

FY 2012 Community Benefit Report



**St. Joseph Health Queen of the Valley
Fiscal Year 2012 COMMUNITY BENEFIT REPORT
PROGRESS ON FY 12-FY 14 CB PLAN/IMPLEMENTATION STRATEGY**



EXECUTIVE SUMMARY

Our Mission

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

Our Vision

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

Our Values

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

Who We Are and What We Do

For over fifty years St. Joseph Health, Queen of the Valley (SJH, QV) has been a vital resource and integral part of the Napa Valley community. A full-service acute care 191 bed medical center, SJH, QV employs approximately 1,404 employees. The medical center is located within the City and County of Napa, and is the major diagnostic and therapeutic medical center for Napa County and the surrounding region. 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.

The health of our community depends on the creation and maintenance of strong physical and social structures, which promote and contribute to the wellbeing of those who live in Napa County. In total, for fiscal year 2012 St. Joseph Health, Queen of the Valley contributed **\$27,024,860 in community benefit**, excluding unreimbursed costs of Medicare. This represents a **3% increase** from FY 11 (from \$26,120,587). The unreimbursed cost of Medicare services totaled **\$30,286,559** representing an **18% increase** from FY 2011 (from \$25,677,124).

The following provides a detailed comparison to FY 11:

- The unreimbursed costs of Medicaid and other means-tested government program services increased in FY 12 by 15% (from \$16,765,671 in FY 11 to \$19,292,694 in FY 12) due to the impact of the Hospital Provider Fee which had an increased net cost impact of approximately \$3.5 million and \$4.6 million in FY 11 and FY 12 respectively.
- Community programs and services for the poor increased by 18% (from \$2,015,100 in FY 11 to \$2,383,208 in FY 12).
- Community services for the broader community decreased by 5% in FY 12 related to shift of focus to increase services and programs for the poor.
- Charity care decreased in FY 12 by 37% (from \$5,077,561 in FY 11 to 3,200,773 in FY 12) primarily due to FY 11 reclassification of prior years' bad debt to charity care.

- The number of persons who were provided charity care decreased by 46% (from 11,258 people to 6,039 people), primarily due to FY 11 reclassification of prior years' bad debt to charity care.

Patient Financial Assistance Program

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why St. Joseph Health, Queen of the Valley has a **Patient Financial Assistance Program** that provides free or discounted services to eligible patients. In FY 12 St. Joseph Health, Queen of the valley provided **\$3,200,773** in charity care to 6,039 persons. This represents a 37% decrease in charity care (from \$5,077,561 in FY 11) and a 46% decrease in number of persons receiving charity care (from 11,258 in FY 11) primarily due to FY 11 reclassification of prior years' bad debt to charity care.

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Community Plan Priorities

Based on identified community needs, SJH, QV provides and/or supports an extensive matrix of well organized and coordinated community benefit service programs and activities, which include:

- Community-based chronic disease management for low-income persons living with chronic illness,
- Mobile Dental Clinic services for low-income children,
- Obesity prevention initiatives including a school-based program "Healthy For Life", "Cooking Matters" a program offering free, six-week-long series of cooking and nutrition classes to low-income families, support to develop a community breastfeeding coalition,
- Behavioral health initiatives including perinatal emotional wellness and counseling, a community-based behavioral health program for underserved older adults, and behavioral health services for underserved chronically ill,
- Community education and empowerment initiatives addressing the social determinants of health such as; Parent University, bilingual community health education, and perinatal education,
- Partnerships for community health providing support for community collaborative efforts toward meeting identified community needs such as asthma coalition, healthy aging, Community Health Clinic Ole (FQHC), Adult Day Services, infant car seat distribution and installation, family resource centers to name a few.

INTRODUCTION

Who We Are and What We Do

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Key medical center services include a community cancer center accredited by the American College of Surgeons (ACOS) with commendations, as well as accreditation in radiation oncology by the American College of Radiology (ACR) and the American Society for Radiation Oncology (ASTRO). The Queen also supports a regional heart center, robotic and minimally invasive surgery center, acute rehabilitation center, Napa County's only level III emergency trauma center, women's health center, and the area's only neonatal intensive care unit. The Queen is committed to community wellness and is one of the first acute care providers to successfully develop and implement a medical fitness center, Synergy, in the Wellness Center on the medical center campus.

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

Since its beginning, St. Joseph Health, Queen of the Valley extended its role far beyond the traditional medical model and has dedicated itself to serving as a catalyst in promoting and safeguarding the health of the community.

We continue our commitment to work collaboratively as a key community partner to enhance the health and quality of life for Napa County's most vulnerable communities. Through the Community Outreach Department, SJH, QV provides programs and community support to address unmet or critical health related needs and improve the health of the community at-large, particularly for low-income underserved community members. Community Outreach works in concert with community partners to expand access, leverage resources, and address broad community concerns.

The following highlight a few key community benefit programs:

CARE (Case Management, Advocacy, Resources, and Education) Network

- Without adequate health insurance, income, and support, managing a chronic illness such as diabetes or heart failure can be extremely costly and difficult. The **CARE Network** provides disease management, socio-economic and behavioral health interventions, and promotion of disease self-management utilizing an interdisciplinary RN, social work, behavioral and spiritual health approach. In FY 12, CARE Network clients had a **60% decrease** in emergency room visits, and a **53%** decrease in hospitalizations, and demonstrated an overall **increase in quality of life** as measured through a validated survey tool (SF12v2).

Children's Mobil Dental Clinic

- To address an identified community need in 2005, SJH, QV launched a **Children's Mobile Dental Clinic**. In response to heightened need in FY 2011, a new mobile dental vehicle was launched, increasing the number of dental chairs from two to three. In FY 12, the clinic provided over **4,000 clinic visits** at 10 sites extending comprehensive dental services to more than 2,200 low-income Napa County children. In addition to clinic visits, it was identified that low-income children with extensive treatment needs had little to no access to oral surgery in Napa County. SJH, QV mobile dental clinic gained access to oral surgery for low-income children utilizing SJH, QV's outpatient surgery center.

Childhood Obesity Prevention

- "**Healthy for Life**" is a school-based obesity prevention program designed to emphasize lifelong fitness and healthy eating behaviors among children and adolescents. The program incorporates physical assessments by pediatricians, the provision of training and exercise equipment to schools, as well as guest instructors for a variety of classes including kick boxing, circuit training and nutrition. In FY 12, we enhanced program access, increasing the number of participating schools by 55% (from 11 to 17). Among the 446 students assessed, 14.5% (24) of the 165 students classified as overweight or obese at the beginning of the school year improved their weight status by yearend. In addition, **41%** of participating students **increased healthy lifestyle** choices. For the 102 student participants identified by the pediatrician with high BMI, high blood pressure, signs of diabetes, and/or scoliosis, physician follow-up was provided.

Behavioral Health

- Access to low cost mental health services ranked as a top priority in the last two community health needs assessments for Napa County. To address this need, SJH, QV took a multipronged approach. In 2006 SJH, QV launched a **postpartum depression program** providing free counseling and referral services for pregnant and postpartum women. In 2008 SJH, QV **integrated behavioral health** into the chronic disease management program, **CARE Network**, providing free mental health services to low-income chronically ill clients. Most recently, in FY 12 SJH, QV partnered in the launch of

“**Healthy Minds, Healthy Aging**”, a community-based behavioral health initiative for underserved older adults at risk for behavioral or cognitive health issues. Services are bilingual Spanish/English and include cognitive and behavioral health assessments, case management, behavioral health sessions/therapy sessions, as well as community presentations, caregiver training and support, and health care provider outreach and training.

Community Education and Empowerment

- **Parent University** is an initiative in partnership with Napa Valley Unified School District (NVUSD) and a local nonprofit, On the Move that is designed to create a learning environment for parents to gain critical parenting and leadership skills. Addressing the social determinants of health, a series of over **55 parent classes** were provided to over **900 parents** at four Title I elementary schools. Course topics included effective parenting techniques, healthy lifestyles, family literacy intervention, introduction to parent teacher conference, how to prepare your child for college, introduction to computer use, how to be an effective volunteer, and leadership training.



Community Partnerships for a Healthier Napa County

- Our mission calls us to improve the health and quality of life of our community and we realize the need to partner with others to make this a reality. To this end SJH, QV provided over **\$590,747** in cash and in kind support to **over 45** local nonprofit organizations offering critical safety net resources to Napa’s most vulnerable including mental health, food security programs, housing programs, domestic violence shelter, teen pregnancy program, gang tattoo removal program, Boys & Girls Club nutrition program, Operation with Love from Home (providing care packages to U.S. troops abroad), Napa County Health and Human Services, Birth Choice Health Clinic, senior services, VIA Foundation, and Napa County family resource centers. Annual required reporting demonstrates thousands of individuals and families were provided critical services through these partnerships.

Community Benefit Investment 2011 and 2012

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Community Benefit Governance Structure

The St. Joseph Health, Queen of the Valley Board of Trustees and Administration take an active and informed role in the development and oversight of the Community Benefit Strategic Plan and initiative reports. Meeting nearly monthly (8 months in FY 12), the Community Benefit Committee (CBC) is composed of trustees, the SJH, QV CEO, executive management, physicians, and community representatives, and is staffed by SJH, QV Community Outreach employees. The CBC serves as an extension of the Medical Center's Board of Trustees and is charged with overseeing and directing SJH, QV's Community Benefit activities including: budgeting decisions, program content, geographic/population targeting, program continuation/termination, fund development support and community wide management. In addition, community benefit plans, processes and programs reflect both the SJH strategic corporate and entity goals and objectives.

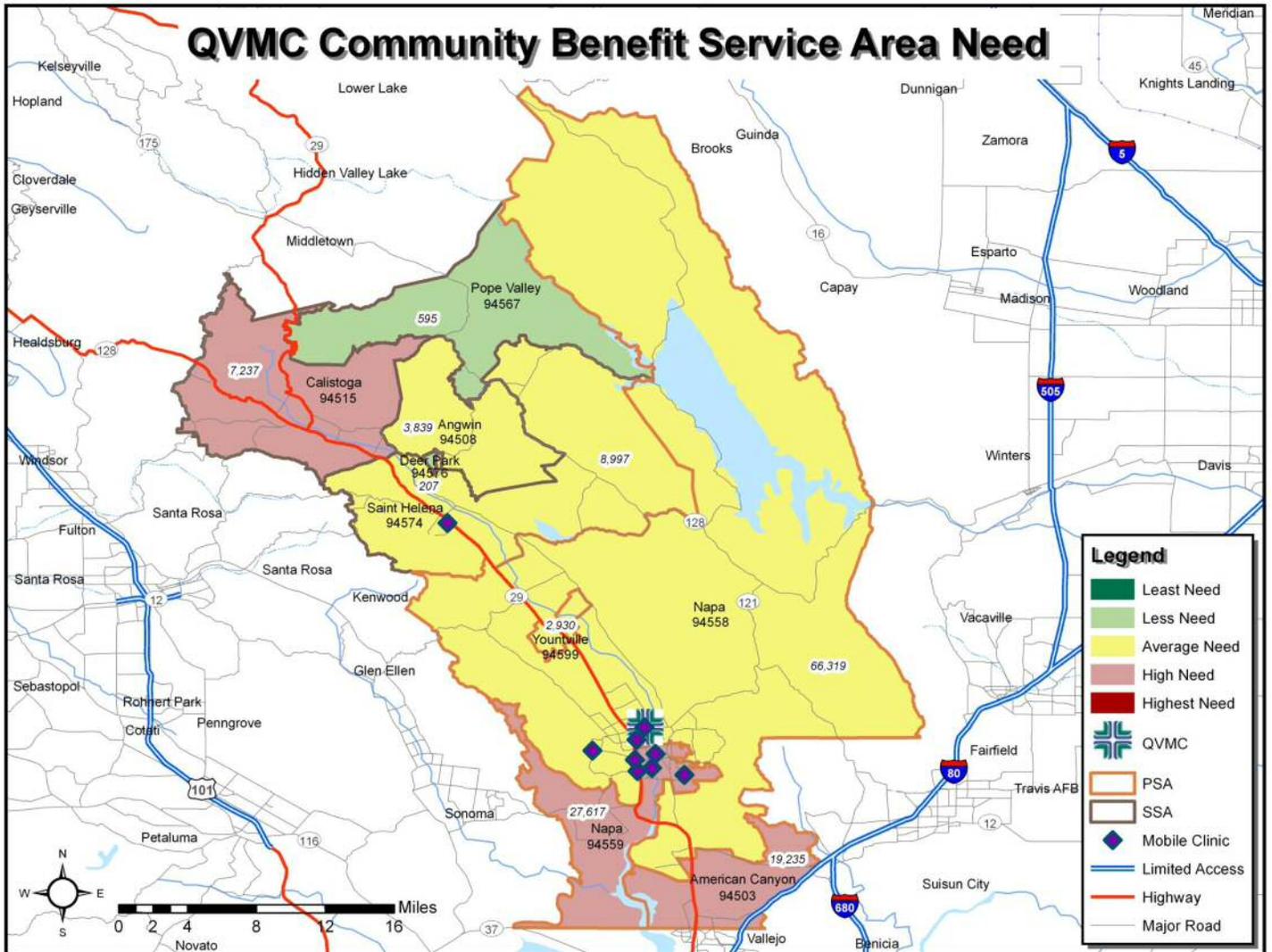
St. Joseph Health, Queen of the Valley demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The Vice President of Mission Integration and Executive Director for Community Outreach are responsible for coordinating implementation of California Senate Bill 697 provisions 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 carrying out the Community Benefit Plan.

The Community Benefit Management Team provides orientation for all new Medical Center employees on Community Benefit programs and activities, including opportunities for participation. Key opportunities for SJH, QV employee participation in community benefit activities for FY 2012 included: cooking and serving monthly soup kitchen meals; quarterly employee blood drives; migrant worker health fairs, Meals on Wheels delivery; Gang Tattoo Removal Program, American Cancer Society Relay for Life; and Operation with Love From Home.

Overview of Community Needs and Assets Assessment

SJH, QV conducts a community health needs assessment every three years. The FY 2010 process consisted of a Napa County Needs Assessment Collaborative of health organizations and funders, including SJH, QV, Kaiser Foundation Health Plan, St. Helena Hospital, Napa County Public Health, Community Health Clinic Ole, and Auction Napa Valley. The assessment process includes an extensive review of existing data as well as conducting English and Spanish language community surveys, focus groups and interviews. Four locations—Napa, Calistoga, St. Helena, and American Canyon—were chosen to ensure geographic representation and nine community focus groups were conducted at sites intended to draw populations that typically gathered there. Key community-based organizations were identified by the Collaborative and asked to host a focus group. Focus groups were co-scheduled at the sites among participants who were already meeting there for other purposes (e.g., young mothers at a parenting class) to facilitate access and promote attendance. In addition the process obtains the community's perspectives about health needs and potential solutions for responding.

Our community benefit primary and secondary service areas (PSA and SSA) are defined by the geographic boundaries of Napa County. In general, the county is divided into four regions: North County consisting of Calistoga, St. Helena, Deer Park, Rutherford, and Oakville; East County consisting of Angwin, Pope Valley, and Lake Berryessa; Central County consisting of Napa and Yountville, and South County consisting of American Canyon. Of Napa County's nearly 139,000 residents 57% live in the City of Napa; however American Canyon is the second largest and fastest-growing city in the county. Our community benefit PSA includes Central and South County, the cities of Napa, Yountville, and American Canyon. Community SSA includes the remaining cities of North and East County.



St. Joseph Health, Queen of the Valley
FY 12 – FY 14 Community Benefit Plan/Implementation Strategies
FY 12 CB Priority Initiative Accomplishments

Disease Case Management for Low-Income Chronically Ill

CARE Network (Case Management, Advocacy, Resources, & Education)

Chronic disease is among the most prevalent and costly of all health problems. Adequate management of chronic diseases is difficult enough for persons with financial resources and social support; however, for those with few financial resources and/or social supports chronic disease management can be overwhelming. Research has demonstrated that chronic disease care is most effective in an outpatient care setting. Use of the emergency department and inpatient hospital care is costly and less effective in improving the quality of life for patients with chronic conditions. As a result, SJH, QV has developed the CARE Network, an American Hospital Association NOVA award winning program, to enable community dwelling residents with chronic disease access to disease management and social services maximizing wellness and quality of life.

Key Community Partners: Adult Day Services of Napa Valley, Community Health Clinic Ole (FQHC), Family Services of Napa Valley, Hospice of Napa Valley, Food Bank, Legal Aid of Napa Valley, local healthcare providers, Napa Community Housing, Napa County Comprehensive Services for Older Adults (CSOA), Napa County Health and Human Services, State Office of AIDS, St. Joseph Health Queen of the Valley's Synergy Medical Fitness Center, Cardiac Rehabilitation, Discharge Planning, and Cancer Center

Target Population: Low-income, chronically ill Napa County residents, their families and caregivers.

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

Scope: All CARE Network clients

How will we measure success?: Community-based disease management requires assistance with medical resources as well as assistance with basic needs such as food and housing. The desired result is that client has an increased understanding of his or her chronic disease, an increased ability to successfully manage at home, and ultimately an improved quality of life. Therefore the measure of success is the median change score on a quality of life survey (SF12v2). The quality of life survey is conducted upon program entry and again after 3 months or at closure to the program (depending on which occurs first).

Three-Year Target: By 6/30/2014 increase the median change score of SF12v2 from baseline (5.13) to 7.5

FY 12 Progress: FY 12 median change score is 5.61

Strategy 1: Deliver necessary medical resources.

Strategy Measure 1: The self-management skills score (SMS) is an evaluation tool completed by case management staff that scores the client in abilities such as knowledge of illness, physical mobility, financial stability, support systems, and ability to obtain and take medications as prescribed, to name a few. Of the 383 CARE Network clients served in FY 12, 292 had both admission and discharge self-management scores for evaluation. Of these 292 clients, 39% (115) showed improved self-management score.

In addition to improved SMS, all 383 CARE Network clients and their caregivers received education and coaching regarding their chronic disease and management. For the 201 clients newly enrolled to services a total of **271 referrals to medical services** such as primary care physicians, specialists, pharmacy, hospice, outpatient palliative care program, cardiac rehabilitation, cancer rehabilitation, and/or adult day services were provided.

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

Strategy Measure 2: Measured by the number of benefits applied for compared to the number of benefits granted within a six month period. Benefits include health insurance (County, State, or Federal), income benefits (State or Federal), veteran's benefits, and caregiving (IHSS). For the 201 clients newly enrolled into service in FY 12, social workers assisted application for benefits on 149 occasions of which 71% (106) were granted.

In addition to benefits, referrals and applications for basic needs were provided for housing (145 occasions), food (344 occasions), and for transportation (273 occasions). Altogether over **900 referrals** for benefits and basic needs were provided.

Strategy 3: Enhance disease self-management.

Strategy Measure 3: CARE Network clients demonstrated an average **60% reduction in ED visits** when compared to pre enrollment (from 29.24 average monthly visits to 11.52 average monthly visits).

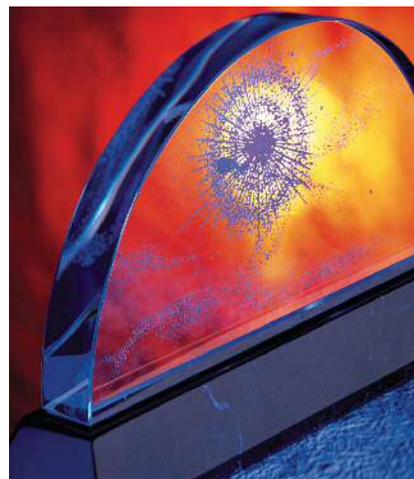
Additionally, clients demonstrated a **53% reduction in hospitalizations** (from 19.68 average monthly to 9.09 average monthly).

Another self-reported disease management indicator relates to our client survey administered by Avatar in which clients are asked "My ability to take care of myself has increased as a result of the care received." Of the 34 survey respondents, 88% replied they agree or strongly agree that they are better able to take care of themselves as a result of CARE Network services.

FY 12 Accomplishments:

American Hospital Association (AHA) NOVA Award

Recipient: This year SJH, QV's CARE Network was one of five hospitals across the nation to receive the prestigious AHA NOVA Award. This award recognizes hospitals that improve community health status through collaborative efforts within the community.



Additional Services: CARE Network services assist the caregiver and/or family as well as the client. For example, financial assistance to purchase food or pay utilities provides support to the entire household. In FY 12 comprehensive community-based disease management services were provided to 383 clients (up from 375 in FY 11), and to 696 household members. Aside from these enrolled clients and household members, an additional 333 non-enrolled individuals seeking social services received brief case management and social service counseling, for a total of **1,412 individuals served** in FY 12.

Medical Fitness Monitored Exercise Program: Recognizing the physical and mental health benefits of increased strength and endurance, we established a partnership with SJH, QV's medical fitness center to sponsor low-income chronically ill clients through a specialized monitored exercise program. This year 34 clients received medical fitness membership services with a total of 642 monitored visits.

Community Care Conferencing: In an effort to improve systems of care through coordination and monitoring among key community partners, CARE Network developed and implemented a coordination of care conference for complex cases on an as needed basis. This successful program component involves multiple agencies from the public and private sector as indicated by the needs of the client.

Dental Care for Low-Income Children

Children's Mobile Dental Clinic

The importance of oral health in the context of overall health and quality of life cannot be underscored. For children, oral pain or discomfort impacts the ability to concentrate in school, the ability to eat a healthy diet, and can lead to serious infection and other medical problems. In light of a community needs assessment indicating a need for oral health care for Napa's low-income children, SJH, QV implemented the Children's Mobile Dental Clinic in 2005.



Key Community Partners: Browns Valley Elementary School, Child Development Programs, Dos Mundos, Harvest Middle School, Los Niños, Menlo, Napa County Child Start Programs, Napa County Health and Human Services Napa County Office of Education, Napa Valley Language Academy, Napa Valley Unified School District, Phillips Elementary School, Puertas Abiertas Family Resource Center, Shearer Elementary School, St. Helena High School, Therapeutic Child Care Center, , Valley Oak Alternative High School

Target Population: Low-income, uninsured and under-insured children 6 months to 21 years of age in Napa County.

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

Scope: Mobile Dental Clinic Patients

How will we measure success?: Percent of patients who demonstrate oral health improvement at recall visit based on set of clinical criteria

Three-Year Target: 6/30/2014, increase percentage from baseline (90%) by 10%

FY 12 Progress: Of 340 random chart audits performed, 309 (91%) of children had **improved oral health** status at follow up visit.

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

Strategy Measure 1: In 2006, the State of California passed legislation (Assembly Bill 1433 (Emmerson/Laird)) requiring that children have a dental check-up by May 31 of their first year in public school, at kindergarten or first grade. This year we provided oral health screenings at 16 different low-income preschool sites to a total of **556 children**, over 400% increase from FY 11 (103). Also, as a new measure beginning January 2012, all 21 children identified without dental homes were referred to a dental home.

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

Strategy Measure 2: In FY 12, a total of 2,579 children were seen for exam and cleaning, 507 of these were new patients. As a new measure beginning January 2012, 80.5% of patients (1,338 of 1,662) returned for regular checkups between 6-9 months.

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

Strategy Measure 3: A routine component of every exam, 2,625 patients received oral health instruction in FY 12. Additionally, based on Avatar satisfaction survey given to the parents, 87% of 175 parent respondents report improved oral health behaviors, 94% of 178 parent respondents report having a better understanding of the importance of healthy teeth, and 93% of parent respondents report they are better able to assist their child with brushing and flossing as needed.

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

Strategy Measure 4: Of the 2,249 children served in FY 12, 1,932 procedures were required (fillings, extractions, pulpotomy, root canals, crowns, scaling and root planning, space maintainer). Of 240 random chart audits performed, 198 (82.5%) of children who received treatment had reduced caries at follow up.

FY 12 Accomplishments:

Sedation Dentistry: Low-income Napa County children requiring extensive oral treatment had no local access to sedation or oral surgery. In response to this identified need SJH, QV's mobile dental director, in collaboration with SJH, QV's outpatient surgery center, implemented access to oral surgery for low-income children. Sedation or oral surgery is reserved for those children requiring full mouth restoration and treatment. This year **9 low-income children** received access to sedation or oral surgery at SJH, QV decreasing the stress and trauma of extensive oral treatment without sedation, while receiving this service within their own community.



Endodontic: Children who require root canals are often in pain with potential nutritional and medical complication if treatment is not obtained. These endodontic services (root canals and crowns) for permanent teeth are extremely costly, severely limiting access for our low-income families. In response to this gap in access to endodontic care, our dentist received training and certification to provide this critical service. This year **6 children received endodontic** treatment for their adult teeth through our mobile dental clinic.

Prevention: Preventing oral health problems is a key priority for our mobile dental team. Parent education begins when the child is 6 months of age and continues with every follow up visit for exams and cleanings. Dental sealants are one strategy to decrease the incidence of cavities. In addition to increase in parent knowledge, improved oral health behaviors of the child, and the extensive number of exams and cleanings performed for low-income children, the mobile dental team applied dental sealants to 882 teeth.

Reducing Prevalence of Childhood Obesity in Napa County

Childhood obesity in the United States has more than tripled in the past thirty years, and carries both immediate and long-term health impacts. Children and adolescents who are obese are at greater risk for bone and joint problems, sleep apnea, and are more likely than normal weight peers to be teased and stigmatized which can lead to poor self-esteem. Moreover, obese youth are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure. Finally, overweight and obese youth are more likely than normal weight peers to be overweight or obese adults and are therefore at risk for the associated adult health problems, including heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis. In Napa County, 17% of preschool children ages 2-4 living in households with an income less than 200% of the federal poverty level were obese with BMI's above the 95th percentile (Napahealthmatters.org). In an effort to address this critical health issue, Queen of the Valley has implemented a variety of initiatives targeting newborns to entire families.

Healthy for Life

St. Joseph Health adopted a system-wide, school-based childhood obesity prevention program titled “**Healthy for Life**,” designed to emphasize lifelong fitness and healthy eating behaviors among children and adolescents. The program incorporates physical assessments by pediatricians, the provision of training and exercise equipment to schools, as well as guest instructors for a variety of classes including kick boxing, circuit training and nutrition.



Breastfeeding Education

Studies show that breastfeeding reduces risk of obesity. According to the Children Now 2010 report card, rates of breastfeeding in the hospital are on a downward trend from 2008. SJH, QV provided \$5,000 in community benefit support and in-kind staff time toward the development of a community **breast feeding coalition**.

Community Nutrition Education

Coordinated and implemented through SJH, QV community benefit is “**Cooking Matters**,” a program offering free, six-week-long series of cooking and nutrition classes to low-income families. Classes are taught by volunteer culinary and nutrition instructors working in teams. In addition to Cooking Matters, SJH, QV offers bilingual community health education specific to nutrition and healthy lifestyle behaviors in over 10 underserved locations throughout Napa County.



Key Community Partners: Catholic Charities, Children and Weight Treatment Coalition, Community Health Clinic Ole (FQHC), family resource centers, Harvest Pediatrics, Kaiser Permanente, Napa Breastfeeding Coalition, Napa Community Housing, Napa County Health and Human Services, Napa Valley Pediatrics, Napa Valley Unified School District, Rainbow House, School Health Committee, Synergy Medical Fitness Center, UC Cooperative kitchen, 8 elementary schools, 5 middle schools, 4 high schools



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

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

Scope: Students participating in Healthy for Life program, pregnant and postpartum women attending breastfeeding education classes and health care providers that provide education or support for breastfeeding.

How will we measure success?:

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

Three-Year Target: By FY 2014 increase percentage by 10% of baseline (baseline is 62%).

FY 12 Progress: Of 365 respondents from two programs; breastfeeding (93 respondents) and Healthy for Life (272 respondents) 52% report increased knowledge. By program, 41% (112 of 272) Healthy for Life respondents reported increased knowledge and 92% (112 of 272) of breastfeeding respondents reported increased knowledge.

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

Strategy Measure 1: Implemented in Napa County in FY 09, FY 12 marks our fourth year expanding the Healthy for Life program within our schools. In FY 12, the number of participating schools **increased by 55%** (from 11 to 17). Of the new schools four were elementary including one lower elementary class. Over 1,000 students participated in some portion of Healthy for Life exercise and nutrition classes; however, only **446 students** were captured for both the beginning and end of school year assessments. Of these 446 students, **41%** showed **improved healthy lifestyle** choices by survey. The number of student contacts at Healthy for Life nutrition and physical education classes was 9,172 (duplicated).

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

Strategy Measure 2: For the 102 student participants identified as obese (BMI greater than 95th percentile), with high blood pressure, signs of diabetes, and/or scoliosis, physician follow-up was provided. Among the 446 students assessed, **14.5%** (24) of the 165 students classified as overweight or obese (BMI greater than 85th percentile) at the beginning of the school year **improved their weight** status by yearend.

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

Strategy Measure 3: Bilingual community health education is provided at over 10 underserved locations throughout Napa County. Curriculum specific to general nutrition constitutes 15 of the classes provided serving 178 participants. Of these participants, 71% reported improved topic knowledge and 73% reported improved confidence to adopt topic behaviors. Also, 19 classes specific to breastfeeding with 221 participants were provided in FY 12. In addition to these educational classes, SJH, QV implemented and coordinates "Cooking Matters" a program offering free, six-week-long series of cooking and nutrition classes to low-income families. Classes are taught by volunteer culinary and nutrition instructors working in teams. In FY 12, 106 persons participated in Cooking Matters and of those 100% reported an increased knowledge of healthy behaviors, and 100% reported increased confidence to adopt the healthy behaviors.

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

Strategy Measure 4: In FY 12 two community-wide breastfeeding trainings for healthcare providers were conducted through Napa Breastfeeding Coalition. A total of 184 healthcare providers participated.

FY 12 Accomplishments:

Healthy for Life School Engagement

To accomplish program expansion to engage 17 Napa County schools, 9 middle school/high school physical education (PE) teachers and 15 elementary school teachers received a full day of Healthy for Life training to incorporate this curriculum into PE classes. Participating schools receive a community benefit donation of fitness equipment for student use. In addition, SJH, QV's medical fitness center contributes a rich variety of resources to the Healthy for Life program including a Registered Dietician and exercise instructors. 446 students completed data collection (beginning and end of school year assessments), a **79% increase** from FY 11 (260).

Behavioral Health

Perinatal Emotional Wellness, Healthy Minds Healthy Aging, CARE Network Behavioral Health

Research indicates that mental health disorders are among the most important contributors to the burden of disease and disability nationwide. Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. Access to low cost mental health services ranked as a top priority in the last two community health needs assessments for Napa County. To address this need, SJH, QV took a multipronged approach. In 2006 SJH, QV launched a **perinatal emotional wellness program** providing free counseling and referral services for pregnant and postpartum women experiencing depression and other behavioral health concerns. In 2008 SJH, QV **integrated behavioral health** into the chronic disease management program, **CARE Network**, providing free mental health services to low-income chronically ill clients. Most recently, in FY 12 SJH, QV partnered in the launch of “**Healthy Minds, Healthy Aging**”, a community-based behavioral health initiative for underserved older adults at risk for behavioral or cognitive health issues. Services are bilingual Spanish/English and include cognitive and behavioral health assessments, case management, behavioral health sessions/therapy sessions, as well as community presentations, caregiver training and support, and health care provider outreach and training.

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

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

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

Scope: Clients of Perinatal Emotional Wellness, CARE Network, or Healthy Minds, Healthy Aging programs.

How will we measure success?: Percentage of clients that reduce depression as measured through PHQ9

Three-Year Target: By 6/30/2014 increase percentage of clients that improve PHQ9 depression score by 10% of baseline (baseline 57%).

FY12 Progress: For clients that completed the pre and post treatment PHQ9, 58% (32 of 55) improved depression.

Strategy 1: Provide universal screening for depression

Strategy Measure 1: Referrals to behavioral health are identified through a variety of processes including the Edinburg Depression Scale (EPDS) for perinatal wellness, the SF12v2 screen for CARE Network, and the PHQ2 for the Healthy Aging program. For all 3 programs, a total of 1,454 persons had universal screening for depression conducted.

Strategy 2: Conduct assessment of needs

Strategy Measure 2: Once clients are enrolled in a behavioral health program, clinicians use the PHQ9 depression scale to assess progress. For all 3 programs, 146 clients were assessed for depression by behavioral health clinicians using the PHQ9. Of these, 76% (111) had PHQ9 scores of 5 or above indicating depressive symptoms appropriate for treatment. In addition to depression assessment, clients were assessed for other basic needs. For clients served, referrals and warm hand offs were provided on over 400 occasions to community resources and services including food and housing.

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

Strategy Measure 3: For all three programs, 477 individuals received behavioral health intervention for a total of 752 sessions/interventions. For CARE Network, 20 clients required and were referred for additional behavioral health services and 100% of these clients received these additional services.

FY 12 Accomplishments:

Although SJH, QV has provided or supported behavioral health services for low-income, vulnerable members of the community over the years, FY 12 is the first year we collectively standardized outcome measures and strategies for all behavioral health programs. As new measures for FY 12, baseline data collection time frame was 9/1/2011 – 3/31/2012. Not all report data represents a full year due to planning and implementation time required to collect and track data.

St. Joseph Health, Queen of the Valley

FY 12 – FY 14 Community Benefit Plan/Implementation Strategies

FY 12 CB Priority Initiatives Accomplishments

Community Education and Empowerment

One approach for addressing social determinants of health is to provide education and facilitate empowerment for vulnerable populations. SJH, QV is a primary provider of community health education among low-income Spanish-speaking community members in Napa. We provide health education that seeks to teach community members how to prevent health problems, navigate the system of care, enhance health and wellness and empower changes that can contribute to health now and in the future. Whereas Napa is not considered a “poor” county, the substantial wealth of a disproportionate small number of Napa residents skews the economic indicators for a sizeable portion of the population. According to 2012 Migration Policy Institute Profile of Immigrants in Napa County, Latinos are leading the county’s population growth. Twenty six percent of households in Napa County are immigrant households. For the 2008 -09 school year Latinos were 46% of students in Napa County public schools, the majority were English language learners. Disparities are evident in academic achievement and health. Between 2002 and 2009, 11.3% of Latino high school graduates in NVUSD were eligible to enter the UC/CSU system, as compared to 31.6% of their White peers. Additionally, the 2010 Napa Community Health Needs Assessment identified an ongoing need for health education aimed at prevention of health problems particularly for those disproportionately affected by health conditions.

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



Key Community Partners: Adult Education, Head Start, McPherson Elementary School, Napa Community Housing, Napa County Health and Human Services, Napa Valley Community Foundation, Napa Valley Unified School District (NVUSD), On the Move, Parents CAN, Philips Elementary School, Puertas Abiertas, Salvador Elementary School, Shearer Elementary School

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

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

Scope: Participants of Parent University, perinatal education and community health education programs.

How will we measure success?: Percentage of participants who report improved self-efficacy as measured through surveys and questionnaires.

Three-Year Target: By 6/30/2014 decrease the self-efficacy gap by 10 percent. Baseline measure is 88% with a 12% gap. A 10% gap reduction represents 1.2% gain in self-efficacy.

FY 12 Progress: In FY 12 84% (553 of 651 respondents) reported improved self-efficacy

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

Strategy Measure 1: 100% of classes utilize culturally appropriate tools (curricula, materials, and visuals). 100% of classes are provided in the language of the participants, either English or Spanish. Of the 749 survey respondents, 95% report programs as culturally appropriate

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

Strategy Measure 2: Bilingual community health education classes are provided at over 10 underserved community locations utilizing 12 different class curriculums with a total of 753 participant contacts. **Parent University** consists of 50 different class curriculums and is conducted at 4 different underserved elementary schools with a total of 5,691 parent participants. **Perinatal** education workshops offer more than 15 different curriculums, are taught both in the community and at SJH, QV targeting the broader community with a total of 2,468 participant contacts. **80% of class participant respondents (593 of 739) report improved knowledge**

FY 12 Accomplishments:

Profile of Immigrants in Napa County: In FY 11 SJH, QV provided a community benefit in the amount of \$5,000 in support of Napa Valley Community Foundation (NVCF) to commission the Migration Policy Institute to provide a profile of the county's immigrants using the most up-to-date data. Key findings around county demographic changes, economic wellbeing, housing and commuting, immigrants in the Napa County workforce, immigrant contributions to county, economic growth, and fiscal impacts were analyzed. Once published, NVCF facilitated community dialogues in a variety of venues and forums in an effort to educate the community with factual data and gain a better understanding of the Napa community now as well as planning for the future.

Community Navigator Trainings: On a quarterly basis, SJH, QV conducts trainings for frontline community navigators, staff from other organizations that provide community resource information and referral assistance in the community. In FY 12 we had over 150 attendees including staff from family resource centers, Childstart, Clinic Ole, Napa Valley Unified School District, Migrant Education, VOICES (emancipated foster youth), Even Start, and Children's Health Initiative. We invited speakers from the 16-20 agencies covered over the year which

included legal aid, the Mexican consulate, cultural competence, child protective services, Talent Search (Napa Valley College), and Youth Drug and Alcohol services.

Other Community Benefit Initiatives

Community Partnerships for Community Health

Our mission calls us to improve the health and quality of life of our community and we realize the need to partner with others to make this a reality. To this end SJH, QV provided over **\$590,747** in cash and in kind support to **over 45** local nonprofit organizations offering critical safety net resources to Napa's most vulnerable including mental health, food security programs, housing programs, domestic violence shelter, teen pregnancy program, gang tattoo removal program, Boys & Girls Club nutrition program, Operation with Love from Home (providing care packages to U.S. troops abroad), Birth Choice Health Clinic, senior services, and Napa County family resource centers. Annual required reporting demonstrates thousands of individuals and families were provided critical services through these partnerships.

The following highlight a few key community partnerships.

Community Health Clinic Ole

SJH, QV is dedicated to improving the health and quality of life for our entire community, including our community's most vulnerable. To this end, we partner with Napa's Federally Qualified Health Center, Community Health Clinic Ole (CHCO) to support a variety of programs and services totaling **\$108,000** in community benefit.



Cancer Screening and Oncology Clinic: As the result of an identified community need, in FY 11 SJH, QV, CHCO, and Redwood Oncology developed an **oncology clinic for the uninsured**. This clinic is scheduled by and staffed with an **in-kind SJH, QV RN and social worker**, an oncologist and is conducted at CHCO. In FY 12, 49 oncology clinic visits were provided for uninsured cancer patients. In addition to in kind staff time, SJH, QV provides a cash donation to CHCO supporting the oncologist's services. SJH, QV also supports CHCO women's cancer screening program and colon cancer screening program for a total **\$65,000** cash donation for cancer detection and care.

HIV Clinic: In FY 12 a community benefit in the amount of **\$36,000** to CHCO provides an HIV physician specialist to conduct **HIV clinic** for Napa County HIV positive individuals. This clinic is also staffed with **SJH, QV in kind RN and social work**. This year 195 clinic visits were provided for 30 HIV positive clients.

Adult Dental: SJH, QV contributed **\$ 2,772** toward the provision of **dental services for older adults**. An identified community need, this partnership with Sister Ann Dental Clinic, under the FQHC umbrella of CHCO, provided older adults with dental care and treatment including preventive care, dentures, extractions, fillings, root canals, and crowns.

Migrant Farm Worker Health Screenings: This year SJH, QV participated with CHCO to provide health screenings at 4 low-income housing sites in Napa County, contributed a community benefit of **\$4,037** toward supplies as well as in kind RN and Community Care Aid time. Services include cholesterol and blood sugar screenings. A total of 300 individuals were served.

Napa Valley Adult Day Services: Alzheimer's Care

Adult Day Services provides professional care and respite for families and caregivers of individuals with Alzheimer's disease and other cognitive and mental health issues. These groups of individuals are at high risk for institutionalization. With pending state budget cuts and diminishing resources toward Adult Day Services, SJH, QV provided a community benefit in the amount of **\$44,000** to sustain this critical community program.



Healthy Aging Planning Initiative (HAPI)

With 15.7 % of all residents over the age of 65, Napa County has a higher proportion of older residents than California as a whole (2010 Napa Community Health Needs Assessment). Queen of the Valley recognizes the importance of a community benefit focus on the needs of older adults. This community benefit of **\$40,000** supported the county wide collaborative Healthy Aging Planning Initiative (HAPI), which brings together senior-serving organizations throughout Napa Valley to network, coordinate services and outreach to older adults, address service gaps, and advocate for supportive community-based services that protect and enhance the independence of Napa's seniors.

Children's Health Initiative (CHI)

Queen of the Valley and the SJH are founding partners of the Children's Health Initiative Napa County. This public-private partnership established in 2005 ensures that all children in our community have access to comprehensive, quality healthcare. This year SJH, QV provided a community benefit in the amount of **\$25,000** toward health insurance enrollment and retention for Napa County children.



Community Health Needs Assessment

In FY 12 Queen of the Valley contributed community benefit in the amount of **\$25,000** plus in kind staff time toward the upcoming community health needs assessment. This is a highly collaborative effort with Napa County Health and Human Services, Napa Coalition of Nonprofit Agencies, Kaiser Permanente, and St. Helena Hospital. Once implemented, the 18 month process "Live Healthy Napa County" promises to engage the community through a variety of venues to complete comprehensive data collection, needs and assets assessments, as well as a community health improvement plan.

Community Benefit Investment FY 2012

FY12 COMMUNITY BENEFIT INVESTMENT
ST. JOSEPH HEALTH, QUEEN OF THE VALLEY
(ending June 30, 2012)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services ¹	FY12 Net Benefit
Medical Care Services for Vulnerable² Populations	Financial Assistance Program (FAP) (Charity Care-at cost)	\$3,200,773
	Unpaid cost of Medicaid ³	\$15,688,803
	Unpaid cost of other means-tested government programs	\$3,603,891
Other benefits for Vulnerable Populations	Community Benefit Operations	\$1,896,863
	Community Health Improvements Services	\$293,891
	Cash and In-kind Contributions for Community Benefit	\$82,450
	Community Building	\$0
	Subsidized Health Services	\$110,004
Total Community Benefit for the Vulnerable		\$24,876,675
Other benefits for the Broader Community	Community Benefit Operations	\$1,553,269
	Community Health Improvements Services	\$79,239
	Cash and In-kind Contributions for Community Benefit	\$508,297
	Community Building	\$2,000
	Subsidized Health Services	\$0
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	\$5,380
	Total Community Benefit for the Broader Community	
TOTAL COMMUNITY BENEFIT (excluding Medicare)		\$27,024,860
Medical Care Services for the Broader Community	Unpaid cost of Medicare ⁴ <i>(not included in CB total)</i>	\$30,286,559
TOTAL COMMUNITY BENEFIT (including Medicare)⁴		\$57,311,419

¹ Catholic Health Association-USA Community Benefit Content Categories, including Community Building.

² CA SB697: "Vulnerable Populations" means any population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medicaid, Medicare, California Children's Services Program, or county indigent programs. For SJH, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.

³ Accounts for Hospital Fee. The pledge/grant (separate from the quality assurance fee) is reported in Cash and In-kind Contributions for other vulnerable populations.

⁴ Unpaid cost of Medicare is calculated using our cost accounting system. In Schedule H, we use the Medicare cost report.

Telling Our Community Benefit Story: Non-Financial⁵ Summary of Accomplishments

SJH, QV recognizes that the health of our community depends on the creation and maintenance of strong structures, both physical and social, which promote and contribute to the wellbeing of those who live in Napa County. Our mission calls us to improve the health and quality of life of our community, and we partner with others to make this a reality.

In FY 12, SJH, QV leadership and staff **contributed over 450 hours** of community service and volunteer hours for efforts toward feeding the hungry, bereavement support, Birth Choice Health Clinic, holiday assistance, care packages for troops abroad, migrant farm worker health



fairs, Napa Valley AIDS Walk, teen mom support group, and Stop Falls Napa Valley home assessments. In addition, SJH, QV representation on community board of directors includes staff on Birth Choice Health Clinic, Catholic Charities, Justin Sienna High School, Napa Nonprofit Coalition, Napa Valley Community Foundation, Napa Valley Hospice and Adult Day Services, and Parent Child Advocacy Network.

In addition to volunteerism, SJH, QV offers in-kind use of conference room space for 18 community support groups and a variety of community coalition meetings.

⁵ Non-financial summary of accomplishments are referred to in SB697 as non-quantifiable benefits.

St. Joseph Health

500 S. Main St., Ste. 1000
Orange, CA

<http://www.stjhs.org/>

St. Joseph Health (SJH) is an integrated healthcare delivery system providing a broad range of medical services. The system is organized into three regions--Northern California, Southern California, and West Texas/Eastern New Mexico - and consists of 14 acute care hospitals, as well as home health agencies, hospice care, outpatient services, skilled nursing facilities, community clinics, and physician organizations. The ministries that comprise SJH offer a wide variety of services within each of the three regions. From well-established acute care hospitals to clinics in non-traditional settings like school rooms, SJH is establishing a "continuum of care," that is, a system that links and coordinates an entire spectrum of health services.