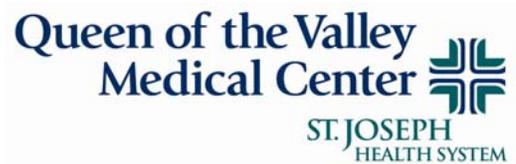


FY 2011 Community Benefit Report



**QUEEN OF THE VALLEY MEDICAL CENTER
FISCAL YEAR 2011 COMMUNITY BENEFIT REPORT**



Founded by the Sisters of St. Joseph of Orange

MISSION, VISION AND VALUES

Our Mission

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

Our Vision

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

Our Values

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

EXECUTIVE SUMMARY

Who We Are and What We Do

For over fifty years Queen of the Valley Medical Center (QVMC) has been a vital resource and integral part of the Napa Valley community. A full-service acute care 191 bed medical center, Queen of the Valley employs approximately 1,520 employees. The medical center is located within the City and County of Napa, and is the major diagnostic and therapeutic medical center for Napa County and the surrounding region. We recognize and embrace the social obligation to create, collaborate on and implement programs that address identified needs and provide benefits to the communities we serve.

The health of our community depends on the creation and maintenance of strong physical and social structures, which promote and contribute to the wellbeing of those who live in Napa County. In total, for fiscal year 2011 QVMC contributed **\$26,120,587 in community benefit**, excluding unreimbursed costs of Medicare. This represents an **83% increase** from FY 2010, due to the following:

- Charity care increased in FY 11 by 96% and number of persons who were provided charity care increased by 427% (from 2,136 people to 11,258 people), both primarily due to reclassification of prior year's bad debts to charity care. Without the impact of this reclassification, charity care still increased 16% over last year.
- The unreimbursed costs of Medicaid and other means-tested government program services doubled in FY 11 due to the impact of the hospital provider tax in FY 11 plus other adjustments. If we normalize both years the increase in the unreimbursed costs would be 32% as a result of lower reimbursement from these programs.
- Community services for the poor and broader community programs have also increased in FY 11 related to the expansion of childhood obesity and chronic disease management programs.

The unreimbursed cost of Medicare services totaled \$25,677,124 representing an 8% decrease from FY 2010 due to a total decrease in Medicare discharges and patient days experienced in FY 2011 along with relatively flat expenses.

Community Plan Priorities

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

- Mobile Dental Clinic services for low-income children,
- Community-based chronic disease management for low-income persons living with chronic illness,
- Women's health programs including perinatal education, postpartum depression services, and cancer screening for low-income women,
- Health insurance enrollment and retention for uninsured children and adolescents,
- Partnership addressing access to mental health services for low- income individuals,
- Childhood asthma prevention through focus on indoor air quality in schools,
- Obesity prevention for at-risk children through a school-based program "Healthy For Life",
- Academic achievement and community building addressing the social determinants of health through Parent University, and
- Wellness and prevention including bilingual community health education series, health screening, support groups, infant car seat distribution and installation, senior programs.

INTRODUCTION

Who We Are and What We Do

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

As a member-hospital of the St. Joseph Health System (SJHS), a ministry of the Sisters of St. Joseph of Orange, we are committed to: "...bring people together to provide compassionate care, promote health improvement and create healthy communities". We recognize and embrace the social obligation to create, collaborate on and implement programs that address identified needs and provide benefits to the communities we serve.

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

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

The following highlight a few key community benefit programs.

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

- Without adequate health insurance, income, and support, managing a chronic illness such as diabetes or heart failure can be extremely costly and difficult. The **CARE Network** provides disease management, socio-economic and behavioral health interventions, and promotion of disease self-management utilizing an interdisciplinary RN, social work,

behavioral and spiritual health approach. In FY 11, CARE Network clients had a **77% decrease** in emergency room visits, and a **40%** decrease in hospitalizations, and demonstrate an overall **increase in quality of life** as measured through a validated survey tool.

Children's Mobil Dental Clinic

- To address an identified community need in 2005, QVMC launched a **Children's Mobile Dental Clinic**. In response to heightened need in FY 2011, a new mobile dental was launched, increasing the number of dental chairs from two to three, and increasing the number of clinic sites from seven to ten, providing comprehensive dental services to more than 2,500 low-income Napa County children, an increase of 56% from FY 10 (from 1,600 to 2,500 active patients). With increased capacity in FY 11 we were able to increase the number of new patients served by 63% (from 554 to 904).

Childhood Obesity Prevention

- **"Healthy for Life"** is a school-based obesity prevention program designed to emphasize lifelong fitness and healthy eating behaviors among children and adolescents. The program incorporates physical assessments by pediatricians, the provision of training and exercise equipment to schools, as well as guest instructors for a variety of classes including kick boxing and circuit training. In FY 11, among the 260 student participants, 27.5% were classified as obese (BMI > 95th percentile) at the beginning of the school year. This number decreased to 25% by the end of the school year. In addition, healthy lifestyle behaviors also improved including increased exercise frequency and eating more fruits and vegetables. For student participants identified by the pediatrician with high BMI, high blood pressure, signs of diabetes, or scoliosis, physician follow-up was provided.

Community Empowerment and Social Justice

- **Parent University** is a new initiative in partnership with Napa Valley Unified School District (NVUSD) that is designed to create a learning environment for parents to gain critical parenting and leadership skills. Addressing the social determinants of health, a series of over **50 parent classes** were provided to over 700 parents at two Title I elementary schools.



Course topics included effective parenting techniques, healthy lifestyles, family literacy intervention, introduction to parent teacher conference, how to prepare your child for college, introduction to computer use, how to be an effective volunteer, and leadership training.

Community Partnerships for a Healthier Napa County

- Our mission calls us to improve the health and quality of life of our community and we realize the need to partner with others to make this a reality. To this end QVMC provided over **\$700,000** in community benefit to over 35 community programs offering critical safety net resources to Napa's most vulnerable including mental health, food security programs, housing programs, domestic violence shelter, teen pregnancy program, gang tattoo removal program, Boys & Girls Club nutrition program, Operation with Love from Home (providing care packages to U.S. troops abroad), senior services, and Napa County family resource centers. Annual required reporting demonstrates thousands of individuals and families were provided critical services through these partnerships.

Community Benefit Investment 2010 and 2011

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Community Benefit Governance Structure

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

Queen of the Valley Medical Center demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The Vice President of Mission Integration and Executive Director for Community Outreach are responsible for coordinating implementation of California Senate Bill 697 provisions as well as provide the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and carrying out the Community Benefit Plan.

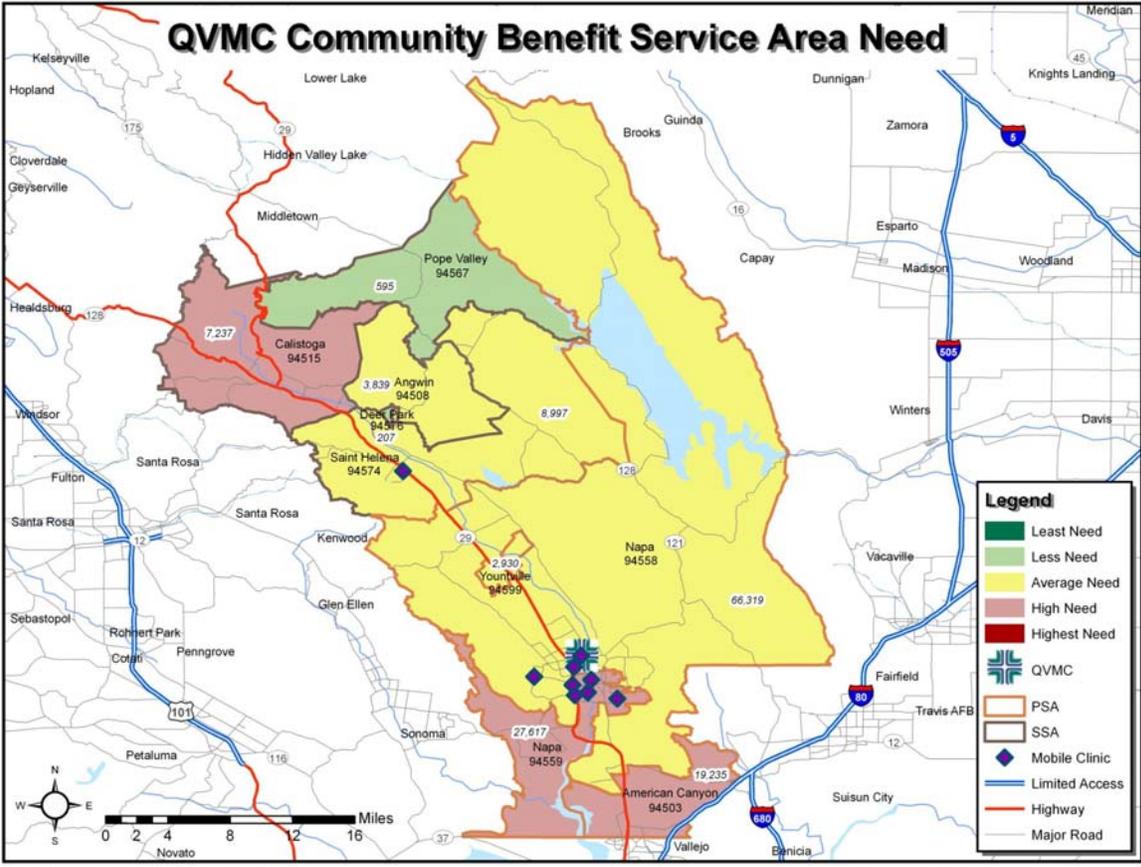
The Community Benefit Management Team provides orientation for all new Medical Center employees on Community Benefit programs and activities, including opportunities for participation. Key opportunities for QVMC employee participation in community benefit activities

for FY 2011 include: cooking and serving monthly soup kitchen meals; quarterly employee blood drives; migrant worker health fairs, Meals on Wheels delivery; Gang Tattoo Removal Program, AIDS Walk Napa Valley; American Cancer Society Relay for Life; and Operation with Love From Home.

Overview of Community Needs and Assets Assessment

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

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



Patient Financial Assistance Program

Our mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why St. Joseph Health System has a **Patient Financial Assistance Program** that provides free or discounted services to eligible patients. **Charity care increased in FY 11 by 96%** (from \$2,592,000 to \$5,077,561) and number of persons provided charity care increased by 427% (from 2,136 persons to 11,258 persons).

The Health System enhanced its process for determining charity care by adding an assessment for presumptive charity care. This assessment used predictive modeling and public records to identify and qualify patients for charity care, without a traditional charity care application.

Queen of the Valley Medical Center FY 09 – FY 11 Community Benefit Plan: FY 11 CB Priority Initiatives

Disease Case Management for Low-Income Chronically Ill

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

Research on chronic disease management has demonstrated that care for the chronically ill is most effective in an outpatient care setting. Use of the emergency department and in-patient hospital care is costly and less effective in improving the quality of life for patients with chronic conditions. As a result, QVMC has developed the CARE Network program to enable community dwelling residents with chronic disease access to disease management and social services maximizing wellness and quality of life.

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

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

Goal: Improve health outcomes and quality of life for low-income individuals with chronic illness through provision of a holistic and comprehensive community-based chronic disease management approach: disease management education and support, mental health services, spiritual support, access to medically supervised exercise, and assistance with medication, transportation and other social service needs.



How will we measure success?

Expanding access (as measured by increased numbers served), reducing inappropriate use of emergency services (as measured by decreased frequency of emergency department visits), reducing unnecessary hospitalizations (as measured by decreased frequency of hospitalizations), and increased self-reported quality of life.

Strategy Measure 1:

- Number of individual served
- Number of resources and referrals
- Number of hospitalizations and emergency room visits

FY 11 Accomplishments

Number Served: Provided comprehensive community based disease management services to 375 clients, a **22% increase** from FY 10 (307 in FY 10). Of these 375, 57% (213) were newly enrolled, and represents a **35 % increase** of newly enrolled clients from FY 10 (from 139 to 213). Aside from enrolled clients, an additional 236 non-enrolled individuals seeking social

services received brief case management and social service counseling, for a total of **611 individuals served** through this program in FY 11.

Reduced Emergency Department Visits and Hospitalizations: Of the 375 enrolled clients receiving full program services, the average monthly **emergency room visits** decreased by **77%** (from 39 average monthly visits pre enrollment, to 9 average monthly visits post enrollment), and average monthly **hospitalizations decreased by 40%** (from 26 average monthly hospital admissions 5).

Resource and Referrals: In addition to RN disease management monitoring and education, these clients received advocacy and support in the following areas: health insurance enrollment (207 occasions), housing (91 occasions), pharmaceutical (214 occasions), food (314 occasions), and transportation to medical appointments (257 occasions). Through CARE Network support, clients received permanent housing, monthly income, health insurance, food security, and a social support system.

Strategy Measure 2:

- % of patients reporting increased quality of life
- % of patients reporting increased ability to manage disease

FY 11 Accomplishments

Quality of Life: In alignment with our mission "...to enhance the health and quality of life of the people in the communities we serve", measuring quality of life (QOL) for our clients is of significant importance, yet a difficult qualitative measure. Using a recently adopted health system wide community benefit quality improvement methodology, one FY 11 performance improvement project aims at establishing a validated QOL measure process. Of the 77 clients completing the newly implemented QOL survey process, **60% report improved QOL**. In addition, **93%** of satisfaction survey respondents report an **increased ability to manage** their chronic illness.

Strategy Measure 3:

- Increase access to HIV specialty care for HIV positive clients

FY 11 Accomplishments:

HIV Clinic: Specialized care for people with HIV/AIDS is critical to improving health outcomes. QVMC Community Benefit supports a twice monthly HIV clinic at Napa's FQHC Community Health Clinic Ole accessing a San Francisco based HIV/AIDS physician specialist. The HIV clinic is managed and staffed by CARE Network HIV RN and social work case managers, providing a multidisciplinary approach to the HIV clinic visit. This year 23 HIV clinics (83 clinic hours) provided 166 clinic visits. Of our 52 HIV clinic clients, 46 required HIV medication treatment and monitoring to manage their HIV disease and prevent progression to AIDS.

Additional FY 11 Accomplishments CARE Network

County MediCal Services Program (CMSP) Grant: As a recipient of a three year CMSP Local Health Connections grant, FY 11 began implementation phase of this project. This program serves low-income CMSP or CMSP eligible persons with complex medical and psychosocial conditions. For the three quarters of FY 11 the program was implemented, 69 clients were enrolled. Of these 69, 25 received one or more of the following benefits: CMSP, QVMC financial assistance, MediCal, State Disability, SSI, Veterans Affairs (VA) services. All received comprehensive disease management services and critical community resource linkages.

Medical Fitness Monitored Exercise Program: Recognizing the physical and mental health benefits of increased strength and endurance, we established a partnership with QVMC's medical fitness center to sponsor low-income chronically ill clients through a specialized monitored exercise program. This year 50 clients received medical fitness membership services with a total of 1,765 monitored visits.

Community Care Conferencing: In an effort to improve systems of care through coordination and monitoring among key community partners, CARE Network developed and implemented a monthly coordination of care conference; ensuring privacy and confidentiality are maintained. This successful program component involves 23 agencies from the public and private sector as needed, on a case by case basis, and includes EMS, Police, County HHS, County Mental Health, Family Resource Centers, Hospice, and key ministry departments.

Expanding Dental Care for Low-Income Children

Children's Mobile Dental Clinic

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

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

Target Population: Low-income, uninsured and under-insured children

Goal: Expand access to affordable, quality oral health services including preventive care and education to low-income children in Napa County.

How will we measure success? Increase numbers served and demonstrated increase in oral health knowledge and behavior.

Strategy Measure 1:

- Number of children on waiting list
- Number of children seen daily
- Number of services provided
- Percent of children returning for regular check-ups

FY 11 Accomplishments

Expanded access to preventive and restorative oral health services: The Children's Mobile Dental Clinic provides comprehensive dental services to more than 2,500 low-income



Napa County children, an **increase of 56%** from FY 10 (from 1,600 to 2,500 active patients). This year, in response demonstrated community need, a **new mobile dental** was launched increasing the number of dental chairs from two to three. In addition, the number of clinic sites increased from six to nine. With these enhancements, we were able to **decrease the delay in our recall visits** from nine months to the standard six months while accommodating **904 new patients**, an increase of 63% from FY 10 (from 554 to 904).

For the active 2,500 clinic patients, mobile dental services provided 4,189 clinic visits in FY 11, an average of nearly 350 a month. Services include oral exams, cleanings, dental sealants, fluoride varnish, extractions, space maintainers, composite (white) fillings, pulpotomies, stainless steel crowns (for primary/baby teeth), root canals, white crowns (for permanent teeth), scaling and root planning, and palliative (urgent) visits.

Strategy Measure 2:

- Increase in oral health behaviors reported at recall visit
- Percent of parent demonstrating knowledge regarding oral health
- Percent of reduction in fillings or extractions related to decay among returning children

FY 11 Accomplishments

An important component of mobile dental services includes oral health education aimed at empowering parents and children to improve and maintain oral health. With each visit, the child's health history is updated and education is tailored to meet the patients' needs. Random audit of over 450 dental records of new clinic patients demonstrates 94% improvement in oral health at the recall visit. This measure correlates with an 86% decrease in fillings or extractions related to tooth decay among these returning children.

Strategy Measure 3:

- Percent of families/children with perceived social service needs receive follow-up and assessment

FY 11 Accomplishments

The mobile dental team incorporates a coordinated system of care for mobile dental clinic families with social service needs that includes well established referral processes to appropriate community agencies as well as support for more difficult situations through our onsite certified application assister and onsite social workers.

Additional FY 11 Accomplishments Mobile Dental Clinic:

Sedation Dentistry: Low-income Napa County children requiring extensive oral treatment had no access to sedation dentistry. In response to this identified gap in access, in collaboration with local pediatricians and QVMC, a community benefit extending access to **sedation dentistry** within QVMC was developed in FY 10. This year **26 low-income children** received access to sedation dentistry at QVMC (from 6 children in 2010), decreasing the stress and trauma of extensive oral treatment without sedation, and receiving this service within their own community.



Endodontic: Children who require root canals are often in pain with potential nutritional and medical complication if treatment is not obtained. These endodontic services (root canals and crowns) for permanent teeth are extremely costly, severely limiting access for our low-income families. In response to this gap in access to endodontic care, our dentist received training and certification to provide this critical service. This year **12 children received endodontic** treatment for their adult teeth through our mobile dental clinic.

State required pre-school oral health screenings: In 2006, the State of California passed legislation (Assembly Bill 1433 (Emmerson/Laird)) requiring that children have a dental check-up by May 31 of their first year in public school, at kindergarten or first grade. Queen of the Valley Medical Center Mobile Dental Clinic recognizes the need to partner with local organizations to support parents to meet this requirement. In partnership with Napa County Child Start programs, our Mobile Dental team completed a total of 103 oral health examinations to pre-school children in 4 separate locations. For the many pre-school children who did not have a dental home and/or needed treatment for identified cavities during the screening, on site linkage to care and services was provided.

Reducing Prevalence of Childhood Obesity in Napa County

Healthy For Life

Childhood obesity in the United States has more than tripled in the past thirty years, and carries both immediate and long-term health impacts. Children and adolescents who are obese are at greater risk for bone and joint problems, sleep apnea, and are more likely than normal weight peers to be teased and stigmatized which can lead to poor self-esteem. Moreover, obese youth are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure. Finally, overweight and obese youth are more likely than normal weight peers to be overweight or obese adults and are therefore at risk for the associated adult health problems, including heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis. In Napa County, 17% of children ages 12-17 were overweight or obese in 2007, and in 2009 the percentage of children aged 2-4 living in households with an income less than 200% of the federal poverty level were obese with BMI's above 95th percentile (Napahealthmatters.org). In an effort to address this critical health issue, St. Joseph Health System adopted a health system wide, school-based childhood obesity prevention program titled "Healthy for Life".



Key Community Partners: Napa Valley Unified School District, Synergy Medical Fitness Center, American Canyon Middle School, American Canyon High School, McPherson elementary School, Napa High School, Napa Junction Elementary School, Vintage High School, Valley Oak Alternative High School, Harvest Middle School, Redwood Middle School, River Middle School, Silverado Middle School, Children and Weight Treatment Coalition, Andrea's Voice (eating disorder) Foundation.

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

Goal: Improve fitness and health behaviors for children at risk for obesity.

How will we measure success?: Increase access to early intervention programs to improve fitness and nutrition demonstrated by improved fitness, nutrition and health behaviors as well as improved self esteem.

Strategy Measure 1:

- Number of children participating

FY 11 Accomplishments

Increased Access: The “**Healthy for Life**” school-based initiative successfully expanded from 5 schools in FY 10 to **11 engaged Napa County schools** in FY 11. To accommodate this expansion, 22 school district physical education (PE) teachers received a full day of Healthy for Life training to incorporate this curriculum into PE classes. Participating schools receive a donation of fitness equipment for student use. In addition, QVMC’s medical fitness center contributes a rich variety of resources to the Healthy for Life program including a Registered Dietician and exercise instructors. Classes include education regarding nutrition and healthy lifestyle behaviors as well as fun, energetic classes such as kick boxing, Zumba dancing, and circuit training. 260 students completed data collection (beginning of school year and end of school year assessments), a **120 % increase** in student participants from FY 10 (from 118 to 260).

Strategy Measure 2:

- Health assessment – identify at risk youth and refer for follow up care and services

FY 11 Accomplishments

Of 260 students participating in data collection, 17% were identified with undiagnosed acanthosis nigricans (skin rash indicating high risk for diabetes), 14% were identified with high blood pressure, and 27% fell into the clinically obese category with a body mass index (BMI) of greater than the 95th percentile. All students identified with these health findings were provided physician to physician referral and follow up to ensure medical attention. Of the student participants that had a BMI of greater than the 95th percentile (obese), two percent demonstrated a reduction in their BMI by the end of the school year.



Strategy Measure 3:

- Lifestyle behavior change – increase in regular physical activity, reduced fast food consumption

FY 11 Accomplishments

Healthy for Life strives to empower youth and their families to make healthy choices related to diet and activity. Of students participating in Healthy for Life 15% reported an increase in exercising 6 or more days a week, 9% reported an increase in consuming fruits and vegetables 6 or more days a week, and 3.7% of student participants decreased the number of days a week they ate “fast food.”

Improving Access to Perinatal and Women’s Health Care Services

QVMC ensures access to preventive care for low-income women as well as maternal health education for the broader community enhancing birth outcomes and ultimately the future health and quality of life for Napa County infants and children.

Key Community Partners: Community Health Clinic Ole (FQHC), Synergy Medical Fitness Center, Even Start, New Beginnings, Napa Valley Community Housing, Von Brandt Community Center, Puertas Abiertas Community Center, COPE Family Resource Center, Parents CAN Family Resource Center for children with disabilities, local pediatrician and obstetrician providers.

Target Population: Low-income women and families

Goal: Improve access to consistent and high quality prenatal education, preventive cancer screening, and post partum depression screening and services for low-income Spanish and English speaking women in Napa County.

How will we measure success? Maintained or increased number of low-income women receiving post partum depression screening and services, prenatal education, and preventive cancer screening



Strategy Measure 1: Perinatal education for Napa County women and families:

- Percent of participants demonstrating improved knowledge of perinatal health through pre-post test
- Number of underserved community locations, number of participants
- Number of sessions in Spanish

FY 11 Accomplishments

QVMC offers 17 different perinatal education classes for Napa County women and their families regardless of income or insurance status. Classes include a variety of childbirth preparation, labor pain management, breastfeeding, sibling preparation, newborn care, boot camp for dads, fitness for two, pre and postnatal exercise, prenatal water aerobics, home and car seat safety, and infant massage. Outreach to low-income and Spanish speaking residents involves offering off-site classes at locations convenient for families, in addition to our onsite classes. In FY 11, a total of **383 perinatal classes** were offered, 77 of these at offsite locations, and 66 taught in Spanish. A total of over **5,128 participant** contacts were served (compared to 4,000 FY 10) with 100% of participants reporting increased knowledge of class content.

Strategy Measure 2: Post partum depression services:

- Number of providers screening and referring clients for postpartum depression assessment
- Number of identified women with a postpartum depression

FY 11 Accomplishments

The perinatal emotional wellness program offers community obstetricians, pediatricians, and other community organizations a single referral point to QVMC Community Outreach for mothers experiencing symptoms of post partum depression. Providers screened 1,054 women for depression. Our mental health therapist provided 247 counseling visits for 104 women experiencing post partum depression. In addition to the client (mother's) visits, therapy may include the spouse, significant other, caregiver, or family member - in FY 11 this represents an additional 93 persons served. This program ensures a seamless continuum of care should more intensive psychiatric or substance abuse intervention be required. All (100%) of QVMC **obstetric and pediatric providers** received training and **participate** in the postpartum depression screening and referral process through QVMC Community Outreach. Referrals are received from the emergency department, health care providers, and other community agencies.

Additional FY 11 Accomplishments: Preventive Women's Health Exams

For women who do not qualify for comprehensive preventive screening services, a \$33,794 care for the poor partnership from QVMC to Community Health Clinic Ole, a federally qualified health center (FQHC), provided preventive women's health exams and treatment as indicated for **416 low-income women**.

Increasing Access to Mental Health Service

Research indicates that mental health disorders are among the most important contributors to the burden of disease and disability nationwide. Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. According to the Napa Community Health Needs Assessment 2010, access to mental health is one of the top four ranked unmet health needs.

Key Community Partners: Family Service of Napa Valley, Community Health Clinic Ole, local community health providers, mental health and substance abuse providers, mental health committee of the Napa Valley Non Profit Coalition, Adult Day Services of Napa Valley- Alzheimer's Day Care, Healthy Aging Planning Initiative (HAPI), Napa County Mental Health and Health and Human Services, Area Agency on Aging (AAA), Napa County comprehensive Services for Older Adults (CSOA).



Target Population: Low-income adults, older adults, children and their families

Goal: Improve access to a coordinated continuum of mental health services and programs for low-income adults, families and seniors

How will we measure success? Improved mental health scores for clients receiving home-based and site-based services.

Strategy Measure 1: CARE Network Behavioral Health Integration

Through a partnership with Family Services of Napa Valley, an on-site bilingual licensed clinical social worker (LCSW) provides in-home or in-office mental health services for CARE Network low-income, chronically ill clients, families and caregivers.

- Number of behavioral health assessments
- Number/percent improved mental health scores

FY 11 Accomplishments

65 CARE Network clients were referred for mental health services, with a total of 50 clients accepting or enrolled. Of the 50 clients, 20 completed treatment with pre/post scores within FY 11. For these 20 clients, 19 demonstrated an increased Global Assessment of Functioning (GAF); a tool that examines social, occupational, and psychological functioning of adults. In addition, 100% demonstrated overall lowered emotional distress scores.



Family Service
of Napa Valley

Strategy Measure 2: Increase Community-Based Behavioral Health Services

- Number of collaborative planning sessions/partners
- Development of defined activities and strategies

FY 11 Accomplishments

Funding and planning phase of the “Healthy Minds-Healthy Aging” program was completed in FY 11, a community-based behavioral health program for underserved older adults 60 years of age or older at risk for behavioral or cognitive health issues, and their caregivers. Queen of the Valley Community Benefit provides funding and support for Healthy Minds also funded through the Napa County Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Funds. The program is a collaborative with 4 other community partners and will launch in FY 12.

In this program, eligible older adults are provided *Comprehensive Psychosocial Assessment, Brief Case Management, and Mental and Cognitive Health Interventions*. The program provides training for professional and volunteer gatekeepers in recognizing signs and symptoms of depression and cognitive problems among older adults. Linkages with primary care providers and community social service organizations will expand community screening among older adults for behavioral health challenges and reduce the stigma often associated with mental health services. The program is projected to screen hundreds of older adults and offer therapeutic services and case management support to 30 eligible clients annually. Services are free and provided in Spanish and English.



Childhood Asthma Prevention

Asthma is a serious health condition affecting approximately 13,000 children and adults in Napa County, and according to the 2007 California Health Interview Survey (CHIS), almost 97% of Napa County children and adolescents with asthma experienced symptoms in the preceding year,

comparatively higher than the 89% in California as a whole. In 2009, there were 457 asthma diagnosis-related emergency department (ED) visits to Napa County hospitals that did not result in hospitalization (2010 Napa Community Health Needs Assessment), suggesting opportunity to enhance education regarding asthma triggers and management. QVMC is a founding member and supporter of the Napa County Asthma Coalition (NCAC), a community collaborative consisting of members from the public and private sector.

Key Community Partners: Green builders, Napa County Office of Education, Napa Valley Unified School District, local pediatricians, Environmental Protection Agency (EPA), California Teachers Association (CTA), Kaiser Permanente, Solano Asthma coalition, Child Start Inc., California Department of Public Health, local policy makers.

Target Population: Napa County Child Start preschools, including staff, students, and parents.

Goal: Decrease classroom asthma triggers.

How will we measure success? Enhance knowledge regarding indoor air quality and asthma triggers.

Strategy Measure 1:

- Number of Child Start classrooms assessed for asthma triggers
- Number of teachers provided air quality/asthma trigger education

FY 11 Accomplishments

The Napa County Asthma Coalition (NCAC) provided the lead role in the design of “Tots Breathe Freely”, and indoor air quality assessment program. The collaborative received 2-year funding to conduct the program through the California Department of Public Health SPIG grant.



Thirteen Child Start classrooms were assessed for asthma triggers, teachers provided with training and education and child Start Center air quality policies were reviewed. Recommendation with remediation suggestions and policy change suggestions were made to Child Start Inc.

Enrolling Uninsured Children

As a founding member of Children’s Health Initiative Napa County in 2005, QVMC implemented a children’s health insurance enrollment program through the Community Outreach Department in concert with CHI enabling medical center in-reach as well as community support for children’s health insurance enrollment.

Key Community Partners: Napa County Children’s Health Initiative (CHI), Community Social Service Organizations, Family Resource Centers, QVMC Emergency Department and Children’s Mobile Dental Clinic.

Target Population: Uninsured low-income children and families.

Goal: Increased access to health insurance for children in Napa County through enrollment assistance and retention strategies.

How will we measure success? Increased number of children enrolled and retained in health insurance.

Strategy Measure 1:

- Number of children enrolled and retained

FY 11 Accomplishments

Through a targeted medical center in reach and outreach program to identify and enroll uninsured children, **340** children were identified and enrolled in health insurance through QVMC community outreach. All families enrolled are case managed, assisted to find a medical home, access care, and to retain health insurance. All (100%) of the Napa County children enrolled and case managed through QVMC agreeable to case management services retained insured status for the past year. As part of a larger community collaborative, QVMC's certified application assistor (CAA) works in tandem with Napa County Children's Health Initiative (CHI) and other CAA's across the county in an effort to ensure every child.

Additional FY 11 Accomplishments: Enrolling Uninsured Children

Strengthen Community Safety Net: To enhance the strength of the community safety net and linkage of families to appropriate community resources, QVMC's CAA also coordinates quarterly one day **community resource classes** for staff of Napa County family resource centers, community resource centers, and school district parent liaisons. Classes include a series of 15 minute presentations from a variety of local nonprofit organizations followed by question and answer sessions.

Bilingual Community Health Education

In FY 11, QVMC invested **\$600,000** in community benefit toward **bilingual face to face, and media-based via radio and television, community health education** with a focus on providing health education and improving health literacy among the county's most underserved. Napa County's population continues to become increasingly diverse. According to the 2010 Napa Needs Assessment, 28% of Napa's overall population identifies themselves as Hispanic or Latino, while among children age 0-5 the proportion is closer to 50%. Whereas Napa is not considered a "poor" county, the substantial wealth of a disproportionate number of Napa residents skews the economic indicators for a sizeable portion of the population. For instance, 51% of Latino households were below the self-sufficiency standard, compared to 24% for the county as a whole. QVMC Community Outreach community health education programs target our Spanish speaking community enhancing knowledge regarding preventive health and access and navigation of health care resources.

Key Community Partners: 19 different locations including community housing centers, community resource centers, Head Starts, schools or other established programs.

Target Population: Low-income Napa County individuals and families, including Spanish speaking

Goal: Improve health literacy and knowledge among underserved Latinos to prevent health problems and increase access to care in partnership with community organizations.

How will we measure success? Ensure access and availability of culturally and linguistically appropriate health education to empower the Latino community and reduce health inequities.

Strategy Measure 1: County Wide, Bilingual Health & Wellness Education

- Number of classes
- Number of locations
- Average percent increase in knowledge based on pre/post test

FY 11 Accomplishments

QVMC community outreach offers bilingual community health education at **19 different locations** spanning all of Napa County. Our partnership with the community lends to consistent presentations throughout key community locations.

The **12 class curriculums** regarding prevention and healthy lifestyle include H1N1 prevention, nutrition, asthma, diabetes, obesity, heart disease, depression, turn off TV (active lifestyle), computer safety for children (parental control program), dental health and home safety for children. Education includes navigation of community resources and access to care and services. This year, **137** off site Spanish language community health classes were taught, and participant contacts totaled 1,940 with an average 40% increase in participant knowledge measured by pre/post testing.

TV / Radio Outreach: In addition to offsite classes, bilingual community health, wellness and prevention education is offered through regional Spanish TV and radio stations on a regular basis.

Other Community Benefit Initiatives and Programs

QVMC recognizes that the health of our community depends on the creation and maintenance of strong structures, both physical and social, which promote and contribute to the well-being of those who live here. A focused desire to work collaboratively as a key community partner enhancing the health and quality of life for Napa County's most vulnerable remains a constant objective, as evidenced through the many community collaborative programs and activities QVMC provides and/or supports. The following are a list of key community benefit partnerships:

Reducing Health Inequities through Education and Empowerment

Parent University

Related to a transition in community partnerships, FY 11 efforts at reducing health inequities through education and empowerment shifted from Binational Health activities to Parent University, a collaborative effort in two title one elementary schools aimed at increasing parental involvement in their child's education, particularly in Latino families.



Key Community Partners: On The Move, McPherson Elementary School, Philips Elementary School, Napa Valley Unified School District (NVUSD), Napa Adult School, Parents CAN,

Target Population: Spanish speaking parents of children, title one elementary schools

Goal: To create a learning environment for parents where they can take an array of classes that will help them to gain critical skills in order to be more effective parents and leaders at school and in the community

How will we measure success? Number of parent graduates

FY 11 Accomplishments

Parent University is a new initiative in partnership with Napa Valley Unified School District (NVUSD) and On The Move that is designed to create a learning environment for parents to gain critical parenting and leadership skills. A course catalogue with a series of over **50 parent classes** is established. A collaborative of community agency representatives to teach classes is coordinated. Over 700 parents at two Title I elementary schools participated in these Parent University courses. Course topics included effective parenting techniques, healthy lifestyles, family literacy intervention, introduction to parent teacher conference, how to prepare your child for college, introduction to computer use, how to be an effective volunteer, and leadership training.

Healthy Aging Planning Initiative (HAPI)

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

Key Community Partners: More than 12 agency collaborative including QVMC, Area Agency on Aging (AAA), Napa Valley Hospice - Adult Day Services, Comprehensive Services for Older Adults of Napa County, local physicians, housing, senior center, volunteer center, St. Helena Hospital, and FQHC Clinic Ole.

Target Population: Napa County Older Adults

Goal: Enhance health and quality of life for Napa County older adults

How will we measure success? Growth, development, and sustainability of HAPI programs and advocacy efforts

FY 11 Accomplishments

During FY11, HAPI continued to focus on improving Information and Assistance services for older adults through provider training, enhanced referral protocols and community outreach.

HAPI developed a 10-page transportation policy platform presented to local and county officials and community leaders. Advocacy resulted in enhanced services and ongoing dialogue with the Napa county Transportation Authority. The HAPI Rides voucher program received additional support through Napa Valley Community Foundation.

To assist partners to understand and proactively meet challenges resulting from county, state and federal cuts, HAPI invited Napa County Health and Human Services leadership to provide education on anticipated cuts and realignment that could impact services such as in-home support services, respite care, protective services and health care access. HAPI influenced the Nonprofit Coalition to take a broad-based look at risks across sectors serving all vulnerable populations.

In partnership with the Commission on Aging, HAPI supported the implementation of the Caregiver Ordinance. This first of its kind local ordinance mandates fingerprint screening of in-home caregivers.

HAPI successfully launched the Healthy Minds-Healthy Aging, a behavioral and cognitive health prevention and early intervention program funded through Mental Health Services act funds and Queen of the Valley Community Outreach.

StopFalls Napa Valley (SFNV) began work with QVMC to implement a falls prevention protocol in the emergency department aimed at addressing falls risk factors among ED patients. SFNV provides home assessments for at-risk older adults. The SFNV Coalition continues to provide community education for providers and older adults.

HAPI has obtained **\$1.5 million** in grant funds to Napa County senior programs in the past 5 years.

Napa Valley Adult Day Services (NVADS)

NVADS is the only Alzheimer's Day Care Resource Center (ADCRC) in our region; however state funding for this critical community program continues to be tenuous. NVADS provides services to vulnerable functionally and chronically ill individuals, over 80% of whom are also economically disadvantaged. The program includes comprehensive medical, social, and therapeutic services and is a viable long term care solution, which helps families avoid nursing home placement for their loved ones. QVMC's community benefit contribution of over **\$94,000** allows provision of NVADS including caregiver counseling and support groups while maintaining high quality staffing ratios to attend to the multi-dimensional needs of individuals with Alzheimer's and other cognitive and physical disabilities.



Target Population: Frail elderly with early to sever Alzheimer's disease or related dementias, and younger adults with physical or mental impairments. 80% are low-income.

Goal: Support capacity building and sustainability of this vital community resource.

How will we measure success? NVADS will sustain services in light of state budget cuts and poor economy.

FY 11 Accomplishments

NVADS provided comprehensive program services to 128 individuals. 418 counseling hours were provided to 179 family members through individual counseling and support groups. **Nursing home placement was avoided for 94% of participants.**

Children's Health Initiative (CHI)

Queen of the Valley and the SJHS are founding partners of the Children's Health Initiative Napa County. This public-private partnership established in 2005 ensures that all children in our community have access to comprehensive, quality healthcare.

Key Community Partners: Children's Health Initiative, Napa County Health and Human Services, Clinic Ole, Napa Valley Unified School District, Napa County Office of Education, Calistoga School District, St. Helena School District, and all Family Resource Centers in Napa County.

Target Population: Uninsured Napa County Children

Goal: Community benefit in the amount of **\$25,000** to sustain this critical community program providing access to health insurance for all Napa County children.



How will we measure success?: Continued outreach and insurance enrollment and retention efforts resulting in over 90% of Napa County children enrolled in health insurance.

FY 11 Accomplishments

There are now 14,300 Napa County children covered by subsidized health insurance, 75% more than when CHI started in 2005. In the last year, CHI has increased the number of insured Napa County children by 537, including 320 (4.1%) more children in the Medi-Cal program and 142 (3.7%) more in Healthy Families. The local increase in Medi-Cal enrollment was 1.57 times the rate (2.6%) for California, and Healthy Families enrollment statewide was essentially unchanged, at +0.1%. Additionally, without re-enrollment assistance, 37%, or 4,879 of these children would lose their health insurance each year (Napa County CHI). Due to the efforts of Napa's CHI and community partners such as QVMC, approximately **96%** of children in Napa County are now covered by some form of health insurance.

Community Health Clinic Ole

QVMC is dedicated to improving the health and quality of life for our entire community, including our community's most vulnerable. To this end, our partnership with Napa's Federally Qualified Health Center (FQHC) furthers our mission. FQHC's provide primary health care to underserved, underinsured, including undocumented persons.

Key Community Partners: Community Health Clinic Ole (FQHC), Sister Anne Dental Clinic, Redwood Regional Oncology, Dr. Daniel Conlin

Target Population: Underserved, underinsured Napa County Residents

Goal: Ensure access to health care for the community's most vulnerable population

How will we measure success? Increased capacity to provide health care services

FY 11 Accomplishments

In addition to the \$33,794 community benefit investment with CHCO toward preventive women's health exams detailed under "Women's Health", QVMC also contributed **\$5,500** toward the provision of **dental services for older adults**. An identified community need, this partnership with Sister Anne Dental Clinic, under the FQHC umbrella of CHCO, provided 31 older adults with dental care and treatment including preventive care, dentures, extractions, fillings, root canals, and crowns.

As part of QVMC community benefit HIV disease management program, a community benefit in the amount of **\$36,000** to CHCO provides an HIV physician specialist to conduct **HIV clinic** for Napa County HIV positive individuals.

As the result of an identified community need, in FY 11 QVMC community benefit care for the poor provided **\$15,000** to CHCO toward the provision of **oncology specialty services for uninsured** individuals with cancer. Implemented midyear, 56 clinic oncology clinic visits were provided.

Community Benefit Investment FY 2010 and FY 2011

FY11 COMMUNITY BENEFIT INVESTMENT
 QUEEN OF THE VALLEY MEDICAL CENTER

(ending June 30, 2011)

CA Senate Bill (SB) 697 Categories	Community Benefit Program & Services ¹	FY11 Financials
Medical Care Services for Vulnerable² Populations	Queen of the Valley Medical Center Financial Assistance Program (FAP) (Charity Care-at cost)	\$5,077,561
	Unreimbursed cost of MediCal ³	\$12,784,283
	Unreimbursed costs- other means tested government programs	\$3,981,388
Other benefits for Vulnerable Populations	Community benefit operations	\$1,487,659
	Community Health Improvements Services	\$297,764
	Cash and in-kind contributions	\$119,677
	Subsidized Services	\$110,000
Other benefits for the Broader Community	Community Benefit Operations	\$1,775,667
	Cash and in-kind contributions	\$425,359
	Community Health Improvements Services	\$59,229
	Community Building	\$2,000
Health research, education, & training	Health Professions Education, Training & Health Research	\$0
TOTAL COMMUNITY BENEFIT (excluding Medicare)		\$26,120,587
Medical Care Services for the Broader Community	Unreimbursed cost to Medicare (not included in CB total)	\$25,677,124
TOTAL COMMUNITY BENEFIT (including Medicare)⁴		\$51,797,711

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 MediCal (Medicaid), Medicare, California Children's Services Program, or county indigent programs. For SJHS, 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.

⁴ Reported below the line per requirement of SB 697.

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

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

In FY 11, QVMC management and staff **contributed over 1,100 hours** of community service and volunteer hours for efforts toward feeding the hungry, Project Homeless Connect, bereavement support, Birth Choice, holiday assistance, care packages for troops abroad, migrant farm worker health fairs, Napa Valley AIDS Walk, teen mom support group, and Stop Falls Napa Valley home assessments. In addition, QVMC representation on community board of directors includes staff on Catholic Charities, Napa Valley Hospice and Adult Day Services, Napa Nonprofit Coalition, Napa Valley Community Foundation, Justin Sienna High School, and Parent Child Advocacy Network.

⁵ Non-financial summary of accomplishments are referred to in SB 697 as non-quantifiable benefits.

St. Joseph Health System
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Orange, CA
stjoe.org



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