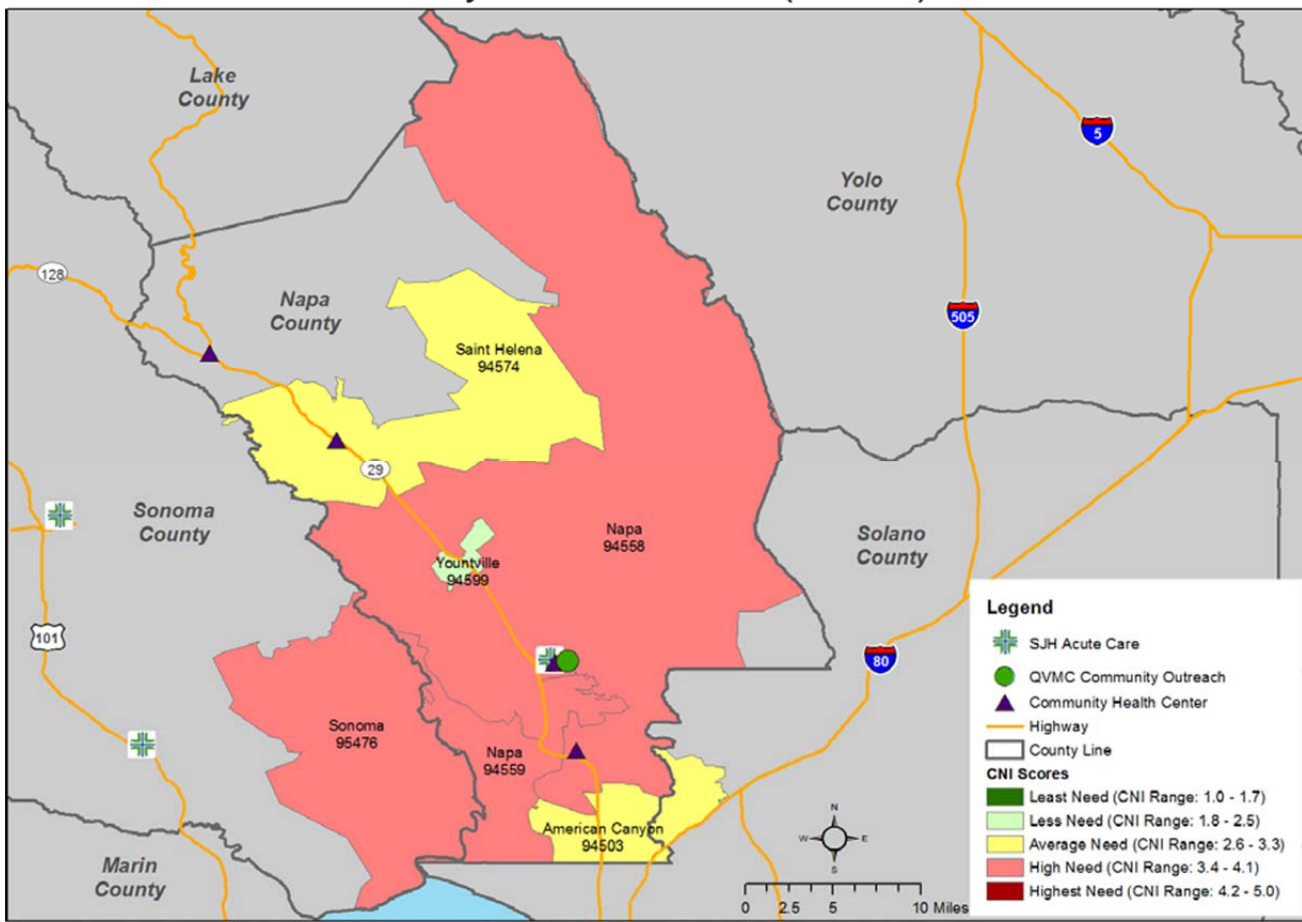
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to experience preventable hospitalizations for manageable conditions such as ear infections, pneumonia or congestive heart failure compared to communities with the lowest CNI scores.

(Ref (Roth R, Barsi E., Health Prog. 2005 Jul-Aug; 86(4):32-8.) The CNI is used to 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 94558 on the CNI map is scored 3.4 - 4.1, 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 as well as the other hospitals in the area that are a part of St. Joseph Health.

**Queen of the Valley Medical Center (QVMC) CNI Scores**



Source: Dignity Health Community Need Index (cni.chw-interactive.org), 2015 (accessed March 2016); Ole Health (olehealth.org) (accessed Oct. 2016).  
 Prepared by the St. Joseph Health Strategic Services Department, April 2016.

**Health Professions Shortage Area – Mental, Dental, Other**

The Federal Health Resources and Services Administration designates Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health

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providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Although Queen of the Valley Medical Center is not located in a shortage area, large portions of the service area to the West and North of Queen of the Valley are designated as shortage areas.

**Medical Underserved Area/Medical Professional Shortage Area**

Medically Underserved Areas and Medically Underserved Populations are defined by the Federal Government to include areas or population groups that demonstrate a shortage of healthcare services. This designation process was originally established to assist the government in allocating community health center grant funds to the areas of greatest need. Medically Underserved Areas are identified by calculating a composite index of need indicators compiled and compared with national averages to determine an area's level of medical "under service." Medically Underserved Populations are identified based on documentation of unusual local conditions that result in access barriers to medical services. Medically Underserved Areas and Medically Underserved Populations are permanently set, and no renewal process is necessary.

Queen of the Valley, along with the majority of the service area, is located in a Medically Underserved Area/Medically Underserved Populations area, signifying the importance of Queen of the Valley Medical Center to the community it serves.

## **COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS**

### **Summary of Community Needs, Assets, Assessment Process and Results**

#### **Process**

Queen of the Valley's CHNA process had rigor and followed a sound methodology to ensure that significant health needs identified by community-level data analysis (quantitative data) were validated through local resident and key stakeholder input (qualitative data). Queen of the Valley's Community Benefit Committee was involved throughout the CHNA process.

The needs assessment process included four phases: (1) CHNA initial design and planning beginning February of 2016, (2) quantitative data collection and analysis beginning July of 2016, (3) qualitative data collection and analysis beginning February 2017, and, (4) the identification, prioritization and selection of priority needs beginning April 2017.

The CHNA process was guided by the fundamental understanding that much of a person's health is determined by the conditions in which they live. 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, health behaviors, and the availability of clinical care.

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In addition, we recognized that where people live tells us a lot about their health and health needs, and that there can be pockets within counties and cities where the conditions for supporting health are substantially worse than nearby areas. To the extent possible, we gathered information at the zip code level to show the disparities in health and the social determinants of health that occur within the hospital service area.

Examples of the types of information that was gathered, by health factor, are:

- Socioeconomic Factors – income, poverty, education, and food insecurity
- Physical Environment – crowded living situations, cost of rent relative to incomes, long commutes, and pollution burden
- Health Behaviors – obesity, sugary drink consumption, physical exercise, smoking, and substance abuse
- Clinical Care – uninsured, prenatal care, and the number of people per physician or mental health worker

In addition to these determinants of health, we also looked at the health outcomes of the people living in the service area, by zip code whenever possible. The health conditions that were examined included:

- Health Outcomes (overall health condition)
- Asthma
- Diabetes
- Heart disease
- Cancer
- Mental health

### **Community Partnership**

Queen of the Valley Medical Center partnered with On the Move Bay Area (OTM) to support, recruit for, and host the Focus Groups and Forums. On the Move, based in Napa, has the mission to develop and sustain young people as leaders by building exceptional programs that challenge inequities in their communities. They do so by creating and implementing innovative programming that challenges communities and local leaders to push beyond mediocrity and into excellence. Supported by a track record of results-oriented programming and in partnership with the hundreds of established community partners, OTM works to unite communities and focus on the safety and inclusion of all people.

### **Quantitative Community-level Data**

Community-level data involved using the most recent data available and finding data at the smallest geographic region available such as zip code or city. Indicators were selected to provide as complete a picture of community health needs as possible, organized by demographic and five categories: health outcomes, health behaviors, clinical care, socioeconomic factors, and physical environment. The data sources used are highly regarded as reliable sources of data (e.g., ESRI Business Analyst Online, US Census Bureau American FactFinder, and California Health Interview Survey). In total, 81 indicators were selected to describe the health needs in the hospital's service area.

This quantitative data was then shared with our community through a methodical and standardized series of group meetings designed to engage dialogue and unearth insights and observations about the community-level data findings. Data collected through the Napa County Public Health Vital Statistics Office and the Public Health Communicable Disease Control program is also utilized.

Quantitative Data Findings showed areas of socioeconomic challenges. While the service area compares favorably to California on issues such as pollution, crime, rental costs, and overcrowding, the City of Napa has challenges on housing and parts of Napa and American Canyon are worse on pollution indicators. Asthma and heart disease rates are notably higher in the Service Area than California averages, although the older demographic may play a part in heart disease being more prevalent. Although both Napa and Sonoma Counties have higher rates of drug and alcohol use among teens, Western Napa generally had worse health outcomes, particularly around obesity at all ages and smoking. Obesity in adults is also an issue in the city of Sonoma.

### **Community Input**

Input was provided through three primary sectors: (1) two resident focus groups, (2) one government/nonprofit stakeholder focus group and (3) one community resident forum. The goal of community input was to engage community resident and local government/nonprofit stakeholders in discovery and discussion related to community health, provide insights and observations about community-level data findings, and solicit ideas from the community about significant health needs.

The government/nonprofit stakeholder group included 16 attendees including representatives from Napa County Health and Human Services Divisions of Public Health, Mental Health, Drug and Alcohol, Economic Self Sufficiency, and county Homeless Services. Other participating organizations included AMR ambulance, COPE Family Resource Center, Healthy Aging Planning Initiative, Housing Authority, Napa Community Health Initiative, Napa Police Department, Napa Valley Lutheran Church, On The Move, Parents CAN, Partnership Health Plan (managed Medicaid), St. John the Baptist Catholic Church, Up Valley Family Centers, and

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the mayor of American Canyon. The community resident forum convened approximately 50 people from diverse backgrounds and experiences.

Community resident and nonprofit and government stakeholder focus group participants identified the following issues as important:

- Transportation and Traffic:
- Housing Concerns
- Mental Health concerns.
- Immigration Status
- Food and Nutrition

The two community resident focus group participants highlighted health issues including the following:

- Diabetes among both children and adults
- Asthma, Heart Disease, and Cancer
- Water Quality (American Canyon)
- Domestic Violence (in Sonoma)
- Community Education

The following concerns were identified by the nonprofit/government stakeholder focus group but were not discussed extensively at the community resident focus groups.

- Housing
- Chronically Homeless
- Substance Abuse and limited services and prevention and education

St. Joseph Health Queen of the Valley anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the 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 St. Joseph Health Queen of the Valley in the enclosed CB Plan/Implementation Strategy.

### **Identification and Selection of Significant Health Needs**

In developing the list of significant health needs, the quantitative data was given equal weight to the community input. After reviewing and rating all the available information, the list of potential health needs was ranked from greatest to lowest need for the ministry. After synthesis and analysis of community level data and community input, is a list of the top 15 significant health needs was developed.

To prioritize the list of significant health needs and ultimately select the three health need(s) to be addressed by Queen of the Valley Medical Center, a four-step process was followed that



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incorporated the experience, expertise, and perspective of both internal and external stakeholders of the ministry.

**Step 1:** Using criteria that were developed in collaboration with the St. Joseph Health System Office and the Community Benefit Lead, The Olin Group Evaluation Team scored each health need on seven criteria.

- **Seriousness of the Problem:** The degree to which the problem leads to death, disability, and impairs one's quality of life
- **Scope of the Problem 1:** The number of people affected, as a percentage of the service area population
- **Scope of the Problem 2:** The difference between the percentage of people affected in the service area compared to regional and statewide percentages
- **Health Disparities:** The degree to which specific socioeconomic or demographic groups are affected by the problem, compared to the general population
- **Importance to the Community:** The extent to which participants in the community engagement process recognized and identified this as a problem
- **Potential to Affect Multiple Health Issues:** Whether or not this issue is a root cause, and the extent to which addressing it would affect multiple health issues
- **Implications for Not Proceeding:** The risks associated with exacerbation of the problem if it is not addressed at the earliest opportunity

**Step 2:** The Community Benefit Lead for Queen of the Valley Medical Center convened a working group of internal and external stakeholders, including the County Public Health Officer, to complete the second stage of prioritization. This working group applied 4 criteria to each need.

- **Sustainability of Impact:** The degree to which the ministry's involvement over the next 3 years would add significant momentum or impact, which would remain even if funding or ministry emphasis on the issue were to cease.
- **Opportunities for Coordination and Partnership:** The likelihood that the ministry could be part of collaborative efforts to address the problem.
- **Focus on Prevention:** The existence of effective and feasible prevention strategies to address the issue.
- **Existing Efforts on the Problem:** The ability of the ministry to enhance existing efforts in the community.
- **Organizational Competencies:** The extent to which the ministry has or could develop the functional, technical, behavioral, and leadership competency skills to address the need.

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**Step 3:** Two final criteria were considered by the Community Benefit Lead for each health need.

- Relevance to the Mission of St. Joseph Health: Is this area relevant to or aligned with the Mission of St. Joseph Health?
- Adherence to Ethical and Religious Directives: Does this area adhere to the Catholic Ethical and Religious Directives?

If the answer were “No” to either question, the health need was dropped from further consideration. None of the needs were dropped at this step.

**Rank-Ordered Significant Health Needs**

The matrix below shows the 15 health needs identified through the selection process, and their scores after the first three steps of the prioritization process. The check marks indicate each source of input and whether this issue was identified as a need by that input process.

Significant Health Need	Health Category	Total Rank Score	Community Data	Resident Focus Groups (FG)	N.P./ Govt. Stakeholder FG	Community Forum
Mental Health	Health Outcome	48.8		✓	✓	✓
Substance Abuse	Health Behavior	48.2	✓		✓	✓
Access to Care	Clinical Care	44.0		✓	✓	
Housing Concerns	Physical Environment	43.3		✓	✓	
Dental Care	Clinical Care	43.2		✓		✓
Food and Nutrition	Health Behavior	42.3		✓	✓	
Obesity	Health Behavior	39.5	✓	✓		
Economic Issues	Socioeconomic	38.5	✓		✓	✓
Cancer	Health Outcome	38.0	✓	✓		
Heart Disease	Health Outcome	36.7	✓	✓		
Diabetes	Health Outcome	36.5		✓		
Immigration Status	Socioeconomic	36.0	✓	✓	✓	✓
Language Barriers	Socioeconomic	35.2	✓		✓	✓
Asthma	Health Outcome	35.0	✓	✓		
Transportation and Traffic	Physical Environment	29.3	✓	✓	✓	

**Community Health Needs Prioritized**

**Step 4:** The final step of prioritization and selection was conducted by the Queen of the Valley Medical Center Community Benefit Committee, which reviewed the list of identified health needs rank-ordered by the results of the first three steps of the prioritization process. The Committee discussed each need and its relevance to the ministry, the potential for progress on

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the issue, and the potential role of the ministry in addressing the need. After extensive discussion, the Committee members each voted, selected and rank ordered three priority needs that will be addressed in the FY 18-20 Community Benefit Plan.

The health priority needs fall into two primary areas: Behavioral Health and Social Determinants of Health.

PRIORITY HEALTH NEEDS
1. Mental Health
2. Substance Abuse
3. Social Determinants of Health: Housing Concerns, Economic Issues and Access to Care

**Mental Health** was supported as a critical need at every step of the process. It was discussed in every focus group; the community groups focused on stress and its negative effects on overall health, while the stakeholders added discussions around overcoming stigma and a lack of necessary services. The need for more culturally and linguistically sensitive services was also a key thread. Mental Health received the most votes in the forum as well. Data on mental health is not always readily available, but the suicidal ideation rate in Napa and Sonoma Counties is in excess of 10%, compared to 8% in California. After the first three stages of prioritization, Mental Health was the highest ranked concern due in part to its importance to the community, its status as a root cause of other concerns, and opportunities both for partnerships and for the ministry to contribute. The Community Benefit Committee selected it because it rises to the top as a critical community need at each level of the assessment and at the CBC prioritization process.

**Substance Abuse** was also cited as an area of importance by several diverse sources. The data show that self-reported teen alcohol and drug use in both Napa (32%) and Sonoma (35%) Counties are more prevalent than California norms (28%). A pilot screening program indicated 34% of pregnant women had used tobacco alcohol and other drugs. The stakeholder focus group talked about the importance of prevention and education, and the links between substance abuse and mental health. Substance Abuse was also extensively discussed in the community forum, and received the sixth most votes of any topic. It was ranked second after the first three steps of the CBC prioritization process, for the same reasons as mental health was selected: data analysis was significant, community input corroborated, and substance abuse links closely with mental health.

**Social Determinants of Health: Housing Concerns, Economic Issues and Access to Care**

Although the data does not show either as a clear problem in the service area in comparison to California, there are definite pockets of poverty within the service area that are hidden by the overall wealth of the Napa Valley, and housing costs can be a burden for almost everyone. This issue was a concern of all three focus groups, at which people discussed the various socioeconomic groups affected by housing costs: low-income, middle-income, youth, and seniors. “Poverty and Economic Stress” received the third most votes in the community forum. Homelessness and impacts on health was specifically discussed at the stakeholder focus group. After the first three steps of prioritization, Access to Care was the third highest concern, Housing Concerns was the fourth and Economic Issues was eighth. Community Benefit Committee recognized that the social determinants of health, including housing/homelessness, economic issues such as poverty and access to care, were identified as having a significant impact on overall health.

**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 St. Joseph Health Queen of the Valley and by funding other non-profits through our Care for the Poor program managed by the 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 and resources to meet the identified needs of underserved communities throughout Queen of the Valley service areas.

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

SJH Queen of the Valley does not directly address Immigration Status. However, community benefit services are provided without consideration of immigration status and the medical center provides charity medical care. In addition, Queen of the Valley Medical Center and Community Benefit programs partners with multiple community-based organizations to address the needs of the undocumented.

While cancer, heart disease, diabetes and asthma are not a primary focus of the CB Implementation Plan, the TSA includes St. Joseph Health Queen of the Valley Medical Center, St. Helena Hospital, Kaiser Clinic and Ole Health that provide medical services to individuals with these conditions. Also, Queen of the Valley’s CARE Network provides care coordination

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and care management for clients with complex medical conditions including chronic diseases such as these.

SJH Queen of the Valley does not directly address issues of transportation and traffic. As a partner in Live Healthy Napa County, Queen of the Valley partners with the community to improve conditions through advocacy and partnerships. In addition, transportation support is provided to CB clients.

While access to food is not a primary focus of the CB Implementation Strategy, SJH Queen of the Valley community benefit provides funding support to local safety food net organizations, works directly with community partners such as the Food Bank and Live Healthy Napa County to expand access, and directly assists low-income chronically ill CARE Network clients with food access.

In addition, Queen of the Valley will collaborate with public agencies and community-based organizations that address language barriers and aforementioned community needs, to coordinate care and referral and address these unmet needs.

## **COMMUNITY BENEFIT PLAN**

### **Summary of Community Benefit Planning Process**

SJH Queen of the Valley Medical Center Community Benefit Committee set the following priority areas to develop the FY18- FY20 CB Plan/Implementation Strategy:

- Mental Health
- Substance Abuse
- Social Determinants of Health: Housing Concerns, Economic Issues and Access to Care

### **Selection of Initiatives, Goals and Strategies**

Following the final selection of top priority areas, a consultant was hired to guide the process of selecting and developing initiatives, goals and strategies to address each priority area for implementation in FY18-FY20. The process included convening key community stakeholders, as well as community benefit program management and key staff, and engaging the community benefit committee at multiple stages of development of the plan.

The Community Benefit Committee met twice to discuss and review both the process for developing key initiatives and to approve the overall framework for investment as well as specific programs, strategies and goals.

The CBC reaffirmed their commitment to the core principles of community benefit and a particular focus on vulnerable populations:

- Emphasis on disproportionate unmet health-related needs of vulnerable population
- Emphasis on primary prevention, health promotion and health protection
- Builds continuum of care
- Builds community capacity
- Collaborative governance

In addition, the Community Benefit Committee approved four guidelines to consider when selecting and developing the initiatives. The guidelines were targeted toward selecting those efforts with greatest feasibility for successful implementation and impact over time.

The four guidelines included:

1. Leverage aligned community planning efforts and potential collaborative partnerships.
2. Build upon significant current community benefit investments that meet critical needs in the community.
3. Assess internal and external resources, including human and financial, to implement efforts and have a measureable impact.
4. Evaluate potential for future funding opportunities to build and sustain initiatives.

### **Community Benefit Staff**

The consultant met with staff to assess current significant initiatives that align with selected health priorities. Initiatives focused on Mental Health, Economic Issues and Access to Care were refined for recommendation to the CBC for ongoing investment.

With facilitation by the consultant, staff identified significant and emerging community planning efforts aligned with the priority health areas. Queen of the Valley Community Benefit staff have been participating in collaborative leadership roles in local housing, homeless and economic stability planning efforts aimed at vulnerable populations. Given the breadth and scope of these issues and the resources available, community collaboration is essential to have a meaningful impact. In addition, CB staff has been engaged with key community organizations and county public health and substance abuse services in implementing a screening pilot to determine the need for substance abuse prevention and intervention programming for pregnant women.

## **Community Stakeholders**

Several focus groups were held with community stakeholders involved with the above efforts as well as other experts to determine the potential for building upon these emerging community initiatives. Groups helped identify priorities for implementation that matched community needs, health data and SJH Queen of the Valley CB capacity and proposed potential collaborative goals and strategies for initiatives as part of the community benefit plan for FY18-FY20.

Additionally, staff and consultant sought input from the Executive Management Team and invited their participation at CBC strategic planning meetings. St. Joseph Health System office staff of the Community Partnership Fund and staff from the Prevention Institute provided additional advice.

This process yielded this final draft plan. The strategic initiatives proposed to CBC reflect an ongoing commitment to both community collaboration and priorities and support for critical services that address identified needs.

The SJH Queen of the Valley Community Benefit Committee approved the FY18-FY20 Implementation Plan Framework and Initiatives at their October 26, 2017 meeting. The Committee recommended approval of the plan by the Board of Trustees. The Executive Committee of the Board of Trustees reviewed and approved the plan at their November 10, 2017 meeting.

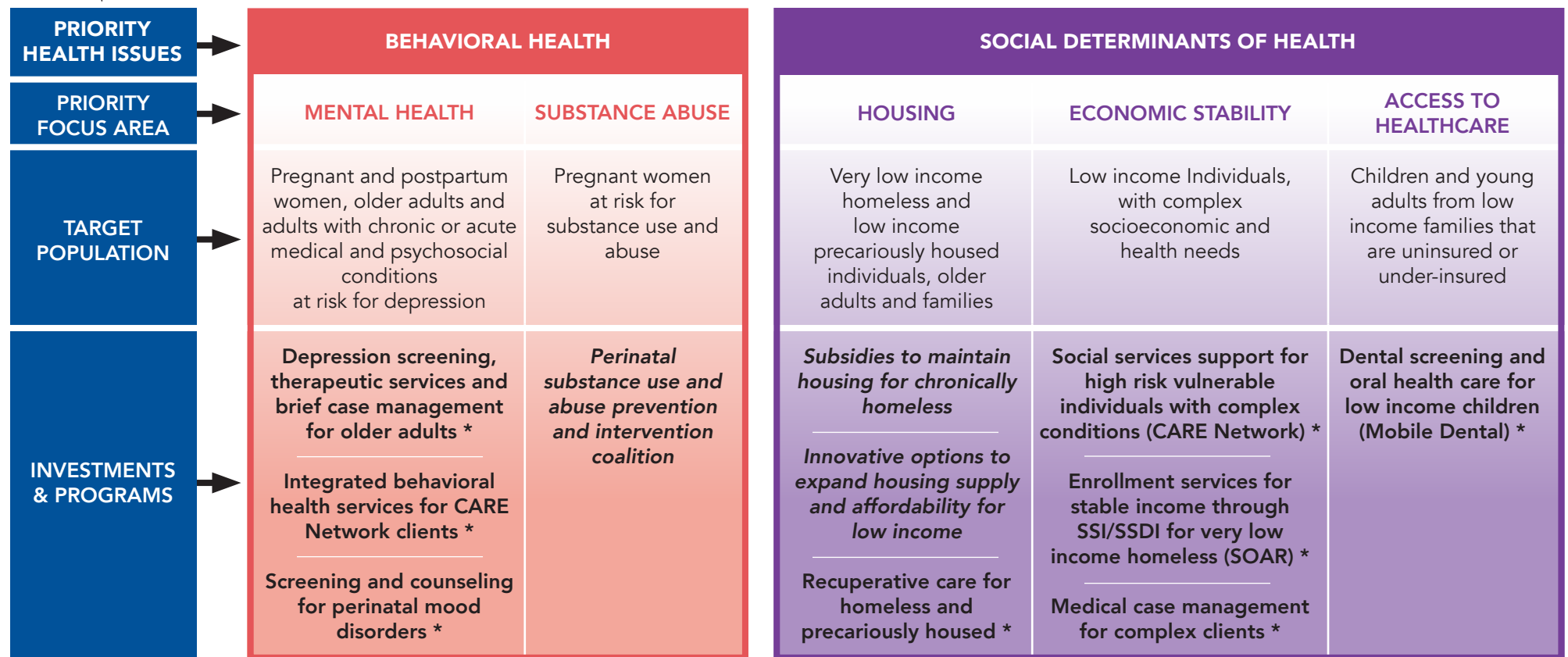
The approved FY18-FY20 SJH Queen of the Valley CB Framework and Initiatives/Programs are provided below.

### CORE PRINCIPLES

- Emphasis on Disproportionate Unmet Health-Related Needs of Vulnerable Populations
- Emphasis on Primary Prevention, Health Promotion and Health Protection
- Builds a Continuum of Care
- Builds Community Capacity
- Collaborative Governance

### MISSION OUTCOMES

- Healthiest Communities
- Perfect Care
- Sacred Encounters



\* Existing programs / Italics = New efforts



**Addressing the Needs of the Community:  
FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan**

1. **Initiative (community needs being addressed):** this initiative is focused on improving **mental health** and wellbeing of 200 vulnerable low-income older adults, individuals with acute medical conditions and pregnant and postpartum women annually. Access to mental health services for low-income individuals is limited. Older adults, postpartum women and those with complex medical conditions are more likely to suffer from depression that can contribute to poor quality of life and place them at higher risk for suicide.

**Goal (anticipated impact):** Reduce depression and improve quality of life among 200 low-income older adults, individuals with acute medical conditions and pregnant and postpartum women annually.

Outcome Measure	Baseline	FY18 Target	FY20 Target
Percentage of clients that improve depression indicators as measured through validated tools (PHQ9)	65% of all discharged clients	Maintain baseline	67% of all discharged clients

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
Assess and provide brief counseling and referral for pregnant and postpartum women screened for depression	Percentage of pregnant or postpartum women with improved depression on PHQ9 from screening to discharge	60% of discharged clients	61% of discharged perinatal clients	62% of discharged perinatal clients
Provide therapy for older adults with positive screens for depression	Percentage of older adults provided therapeutic services with improved depression on PHQ9 from enrollment to discharge	65% of discharged clients	67% of discharged older adults clients	69% of discharged older adult clients
Provide brief case management for older adults screened for depression	Percentage of older adults provided case management who demonstrate improved quality of life from enrollment to discharge on validated tool (SF12)	New tool - To be determined	To be determined	To be determined
Provide behavioral health services for complex care clients with positive screens	Percentage of clients with improved depression on PHQ9 from enrollment to discharge	70% of discharged complex care	72% of discharged complex care	73% of discharged complex care clients

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for depression		clients	clients	
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**Evidence-based:** <https://www.integration.samhsa.gov/integrated-care-models/older-adults> Chapman DP, Perry GS, Strine TW. The vital link between chronic disease and Depressive disorders. Preventing Chronic Disease 2005;2(1). Substance Abuse and Mental Health Services Administration. The Treatment of Depression in Older Adults: Selecting Evidence-Based Practices For Treatment of Depression in Older Adults. HHS Pub. No. SMA-11-4631, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2011. Florio ER , Raschko R . Validity of a Brief Depression Severity Measure Kurt Kroenke , MD,1 Robert L Spitzer , MD,2 and Janet B W Williams , DSW2 Bruce, M. L., Van, Citters, A. D., & Bartels, S. J. (2005). Problem-solving therapy for late-life depression in home care: a randomized field trial. American Journal of Geriatric Psychiatry,15(11), 968–978. Gellis, Z. D., McGinty, J., Horowitz, A., et al. (2007). Problem-solving therapy for late-life depression in home care: a randomized field trial. American Journal of Geriatric Psychiatry,15(11), 968–978. Maternal depression: [http://www.mentalhealthamerica.net/sites/default/files/maternal\\_depression\\_guide.pdf](http://www.mentalhealthamerica.net/sites/default/files/maternal_depression_guide.pdf). <https://www.nimh.nih.gov/health/publications/postpartum-depression-facts/index.shtml>. Cognitive Behavioral Therapy: <http://johnjayresearch.org/cje/files/2012/08/Empirical-Status-of-CBT.pdf>

**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)

**Resource Commitment:** Co-location, funding, perinatal counselor.

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2. **Initiative/Community Need being Addressed:** Substance Abuse was identified as a priority in the Community Health Needs Assessment. A community coalition formed to address perinatal substance use and abuse and piloted screening using evidence- based tool. Perinatal substance use has serious consequences for both mother and child. Obstetrical complications from substance use include an increased risk of miscarriage, intrauterine growth restriction, premature labor, and even fetal demise. Risks extend beyond pregnancy to the newborn. Alcohol use can lead to fetal alcohol spectrum disorder (FASD) associated with numerous disabilities. Opioid use is associated with neonatal withdrawal syndrome (NAS.) Recent estimates identified an increase in the rate of neonatal intensive care unit (NICU) admissions in the United States for NAS from 7 cases to 27 cases per 1000 admissions leading to an increase from 0.6% to 4% of all NICU days being attributed to NAS. (Prevalence and Consequences of Perinatal Substance Abuse. [Subst Abuse](#). 2017; 11: 1178221817704692. Published online 2017 Jun 6. doi: [10.1177/1178221817704692](#)) Intervening with high risk women can also prevent childhood trauma associated with parental substance abuse. In Napa, a screening pilot conducted from October 2015-May 2017 using the validated 4Ps Plus tool to assess use of alcohol, tobacco and other drugs by pregnant women in Napa had the following results: With a total of 1,094 women screened, there were a total of 369 positive screens for substance use, or about 33.7% of the total number of screens. There have been a total of 183 brief interventions, 264 referrals made and 121 (45.8%) of those referrals were accepted.

**Goal (anticipated impact):** Prevent adverse childhood experiences through a comprehensive set of activities to reduce perinatal substance use and abuse serving approximately 500 women annually.

Outcome Measure	Baseline	FY18 Target	FY20 Target
To be developed based on planning coalition research of appropriate measures	Partners agreed to develop comprehensive approaches to address perinatal substance use and abuse	Develop a coordinated action plan among broad-base of institutional and community-based partners	Measure to be determined

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
Build a broad-based local coalition of community and public agency partners to address issues of perinatal substance use and abuse	Local coalition develops a comprehensive, collective plan to prevent and intervene in perinatal substance use and abuse	Key partners convened	Plan developed with resource agreements and scope of work	To be determined

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Advocate for systems change efforts to improve community and institutional responses related to perinatal substance abuse	Number of systems change efforts underway	No work begun	Develop policy and systems change agenda	Measure to be determined Based on plan
Educate professionals community wide (including non-QVMC affiliated professionals), and the public on perinatal substance abuse impacts and best practices	Number of professionals educated and public education efforts implemented	No plan yet developed	Training objectives and social marketing messaging identified	To be determined
Implement integrated patient education, screening and interventions to change patient substance abuse behaviors	To be determined based on plan	To be determined	To be determined	To be determined

**Evidence Based Sources:** Screening: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3103106/>;  
<https://www.ncbi.nlm.nih.gov/pubmed/17805340> Treatment:  
<https://search.proquest.com/openview/6e96bc65f5d0a5ea3fed099b00e47060/1?pq-origsite=gscholar&cbl=30566> Outcomes:  
[http://journals.lww.com/obgynsurvey/Citation/2003/08000/Perinatal\\_Substance\\_Abuse\\_Intervention\\_in.4.aspx](http://journals.lww.com/obgynsurvey/Citation/2003/08000/Perinatal_Substance_Abuse_Intervention_in.4.aspx) Adverse conditions:  
<https://publichealth.gwu.edu/departments/redstone-center/resilient-communities>;  
<http://www.sciencedirect.com/science/article/pii/S016503270400028X>

**Key Community Partners:** Family Resource Centers, First Five, Maternal and Child Health, Child Welfare Services, Mental Health Services, Pediatricians, Kaiser, DV agency, schools, law enforcement, Alcohol and Drug Programs, treatment providers, mental health services and community providers, Boys and Girls Club, On the Move, legal and immigration services, Maternal mood disorder program, FQHC, housing advocates and housing coalitions and ACES coalition.

**Resource Commitment:** funding, staffing, advocacy, partnership, convening

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3. **Initiative/Community Need being Addressed: Social Determinants of Health/Housing as Health.** The program addresses the gap in housing that is available and affordable for chronically homeless, precariously housed and lower income community members. FY17 Community health needs assessment identified socio-economic issues, housing and access to health care particularly for low-income vulnerable populations as significant health concerns.

**Goal (anticipated impact):** Support sustainable, collective efforts to reduce homelessness and improve availability and accessibility of housing that is affordable for low income and other vulnerable populations including those impacted by the Napa fire.

Outcome Measure	Baseline	FY18 Target	FY20 Target
Community-wide collaborative efforts expanding number of individuals (TBD) housed who were homeless or precariously housed	To be determined	To be determined	To be determined

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
Engaging as partner in Whole Person Care and Community Housing to stabilize housing for very low income chronically homeless individuals with mental health and substance abuse issues	Number of homeless individuals housed more than 6 months.	No individuals placed as yet	4 individuals remain in housing	12 individuals remain in housing
Provide recuperative shelter and supportive housing assistance for homeless or precariously housed individuals with medical needs	Number of clients provided recuperative housing	20 individuals served	25 individuals served	25 individuals served
Partner with a community collaborative to expand housing options and supply for low income individuals, seniors and families	Expanded housing supply for low income individuals and families	Pilot planned for accessory dwellings	To be determined	To be determined

**Evidence Based Sources:** Robert Wood Johnson Foundation Invest Health <https://www.investhealth.org/>, Whole Person Care Models [http://www.jsi.com/JSIInternet/Inc/Common/\\_download\\_pub.cfm?id=14261&lid=3](http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14261&lid=3), State of California and Federal Whole Person Care,

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Corporation for Supportive Housing, National Alliance to End Homelessness, [http://www.changelabsolutions.org/sites/default/files/Preserving\\_Affordable\\_Housing-POLICY-TOOLKIT\\_FINAL\\_20150401.pdf](http://www.changelabsolutions.org/sites/default/files/Preserving_Affordable_Housing-POLICY-TOOLKIT_FINAL_20150401.pdf); Perret Y , Dennis D : Improving Social Security disability programs for adults experiencing long-term homelessness; in Strengthening Social Security for Vulnerable Groups. Edited by Reno VP , Lavery J . Washington, DC, National Academy of Social Insurance, 2009. Accessory dwelling units: <http://www.hcd.ca.gov/policy-research/AccessoryDwellingUnits.shtml>. Zerger, S. An evaluation of the respite pilot initiative: Final report, 2006. Available at: <http://www.nhchc.org/Research/RespiteRpt0306.pdf> Kertesz, S, et al. Post hospital medical respite care and hospital readmission of homeless persons. Journal of Prevention and Intervention in the Community, 37(2), 129 42, April 2009 U.S. Interagency Council on Homelessness (2010). Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. (p.44 45) [http://www.usich.gov/PDF/OpeningDoors\\_2010\\_FSPPreventEndHomeless.pdf](http://www.usich.gov/PDF/OpeningDoors_2010_FSPPreventEndHomeless.pdf)

In 2017, SJHQV Community Outreach, along with other sponsors, supported a county-wide summit that focused on Housing for All in Napa County. Housing data and presentations identified the impact of lack of affordable and accessible housing on individuals, homeless, seniors, families and business. Best practice and innovation presentation highlighted several strategies including supportive housing for chronically homeless, small and second units and assisted living for older adults and disabled. Subsequently, SJHQV Community Outreach has participated in three community coalition efforts to plan and implement supportive housing options for chronically homeless mentally ill, respite care for homeless or precariously housed and Invest Health strategies aimed at helping residents expand housing through the development of second units. These are broad-based community, hospital and public health efforts that include policy change, systems integration and resource leveraging, funding, and economic sustainability efforts. Effort will include fire recovery planning.

**Key Community Partners:** Napa County Health & Human Services (Public Health, Homeless Services, Mental Health Services, Substance Abuse Services), City of Napa, Abode, Napa Valley Community Housing, Napa Valley Community Foundation, Partnership Health Plan, Nightingale House, McAllister, Exodus, Ole Health, Queen of the Valley Emergency Department, Police and Fire Departments, Probation, Gasser Foundation, Auction Napa Valley.

**Resource Commitment:** Funding, CARE Network staffing (community health workers, social workers, RN for Nightingale House and shelter support), partnership participation (Funders Coalition, Invest Health Leadership), community convening, consultant services and advocacy.

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**4. Initiative/Community Need being Addressed:** Social Determinants of Health: Economic Stability FY17 Community health needs assessment identified socio-economic issues, housing and access to health care, particularly for low income vulnerable populations, as significant health concerns. The CARE Network Program provides socio-economic and medical care coordination to low income vulnerable individuals with complex needs serving 500 + individuals along with additional caregivers and family members annually through a continuum of services and supports linked to community-based services, financial assistance and medical resources.

**Goal (anticipated impact):** Improved economic stability, access to basic needs and health management of 500 low income vulnerable adults along with additional caregivers and family members annually, including those who are homeless, have complex medical and socio-economic conditions and/or lack of access to essential medical, economic and social service resources.

Outcome Measure	Baseline	FY18 Target	FY20 Target
Percentage improvement in quality of life measures on validated SF12 survey from enrollment to discharge of low income, vulnerable clients	60% of clients show improvement	Maintain baseline	63% of clients show improvement

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
Provide social services care coordination to address socio-economic needs, meet basic needs and address economic stability of vulnerable, at-risk community members	Percentage of discharged clients with completed social services action plans that addressed basic needs and/or secured stabilizing services including shelter, food, and financial and other benefits.	Establish baseline	To be determined from baseline	To be determined
Stabilize income of homeless and precariously housed individuals with complex medical or psychosocial issues (i.e. substance abuse and mental health issues.)	Percentage of eligible individuals successfully enrolled in SSI/SSDI	58% (CA average)	Maintain baseline	Maintain baseline
Provide health care coordination to improve healthcare access for clients	Percentage improvement in hospitalizations and ED visits for	40% reduction in hospitalizations &	41% reduction in hospitalizations &	42% reduction & 70% reduction in

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with complex medical needs at risk for hospitalization or readmission referred from hospital and health care providers	new clients post enrollment compared to pre-enrollment	65% reduction in ED use	68% reduction in ED use	ED use
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**Evidence Based Sources:** Standards of Practice for Social Work and Nursing Case Management Implementation of best practices of models shown to be effective with specific and heterogeneous populations of high cost, high risk patients – adapted to the local community based context and client population (e.g., Chronic Care Management; Care Transitions Program, Interdisciplinary Teams for High Risk Frequent Users). Reducing Hospital Readmissions: Lessons from Top-Performing Hospitals. Commonwealth Fund, Synthesis Report, April 2011. Robert Wood Johnson: Solving Disparities [www.solvingdisparities.org](http://www.solvingdisparities.org)) Dartmouth Atlas: <http://www.dartmouthatlas.org/data/topic/topic.aspx?cat=3>. Health Care's Blind Side: The Overlooked Connection between Social Needs and Good Health," Robert Wood Johnson Foundation, Dec. 8, 2011. Raven et al.: An intervention to improve care and reduce costs for high-risk patients with frequent hospital admissions: a pilot study. BMC Health Services Research 2011 11:270. [https://www.strategyand.pwc.com/media/file/Strategyand\\_Healthcare-for-Complex-Populations.pdf](https://www.strategyand.pwc.com/media/file/Strategyand_Healthcare-for-Complex-Populations.pdf). [http://www.jsi.com/JSIInternet/Inc/Common/\\_download\\_pub.cfm?id=14261&lid=3](http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14261&lid=3). [http://journals.lww.com/lww-medicalcare/Abstract/2000/11000/Reliability\\_and\\_Validity\\_of\\_the\\_SF\\_12\\_Health.8.aspx](http://journals.lww.com/lww-medicalcare/Abstract/2000/11000/Reliability_and_Validity_of_the_SF_12_Health.8.aspx)

**Key Community Partners:** Ole Health FQHC, Practitioners, Hospital ED, Discharge and Social Work Napa County Health and Social Services (Substance Abuse Services, Mental Health Services, Eligibility, Public Health Adult Protective Services, Senior Services), Mentis, Collabria Care, County Probation, Food Bank, Abode, QVMC Inpatient Social Work, Homeless and Housing providers.

**Resource Commitment:** Staffing (RNs, Social workers, community health workers), funding for emergency aid.



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**5. Initiative/Community Need being Addressed:** Social Determinants of Health: Access to Healthcare. This program provides dental care for children 6 months to 26 years of age from low-income families who are Denti-Cal eligible or are uninsured/underinsured. 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. Children’s mobile dental serves approximately 25% of children in Napa living at or below 200% FPL, filling a critical gap for low income families.

**Goal (anticipated impact):** To reduce the economic burden on families and improve oral health status of 2000 children annually 6 months to 26 years of age in Napa County who are uninsured or underinsured.

Outcome Measure	Baseline	FY18 Target	FY20 Target
Percentage of low income patients who demonstrate oral health status improvement at recall visit based on a set of clinical criteria	92 percent	92 percent	93 percent

Strategy(ies)	Strategy Measure	Baseline	FY18 Target	FY20 Target
Provide early oral health screening and education in low income preschools and kindergartens	Number of low income children provided early screening for oral health problems	425 children	450 children	460 children
Provide mobile dental 6- months examinations and cleanings	Percentage of patients in random case review having seen a dentist within 6 months to one year following initial exam	90 percent	Maintain baseline	Maintain baseline
Provide patient/parent education on oral health	Percentage of patients/parents reporting improved oral health behaviors on survey.	97.8 percent FY17	Maintain baseline	Maintain baseline

**Evidence Based Sources:** American Academy of Pediatric Dentistry Recommendations [http://www.aapd.org/media/policies\\_guidelines/g\\_periodicity.pdf](http://www.aapd.org/media/policies_guidelines/g_periodicity.pdf). The California State Audit Report for 2013-2015 shows that only 41% of Medi-Cal beneficiaries under 21 had a dental visit in the past year in Napa County. This places Napa in the higher range of utilization for

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Medi-Cal, but still far below the target. (California Dept of Health Care Services: Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care. California State Auditor, December 2014.)

**Key Community Partners:** Preschools, schools and community sites (WIC, Family Resource Centers, Girls and Boys Club, SJH-QV, OLE Health Dental Clinic and local dental specialists, First 5 Napa

**Resource Commitment:** Funding, staffing, equipment, mobile dental clinic.

## Other Community Benefit Programs and Evaluation Plan

Initiative/Community Need Being Addressed:	Program Name	Description	Target Population (Low Income or Broader Community)
1. Perinatal Health	Perinatal Health Education	Perinatal classes on birth preparation, infant care, breastfeeding and safety	Broader Community
2. Childhood Obesity	Healthy for Life	A school – based obesity prevention program at 17 schools designed to emphasize lifelong fitness and healthy eating behaviors among children and adolescents	Low Income
3. Obesity	Cooking Matters	Series as cooking classes with nutritional education that helps participants serve low cost and health foods to their families	Broader Community
4. Address Social Determinants of Health: Educational 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 1300 parents annually to gain critical parenting and leadership skills to support their child’s academic success. Classes are bilingual.	Low Income
5. Address Social Determinants of Health: Economic Needs	Safety Net/Basic Needs	Small donations to community partners to provide for basic needs such as food, shelter and caregiving	Low Income
6. Access to Healthcare	Operation Access	Collaborative funding to implement access to diagnostic screening, procedures and surgeries for the uninsured	Low Income
7. Access to Healthcare	HIV Clinic	Collaborative with Ole Health to provide HIV clinic services to uninsured and low income	Low Income
8. Access to Healthcare	Farmworker Health Screening	Collaborative effort with Ole Health to screen migrant farmworkers for health concerns	Low Income
9. Community Partnerships for Health	Live Healthy Napa County	A county-wide collective action group of 40 organizations focused on a set of priorities linked to health equity and healthy communities	Broader Community
10. Community Partnerships for Health	Healthy Aging Population Initiative (HAPI)	HAPI is a coalition of 30 older adults serving organizations. HAPI assesses older adult need, advocates for policies that support older adults and develops collaborative strategies to address needs.	Broader Community

## Appendix

### Definition of Terms

**Community Benefit:** 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.

Community benefit includes both services to the 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:

- a. Community health needs assessment developed by the ministry or in partnership with other community organizations;
- b. 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; or
- c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

**Health Equity:** Healthy People 2020 defines *health equity* as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

**Social Determinants of Health:** Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual’s or population’s health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

**Initiative:** An initiative is an umbrella category under which a ministry organizes its key priority efforts. Each effort should be entered as a program in CBISA Online (Lyon Software). Please be sure to report on all your Key Community Benefit initiatives. If a ministry reports at

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the initiative level, the goal (anticipated impact), outcome measure, strategy and strategy measure are reported at the initiative level. Be sure to list all the programs that are under the initiative. Note: All Community Benefit initiatives must submit financial and programmatic data in CBISA Online.

**Program:** A program is defined as a program or service provided to benefit the community (in alignment with guidelines) and entered in CBISA Online (Lyon Software). Please be sure to report on all community benefit programs. Note: All community benefit programs, defined as “programs”, are required to include financial and programmatic data into CBISA Online.

**Goal (Anticipated Impact):** The goal is the desired ultimate result for the initiative’s or program’s efforts. This result may take years to achieve and may require other interventions as well as this program. (E.g. increase immunization rates; reduce obesity prevalence.).

**Scope (Target Population):** Definition of group being addressed in this initiative: specific description of group or population included (or not included, if relevant) for whom outcomes will be measured and work is focused. Identify if this initiative is primarily for persons living in poverty or primarily for the broader community.

**Outcome measure:** An outcome measure is a quantitative statement of the goal and should answer the following question: “How will you know if you’re making progress on goal?” It should be quantitative, objective, meaningful, and not yet a “target” level.