ST. JOSEPH HEALTH QUEEN OF THE VALLEY

FY20 Community Benefit Report
Progress on FY18-FY20 Community Benefit Plan/Implementation Strategies Report

St. Joseph Health
Queen of the Valley

A member of Providence St. Joseph Health
To provide feedback about this *Community Benefit Plan/Implementation Strategy Report*, email
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EXECUTIVE SUMMARY

St. Joseph Health, Queen of the Valley Medical Center (Queen of the Valley), is a member of Providence St. Joseph Health. Providence St. Joseph Health is a new organization created by Providence Health & Services and St. Joseph Health with the goal of improving the health of the communities it serves, especially those who are poor and vulnerable.

Queen of the Valley Medical Center is an acute-care hospital located in Napa, California founded by the Sisters of St. Joseph of Orange in 1958. The facility has 208 licensed beds and a campus that is approximately 12.3 acres in size. Queen of the Valley has 1,687 caregivers including both physicians and employees and 140 volunteers. 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 caregivers 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.

Community Benefit Investment

St. Joseph Health, Queen of the Valley invested $ 33,487,837 in community benefit in FY 2020 (FY19). For FY20, St. Joseph Health, Queen of the Valley had an unpaid cost of Medicare of $41,076,079.

FY18-FY20 CB Plan Priorities/Implementation Strategies

In FY18 the hospital implemented the following strategies addressing priorities as developed in its FY18-FY20 Community Benefit Implementation Plan.

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:

Social Determinants of Health: Access to Health Care

To address the identified community need related to the cost of dental care for un- or underinsured families, Queen of the Valley launched a Children's Mobile Dental Clinic in 2005. Currently as one of only three providers of dental care for low income or Medi-Cal eligible children in Napa County, Queen of the Valley strives to meet this continued community need. This fiscal year our mobile dental clinic provided **over 3750** clinic visits to low-income children in Napa County.

Social Determinants of Health: Economic Stability

Economic stability ranked as a priority on the FY17 CHNA. To address socio-economic issues, housing and access to health care, particularly for low income vulnerable populations, the CARE Network Program, a nationally recognized, award winning community-based program, provides socio-economic and medical care coordination to low income vulnerable individuals with intensive and complex needs through a continuum of services and supports linked to community-based services, financial assistance and medical resources. Services are provided in the clients' home or as needed in a healthcare provider office or other community service location such as homeless shelters and respite care. To address improved access to critical medical and social supports and provide a continuum of care from hospital to outpatient settings, SJH Queen of the Valley expanded the scope of service of the CARE Network to include transitional care, addressing the unique needs of patients recently discharged from inpatient care or at risk for hospitalization, particularly those patients with complex medical conditions as well as difficult socio-economic needs such as housing insecurity and basic needs deficits. Extensive coordination with community partners to access resources and support vulnerable patients contributes to outcomes.

In FY20, Care Network served 1175 clients through medical and social services care coordination and case management. The CARE Network ED Social Worker provided 621 brief ED encounters. The Transitional Care Team cared for 318 unduplicated clients. CARE Network SOAR specialists submitted 37 applications for SSI/SSDI for homeless and mentally ill and substance use disabled clients. Twenty applications have been approved, 3 applications are pending and 6 applications

remain in the appeal process. CARE Network has been integral to housing efforts aimed at the homeless population providing system linkages and case management.

Social Determinants of Health: Housing

FY17 CHNA identified socio-economic issues, housing and access to health care particularly for low-income vulnerable populations as significant health concerns. SJHQV Community Outreach and CARE Network are working directly and in coordination with key community partners to develop 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 recent fires.

Innovative strategies to expand housing for vulnerable individuals though landlord mitigation activities, damage guarantees, meeting market rates through subsidies, bonuses and assisting individuals with first and last month rent has enabled placement of households and individuals that were previously homeless. Coordination among partner agencies, care management, financial aid and enrollment assistance have provided better outcomes in stabilizing housing for these high risk individuals. In addition, through collaborative efforts of CARE Network, Nightingale Respite Services, and Abode Housing Services, many individuals discharged from Respite Care are sheltered or housed rather than returning to the street. Partners continue to explore supportive housing units and situations that can provide wrap-around care for vulnerable and disabled individuals who would likely remain homeless without such support.

Access to Behavioral Health: Mental Health

Access to low cost mental health services continues to rank as a priority in the FY17 CHNA. To address this need, Queen of the Valley took a multipronged approach with three integrated mental health programs that promote screening of targeted populations for depression, offer brief therapeutic interventions (1-18 sessions) and/or referrals to more intensive services and navigating 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.

In FY20 Behavioral health programs serving perinatal women and their families, older adults and clients in complex care management demonstrating mental health issues served 1367 clients and provided over 4100 therapeutic sessions, encounters, and other encounters (telephonic therapy).

Access to Behavioral Health: Substance Use

Substance Use was identified as a priority in the FY17 Community Health Needs Assessment. A community coalition formed to address perinatal substance use and abuse and piloted screening using an evidence-based tool, 4Ps Plus. An implementation planning process to address perinatal substance use and will continue through FY 2020.

To develop a countywide perinatal substance use integrated continuum of care, a 20 member steering committee of 12 organizations representing health and social welfare services has met regularly to execute a strategic vision for a system of care. The committee strategic plan developed over 2019 included the following goals areas: (1) Build accountable relationships between providers and patients; (2) Address policies and barriers to ensure all women remain connected to care; (3) Increase SUD harm reduction and treatment for perinatal women; (4) pilot perinatal SUD counselor and navigator to assist perinatal providers and programs to support women with SUD concerns. (Grant funding and a contract for this position was secured.)

In early 2020, the broader steering committee, divided into 2 core action planning workgroups: Policy and Protocol and Continuum of Care/Practice. The aim of the Policy Workgroup is to (1) Examine current institutional practices and policies related to women with or at risk for Substance Use Disorder and (2) Determine policies and protocols that are patient and family-centered and improve response to and coordination among institutional partners related to Perinatal SUD. The aim of the Continuum of Care/Practice Workgroup is to determine recommendations regarding patient and family-centered and evidence-based or practice models along a continuum from prevention to treatment that can be leveraged or developed and implemented in Napa. Workgroup action planning ended in March 2020 due to Covid-19 restrictions.

In addition to the perinatal work, SJHQV has supported access to substance abuse treatment with funding support for underinsured or uninsured at the local treatment and Detox center. This has facilitated timely warm-handoff for patients requiring these services. The contracted navigator works to facilitate timely access to services for adult patients requiring SUD treatment.

PROVIDENCE ST. JOSEPH HEALTH

Providence St. Joseph Health is an organization created by Providence Health & Services and St. Joseph Health with the goal of improving the health of the communities it serves, especially those who are poor and vulnerable.

Together, our 119,000 compassionate caregivers serve in 51 hospitals, 829 clinics and a comprehensive range of services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. The Providence St. Joseph Health family includes: Providence Health & Services, St. Joseph Health, Covenant Health in West Texas, Facey Medical Foundation in Los Angeles, Hoag Memorial Presbyterian in Orange County, Calif., Kadlec in Southeast Washington, Pacific Medical Centers in Seattle, and Swedish Health Services in Seattle.

Bringing these organizations together is a reflection of each of our unique missions, increasing access to health care and bringing quality, compassionate care to those we serve, with a focus on those most in need. By coming together, Providence St. Joseph Health has the potential to seek greater affordability, achieve outstanding and reliable clinical care, improve the patient experience and introduce new services where they are needed most.

It begins with heritage

The founders of both organizations were courageous women ahead of their time. The Sisters of Providence and the Sisters of St. Joseph of Orange brought health care and other social services to the American West when it was still a rugged, untamed frontier. Now, as we face a different landscape – a changing health care environment – we draw upon their pioneering spirit to guide us through these transformative times.

Providence Health & Services

In 1856, Mother Joseph and four Sisters of Providence established hospitals, schools and orphanages across the Northwest. Over the years, other Catholic sisters transferred sponsorship of their ministries to Providence, including the Little Company of Mary, Dominicans and Charity of Leavenworth. Recently, Swedish Health Services, Kadlec Regional Medical Center and Pacific Medical Centers have joined Providence as secular partners with a common commitment to serving all members of the community. Today, Providence serves Alaska, California, Montana, Oregon and Washington.

St. Joseph Health

In 1912, a small group of Sisters of St. Joseph landed on the rugged shores of Eureka, Calif., to provide education and health care. The ministry later established roots in Orange, Calif., and expanded to serve Southern California, the California High Desert, Northern California and Texas. The health system established many key partnerships, including a merger between Lubbock Methodist Hospital System and St. Mary Hospital to form Covenant Health in Lubbock Texas. Recently, an affiliation was established with Hoag Health to increase access to services in Orange County, Calif.

MISSION, VISION, AND VALUES

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

Our Vision
Health for a Better World

Our Values
Compassion

Dignity

Justice

Excellence

Integrity

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), a member of Providence St. Joseph Health, lives out the tradition and vision of community engagement set out hundreds of years ago. Providence St. Joseph Health is a new organization created by Providence Health & Services and St. Joseph Health with the goal of improving the health of the communities it serves, especially those who are poor and vulnerable.

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greater affordability, achieve outstanding and reliable clinical care, improve the patient experience and introduce new services where they are needed most.

Established in Napa California nearly 60 years ago, St. Joseph Health Queen of the Valley Medical Center is an acute-care hospital located in Napa, California founded by the Sisters of St. Joseph of Orange in 1958. The facility has 208 licensed beds and a campus that is approximately 12.3 acres in size. Queen of the Valley has 1,687 caregivers including both physicians and employees and 140 volunteers. 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.

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.

COMMUNITY BENEFIT INVESTMENT

St. Joseph Health, Queen of the Valley invested $ 33,487,837 in community benefit in FY 2020. For FY20, St. Joseph Health, Queen of the Valley had an unpaid cost of Medicare of $41,076,079.

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 Northern California Regional Director of Community Health Investment (CHI) and the Manager of CHI at 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 7 Board of Trustees, 11 community members, and 7 Providence St. Joseph Health caregivers. 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, Providence 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

Patient Financial Assistance Program

The St. Joseph Health (SJH) Financial Assistance Program helps to make our health care services available to everyone in our community needing emergent or medically necessary care. This includes people who do not have health insurance and are unable to pay their hospital bill, as well as patients who do have insurance but are unable to pay the portion of their bill that insurance does not cover. In some cases, eligible patients will not be required to pay for services; in others, they may be asked to make partial payment. At St. Joseph Health, Queen of the Valley, our commitment is to provide quality care to all our patients, regardless of their ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance or are worried about their ability to pay for their care. This is why we have a Financial Assistance Program for eligible patients. In FY20, St. Joseph Health, Queen of the Valley ministry, provided $2,646,747 free and discounted care following a policy providing assistance to patients earning up to 500% of the federal poverty level. This resulted in 2306 patients receiving free or discounted care.

For information on our Financial Assistance Program click here.

Medi-Cal (Medicaid)

Queen of the Valley Hospital provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California. In FY20 Queen of the Valley Medical Center, provided $21,391,502 in Medicaid shortfall. The hospital provided service to 18,472 Medicaid participants in FY20.

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 the comprised of both the Primary Service Area (PSA) as well as the Secondary Service Area (SSA) and is established based on the following criteria:

- PSA: 70% 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

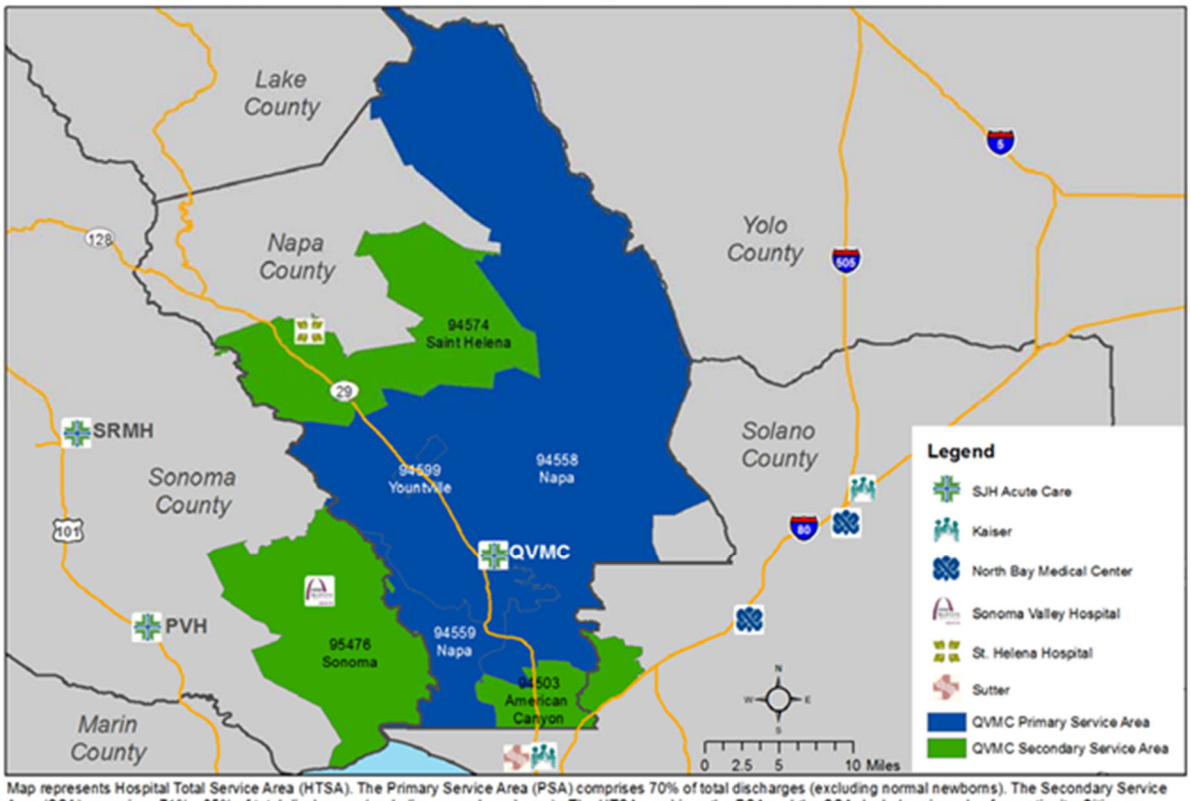
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients resides. The PSA is comprised of the cities of Napa and Yountville. The SSA is comprised 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.

Queen of the Valley (QVMC) Hospital Total Service Area



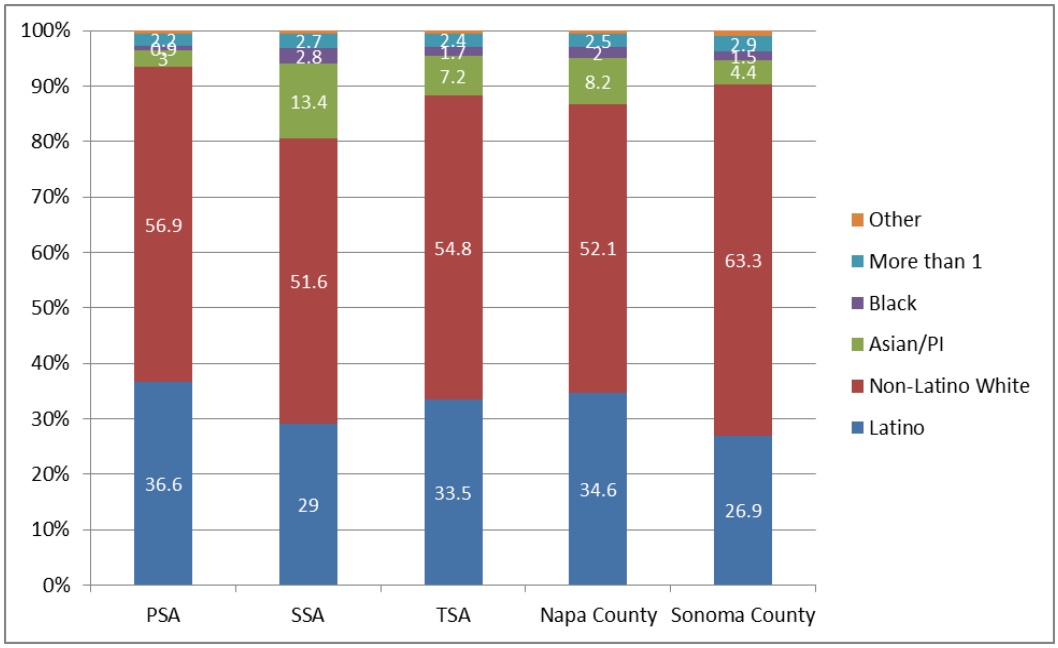
Map represents Hospital Total Service Area (HTSA). The Primary Service Area (PSA) comprises 70% of total discharges (excluding normal newborns). The Secondary Service Area (SSA) comprises 71% - 85% of total discharges (excluding normal newborns). The HTSA combines the PSA and the SSA. Includes zip codes for continuity. Cities are placed in either PSA or SSA, but not both. SRMH = Santa Rosa Memorial Hospital; PVH = Petaluma Valley Hospital.
Prepared by the St. Joseph Health Strategic Services Department, April 2016.

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):

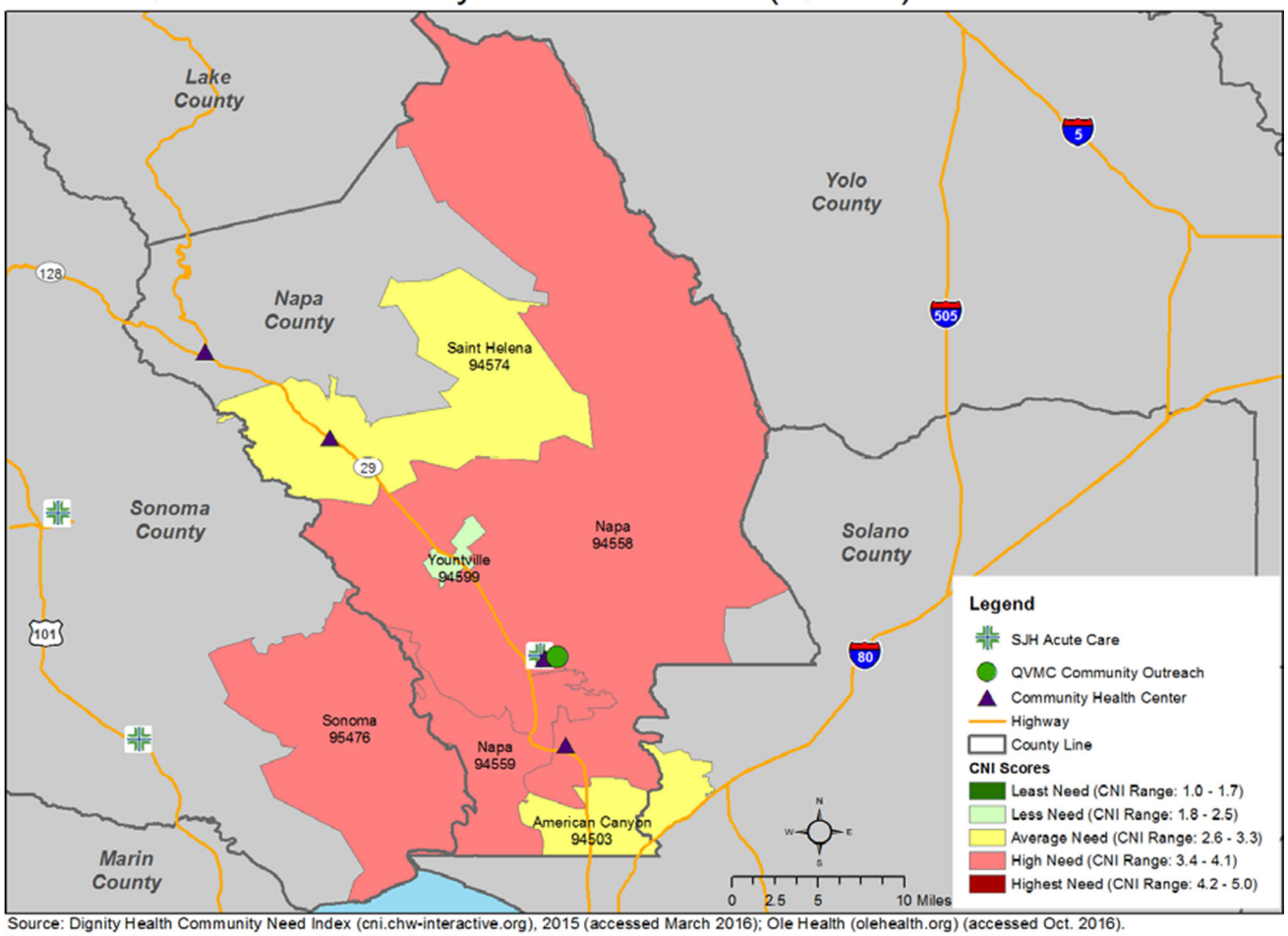
- Income Barriers (Elder poverty, child poverty and single parent poverty)
- Culture Barriers (non-Caucasian limited English);
- Educational Barriers (% population without HS diploma);
- Insurance Barriers (Insurance, unemployed and uninsured);
- Housing Barriers (Housing, renting percentage).

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

(Ref (Roth R, Barsi E., Health Prog. 2005 Jul-Aug; 86(4):32-8.) The CNI is used to a draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources. For example, the ZIP code 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 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 & 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.

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 was 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 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, 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 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 ones 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.

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 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 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 Use Disorder
- 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.

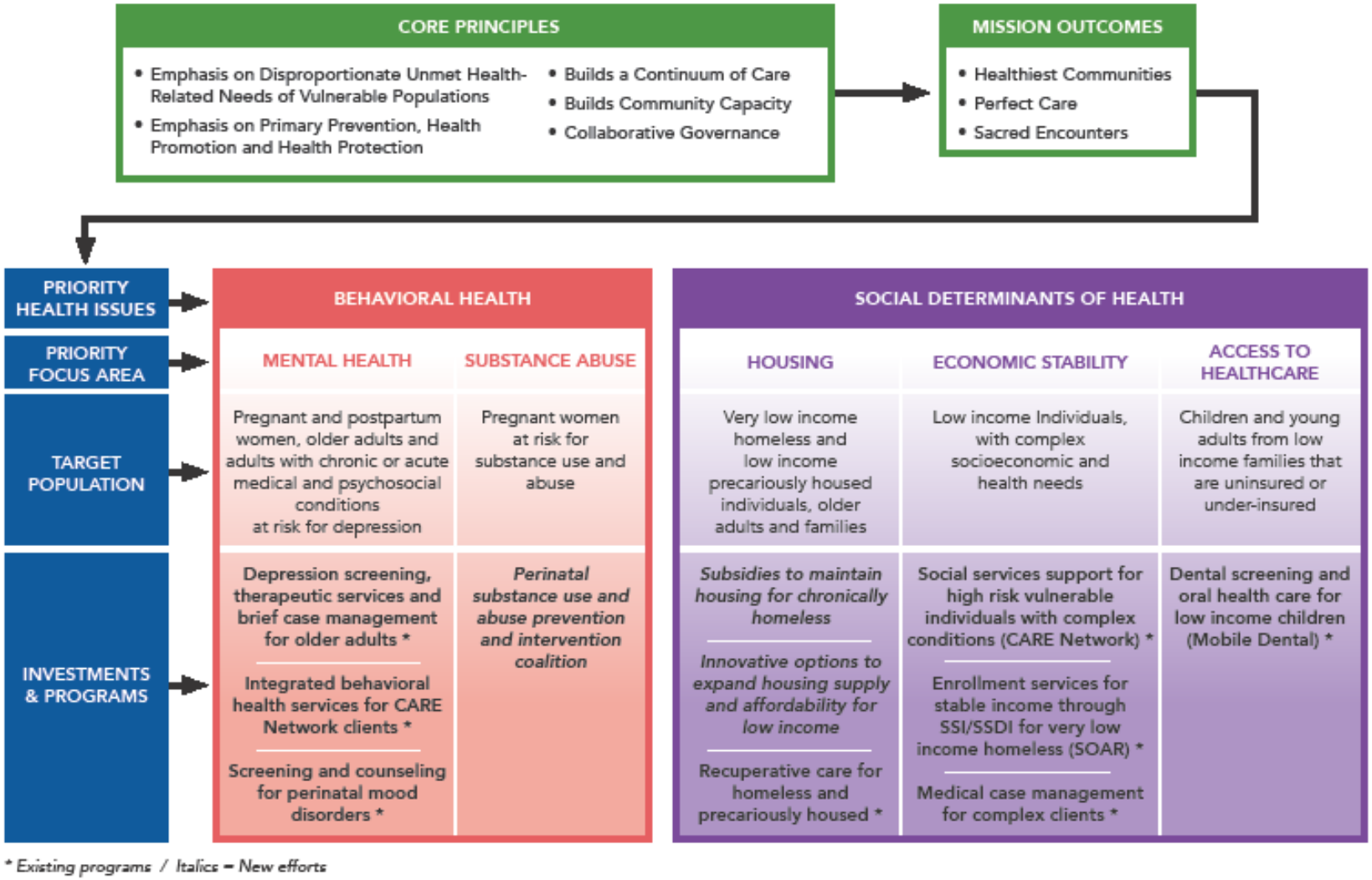
This process yielded this final draft plan. The strategic initiatives proposed to CBC reflect an ongoing commitment to both community collaboration and priorities and support for critical services that address identified needs.

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.

St. Joseph Health
Queen of the Valley

Community Benefit Plan Framework
FY18 - FY20



* *Existing programs / Italics = New efforts*

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

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 Results	FY19 Results	FY20 Results
Percentage of clients that improve depression indicators as measured through validated tools (PHQ9)	65% of all discharged clients	90% of all discharged therapy clients	81.6% of all discharged therapy clients	62% of all discharged therapy clients

Strategy(ies)	Strategy Measure	Baseline	FY18 Results	FY19 Results	FY20 Results
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 completing pre and post PHQ9	100% of discharged perinatal clients (31/31)	98% of discharged clients (39/40)	56% of discharged perinatal clients (40/73)
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	83% of discharged older adult clients (48/58)	51% of discharged older adults (30/59)	84.33% of discharged older adults (52/78)
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	New tool - To be determined	No data yet available	No data yet available.	No data available

	on validated tool (SF12)				
Provide behavioral health services for complex care clients with positive screens for depression	Percentage of clients with improved depression on PHQ9 from enrollment to discharge	72% of discharged complex care clients	100% of discharged complex care clients (15/15)	96% of discharged clients (23/24)	100% of discharged clients (3/3)

Evidence-based: https://www.integration.samhsa.gov/integrated-care-models/older-adultsChapman 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. 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), 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.

FY20 Accomplishments:

Behavioral health programs serving perinatal women and their families, older adults and clients in complex care management demonstrating mental health issues served 1367 clients and provided over 4100 therapeutic sessions, encounters, or other encounters (telephonic).

Due to the Covid-19 pandemic, in March of 2020 all therapeutic sessions and encounters began to be conducted virtually. The need for mental health assistance was exacerbated throughout Napa County. Our professionals seamlessly transitioned from in person therapy to virtual sessions.

FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan
FY20 Accomplishments

2. **Initiative/Community Need being Addressed:** **Substance Use** 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 substanceabuse. 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 Results	FY 19 Results	FY20 Results
To be developed based on planning coalition research of appropriate measures	Partners agreed to develop comprehensive approaches to address perinatal substance use and abuse	Broad framework developed. Community data collection to test assumptions conducted. Implementation Plan to be completed 12/31/18	Action Plan with specific policy, program and training strategies adopted	The committee strategic plan was developed.

Strategy(ies)	Strategy Measure	Baseline	FY18 Results	FY19 Results	FY20 Results
Build a broad-based local coalition of community	Local coalition develops a	Key partners convened	Trained 20 interviewers and	Conducted analysis of information and	Creation of 2 core action planning workgroups:

and public agency partners to address issues of perinatal substance use/abuse	comprehensive, collective plan to prevent and intervene in perinatal substance use and abuse		conducted innovative community data collection using empathic interviews and provider online survey. Plan to be completed 12/18	developed key strategies based on consumer and provider input	Policy and Protocol and Continuum of Care/Practice
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	No decisions finalized. To be completed by December 30, 2018.	Targeted 3 primary areas for policy and practice change: CWS policy clarification, Public charge review and action steps; provider practices that address trauma and SDoH; policy work underway	The aim of the Policy Workgroup is to (1) Examine current institutional practices and policies related to women with or at risk for Substance Use Disorder and (2) Determine policies and protocols that are patient and family-centered and improve response to and coordination among institutional partners related to Perinatal SUD.
Educate professionals community wide (including non-QVMC affiliated professionals), and the public on perinatal substance use impacts and best	Number of professionals educated and public education efforts implemented	No plan yet developed	Survey conducted to assess training needs. No decisions finalized. To be completed by December 30, 2018.	Conducted seminar for providers on trauma informed care; scheduled additional seminar for hospital staff. Training scheduled for 4Ps Plus	Conducted seminar on trauma informed care, "The Science of Healing" training for 44 QVMC caregivers and 35 Napa County Community Partners. Conducted 4 P's training for 13 QVMC

practices				from NIT/Chasnoff for OB staff.	caregivers and 20 Napa County Community Partners.
Implement integrated patient education, screening and interventions to change patient substance use behaviors	To be determined	To be determined	No decisions finalized. To be completed by December 30, 2018	Hired navigator to assist in interventions. Updating screening protocols and tools for intervention. Training staff in intervention skills.	Prepared to onboard Perinatal SUD counselor and navigator to assist perinatal providers and programs to support women with SUD concerns.

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 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

FY20 Accomplishments:

During FY2020, the county-wide Perinatal SUD Steering Committee continued to develop the following goals areas: (1) Build accountable relationships between providers and patients; (2) Address policies and barriers to ensure all women remain connected to care; (3) Increase SUD harm reduction and treatment for perinatal women; (4) pilot perinatal SUD counselor and navigator to assist perinatal providers and programs to support women with SUD concerns. (Grant funding and a contract for this position was secured.)

In early 2020, the broader steering committee, divided into 2 core action planning workgroups: Policy and Protocol and Continuum of Care/Practice. The aim of the Policy Workgroup is to (1) Examine current institutional practices and policies related to women with or at risk for Substance Use Disorder and (2) Determine policies and protocols that are patient and family-centered and improve response to and coordination among institutional partners related to Perinatal SUD. The aim of the Continuum of Care/Practice Workgroup is to determine recommendations regarding patient and family-centered and evidence-based or practice models along a continuum from prevention to treatment that can be leveraged or developed and implemented in Napa. Workgroup action planning ended in March 2020 due to Covid-19 restrictions.

FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan
FY20 Accomplishments

3. **Initiative/Community Need being addressed: Social Determinants of Health/Housing is 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	FY18Results	FY19 Results	FY20 Results
Community-wide collaborative efforts expanding number of individuals (TBD) housed who were homeless or precariously housed	To be determined	52 homeless individuals housed through collaborative effort that includes county, CBOs, SJHQV CARE Network	46 households with 78 individuals housed	46 homeless individuals permanently housed

Strategy(ies)	Strategy Measure	Baseline	FY18 Results	FY 19 Results	FY20 Results
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 30 days.	No individuals placed as yet	16 individuals enrolled in WPC housed more than 30 days	19 additional individuals enrolled in WPC and housed more than 30 days.	12 individuals enrolled in WPC housed more than 30 days
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	70 individuals served	81 individuals provided respite and case mgmt. support	59 individuals provided respite and case mgmt. support. 8 individuals were

					permanently housed. 10 individuals were temporarily housed.
Collaborate with community partners to expand housing options and supply for low income and homeless individuals, seniors and families	Expanded housing supply for low incom , homeless individuals and families	Pilot to provide flexible housing funds to address issues for those who may not meet criteria for housing subsidies but will face or are homeless	Established fund that attracted landlords to rent to vulnerable population and provided rental subsidies that supported housing 19 families/40 vulnerable individuals	Flex fund supported with funding exceeding $100,000. A significant amount of funds have been used to incentivize landlords (eg, higher deposits) to rent to low income families and individuals with mental health issues.	26 Napa County Community Members will be housed through the collaborative work at the Wine Valley Lodge and through Project Room Key.

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, State of California and Federal Whole Person Care, Corporation for Supportive Housing, National Alliance to End Homelessness, 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

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, Center Point, Exodus, Ole Health, Queen of the Valley Emergency Department, City of Napa Police and Fire Departments, Probation, and the Gasser Foundation.

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.

FY20 Accomplishments:

At Providence St. Joseph Health, we believe that Housing is Health. Safe, secure housing is essential to health and well-being. To apply this concept at the local level, PSJH sponsored a housing instability and homelessness workshop in Napa in November 2019, to learn about the specific needs of our community and how best the health system can work to address them. The workshop included review of local data around housing and homelessness as well as an interactive asset mapping and gap analysis exercise. As a result, four goals were developed to address and reduce housing instability and homelessness in Napa County. By the end of 2022, QVMC intends to: support the development of 140 affordable and/or permanent supportive housing units; increase investments and partnerships in supportive services; advocate for healthy and affordable housing for all; and assist the county to implement a data platform and response framework that would ultimately lead to functional zero homelessness.

FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan
FY19 Accomplishments

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 Results	FY 19 Results	FY20 Results
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	*64% (January – June) 14 of 22 Improved quality of life measures on SF12	65% with improved quality of life measures on SF12.	No Data Available*

Strategy(ies)	Strategy Measure	Baseline	FY18 Results	FY19 Results	FY20 Results
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	New online data collection case management system not yet online to capture this data.	New data system in beta implementation. Baseline will be derived in 12 months from September 2019.	Baseline to be finalized January, 2021

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)	70% 23/33 applications approved	55% 12/22 applications approved	59% 20/34 applications approved
Provide health care coordination to improve healthcare access for clients with complex medical needs at risk for hospitalization or readmission referred from hospital and health care providers	Percentage improvement in hospitalizations and ED visits for new clients post enrollment compared to pre-enrollment	40% reduction in hospitalizations & 65% reduction in ED use	71% reduction in hospitalizations & 81% reduction in ED use	87% reduction in hospitalizations and 95% reduction in ED use	No Data Available* Asking Aura

* **Six months outcome data. New strategic plan Quality of life measure for Social Determinants of Health.**

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) 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. 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

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.

FY20 Accomplishments:

Care Network served 1175 clients through medical and social services care coordination and case management. CARE Network RNs, social workers, behavioral health specialists and community health workers provided 16,345 encounters with clients through medical and social services care coordination and care management services. CARE Network SOAR specialists submitted 37 applications for SSI/SSDI for homeless and mentally ill and substance use disabled clients. Twenty applications have been approved, 3 applications are pending and 6 applications remain in the appeal process. CARE Network has been integral to housing efforts aimed at the homeless population providing system linkages and case management.

*In October of 2019 CARE Network completed a conversion of its data collection and analysis system from a homegrown system titled ATC to Activate Care (formerly ACT MD). This required a significant investment of time including training of all caregivers, assurance that the online system was capturing the impact of the program on Social Determinants of Health and Health outcomes as well as retention of case management clients. The system was implemented in the beta phase in September 2019. The caregivers began training on the new system in September of 2019. In October of 2019 the CARE Network began to solely work in Activate Care.

FY18 – FY20 Key Community Benefit Initiatives and Evaluation Plan
FY20 Accomplishments

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 Results	FY 19 Results	FY20 Results
Percentage of low income patients who demonstrate oral health status improvement at recall visit based on a set of clinical criteria	92 percent	91percent	84 percent	77 percent

Strategy(ies)	Strategy Measure	Baseline	FY18 Results	FY19 Results	FY20 Results
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	670 children	619 children	No Data Available Due to Covi-19
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	92 percent	87 percent	90 percent
Provide patient/parent education on oral health	Percentage of patients/parents reporting improved oral health behaviors on survey.	98 percent	91 percent	No Data Available	No Data Available

Evidence Based Sources: American Academy of Pediatric Dentistry Recommendations 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 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. (Family Resource Centers, OLE Health Dental Clinic and local dental specialists)

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

FY20 Accomplishments:

This year our mobile dental clinic provided **3,591** clinic visits to low-income children in Napa County. Due to COVID-19 the Mobile Dental Clinic suspended practice on March 12, 2020. Three of the mobile dental clinic caregivers immediately entered into the labor pool at QVMC. Their primary role was to welcome, screen, and take temperatures as caregivers arrived on campus to care for patients. It was recognized by public health that dental settings have a unique characteristic that warrant infection control considerations. With guidance from Napa County Public Health, the Infection Prevention Manager at QVMC, the California Dental Association and the Center of Disease Control and Prevention the mobile dental began seeing patients again on June 9, 2020. The Queen is grateful to have the ability to offer these services to the most vulnerable in Napa County.

Other Community Benefit Programs and Evaluation Plan

Initiative/Community Need Being Addressed:	Program Name	Description	Target Population (Low Income or Broader Community)	FY20 Accomplishments
1. Perinatal Health	Perinatal Health Education	Perinatal classes on birth preparation, infant care, breastfeeding and safety	Broader Community	Queen of the Valley Community Outreach offers a wide variety of perinatal classes to all in our community, regardless of income or area hospital birthing choice. This year **170** classes were presented with a total of **2215** participants.
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	In FY20 Healthy for Life continued at **9** low-income Title 1 school district sites. A total of **15,501** duplicated students participated in fitness classes over the course of this time period.
3. Access to Healthcare	Farmworker Health Screening	Collaborative effort with Ole Health to screen migrant farmworkers for health concerns	Low Income	**149** people were screened for elevated levels of glucose and cholesterol. The health fairs were at sites that consisted of low income housing apartments, vineyard management sites, and farmworker housing for migrant workers. **1208** people were provided with health education information and resources at local fairs at community sites such as schools, parks, stores, and churches.
4. Address Social Determinants of Health: Educational Equity	Napa Valley Parent University (NVPU)	In partnership with Napa Valley Unified School District and a local nonprofit, On the Move, Parent University is a	Low Income	NVPU offered 317 classes at 5 elementary school sites for a total of 6813 parent participants. Class topics include: becoming an effective school

		learning environment for parents to gain critical parenting and leadership skills to support their child's academic success. Classes are bilingual.		consumer, helping children with homework, computer literacy, becoming an effective volunteer in the school, raising a healthy child and accessing health services.
5. Access to Healthcare	Operation Access	Collaborative funding to implement access to diagnostic screening, procedures and surgeries for the uninsured	Low Income	Through a collaborative effort of area hospitals (Queen of the Valley, St. Helena Hospital, Kaiser Permanente) and Ole Health (FQHC), OA continues in Napa this year linking **99** unique lives to **148** surgical procedures and or diagnostic services.
6. Access to Healthcare	HIV Clinic	Collaborative with Ole Health to provide HIV clinic services to uninsured and low income	Low Income	This year Queen of the Valley provided a community benefit donation of $54,800 to OLE Health for a HIV specialty clinics at the FQHC site. Patients of these specialty clinics are then followed by Queen of the Valley's CARE Network team for care coordination and case management. Clinics provided services to over **66** unduplicated patients for a total of **130** office visits.

FY20 Community Benefit Investment

In FY20 Queen of the Valley invested a total of $ 33,487,837 Community Benefit. Charity Care, which is free or discounted by our Financial Assistance Policy (FAP), was $2,646,747. The unpaid cost of Medicaid for FY20 was $21,391,502. St. Joseph Health Queen of the Valley applies a ratio of cost to charge to quantify financial assistance at cost, unreimbursed Medicaid, other means-tested government programs. The cost to charge ratio is aligned with the IRS Form 990, Schedule H Worksheet 2. Our community benefit program expenses are reported in alignment with the total cost incurred to run our programs, and we offset any restricted revenue received to arrive at our net community benefit expense.

FY20 COMMUNITY BENEFIT INVESTMENT
St Joseph Queen of the Valley
(ending June 30, 2020)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services[1]	Net Benefit
Medical Care Services for Vulnerable[2] Populations	Financial Assistance Program (FAP) (Traditional Charity Care-at cost)	$2,646,747
	Unpaid cost of Medicaid[3]	$21,391,502
	Unpaid cost of other means-tested government programs	$1,029,658
Other benefits for Vulnerable Populations	Community Benefit Operations	$341,848
	Community Health Improvements Services	$4,798,019
	Cash and in-kind contributions for community benefit	$1,140,661
	Community Building	$0
	Subsidized Health Services	$188,021
	Total Community Benefit for the Vulnerable	**$31,536,456**
Other benefits for the Broader Community	Community Benefit Operations	$740,862
	Community Health Improvements Services	$747,167
	Cash and in-kind contributions for community benefit	$463,352
	Community Building	$
	Subsidized Health Services	$
Health Professions Education, Training and Health Research	Health Professions Education, Training & Health Research	$
	Total Community Benefit for the Broader Community	**$1,951,381**
	TOTAL COMMUNITY BENEFIT *(excluding Medicare)*	$33,487,837
Medical Care Services for the Broader Community	Unpaid cost to Medicare[4] ***(not included in CB total)***	$41,076,079

[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 (referred to as Medi-Cal in California), Medicare, California Children's Services Program, or county indigent programs. For SJH, we exclude Medicare as part of Community Benefit total and only include it below the line for SB697 reporting purposes.
[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 IRS Form 990, Schedule H, we use the Medicare cost report.

Telling Our Community Benefit Story: Non-Financial[5] Summary of Accomplishments

Summarize any additional non-financial community benefit/investment that were accomplished by ministry (e.g. volunteer work, board membership participation, community partnerships in building community and employee engagement)

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

Alcohol and Drug Services

Substance use disorder (SUD) continues to be an identified health need in Napa County. In response to this need, Queen of the Valley and Napa County Alcohol and Drug Services (ADS) entered into a formal agreement in September of 2014, partnering to provide screening and outreach services to the community at large as well as provide a warm hand off for patients hospitalized and interested in engaging in services upon hospital discharge. As part of this effort, a Substance Use Counselor from Center Point, a co-educational withdrawal management and treatment center, is co-locating within the Queen of the Valley Community Outreach Department providing services to inpatients and to the community at large.

The Table:

The Table is a safety net food program providing a warm dinner Monday through Friday at The First Presbyterian Church. Since 1999, Queen of the Valley has provided an annual donation and sponsored a meal the second Tuesday of each month. For this meal, Queen of the Valley volunteers, caregivers and their family members create the menu, shop, prepare the meal, decorate, serve the meal and clean up. The two greatest benefits from The Table are relief from hunger and relief from social isolation. This FY20, Queen of the Valley caregivers and volunteers served 1,046 meals and countless smiles to vulnerable community members. The Table did temporarily suspend operation in March of 2021 due to Covid-19.

Blood Drives:

Another form of non-profit collaboration is partnering with Vitalant to host blood drives on the Queen of the Valley campus. We create awareness while inviting the community to join Queen

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

of the Valley caregivers, physicians and volunteers to meet the chronic shortage of lifesaving blood products. In FY20 Vitalant conducted 4 blood drives at Queen of the Valley with a total of 123 units of blood donated.

Community Leaders Coalition (CLC)
The CLC's mission is to mobilize community leaders to collectively advocate for the needs of vulnerable populations throughout Napa County. The group is comprised of nonpartisan community leaders working together to leverage their resources and voices to influence positive change in our community. Proactive efforts include promoting and encouraging participation in the 2020 Census, voter registration and participation, paving the way for an open and effective local government, and strengthening immigrant families. A Queen of the Valley, Community Outreach caregivers serves as a member of the CLC and participates in relevant workgroups and advocacy efforts.

Napa Valley Community Organizations Active in Disaster (COAD)
The Napa Valley COAD develops and enhances partnerships for communication, coordination & collaboration amongst the whole community including non-profit & faith-based organizations, government agencies, and the private sector during all phases of disaster. The organization was developed in response to the 2014 South Napa Earthquake and 2015 Lake County Valley Fire, and in an effort to develop a structure in Napa County to improve community resilience by identifying and directing vital resources to help residents recover from a disaster. Local government cannot meet these needs alone and relies on partnerships with local non-profit agencies for service delivery.

Governance Approval

This FY20 Community Benefit Report was approved at the Thursday, December 10th meeting of the St. Joseph Health Queen of the Valley Community Benefit Committee of the Board of Trustees.

Sr. Nadine McGuinness, CSJ

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Chair's Signature confirming approval of the FY20 Community Benefit Annual Report

December 10, 2020

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Date

PROVIDENCE ST. JOSEPH HEALTH

Providence St. Joseph Health is a new organization created by Providence Health & Services and St. Joseph Health with the goal of improving the health of the communities it serves, especially those who are poor and vulnerable.

Together, our 119,000 caregivers (all employees) serve in 50 hospitals, 829 clinics and a comprehensive range of services across Alaska, California, Montana, New Mexico, Oregon, Texas and Washington. The Providence St. Joseph Health family includes: Providence Health & Services, St. Joseph Health, Covenant Health in West Texas, Facey Medical Foundation in Los Angeles, Hoag Memorial Presbyterian in Orange County, Calif., Kadlec in Southeast Washington, Pacific Medical Centers in Seattle, and Swedish Health Services in Seattle.

Bringing these organizations together is a reflection of each of our unique missions, increasing access to health care and bringing quality, compassionate care to those we serve, with a focus on those most in need. By coming together, Providence St. Joseph Health has the potential to seek greater affordability, achieve outstanding and reliable clinical care, improve the patient experience and introduce new services where they are needed most.