FY15 – 17 Community Benefit Plan/ Implementation Strategy Report

St. Joseph Health, QUEEN OF THE VALLEY

St.JosephHealth
Queen of the Valley

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EXECUTIVE SUMMARY

St. Joseph Health, Queen of the Valley Medical Center (SJH – QV) is an acute-care hospital founded in 1958, is located at Napa, California. It became a member of St. Joseph Health in 1982. The facility has 191 licensed beds and a campus that is approximately 12.3 acres in size. Queen of the Valley has a staff of more than 1,368 and professional relationships with more than 300 local physicians. Major programs and services include cardiac care, critical care, cancer care, diagnostic imaging, emergency medicine, obstetrics, and a community medical fitness center. With no county hospital, SJH Queen of the Valley serves as the primary source of charity care.

In response to identified unmet health-related needs identified in the Community Health Needs Assessment conducted in 2014, the FY15-17 community benefit plan will focus on Childhood Obesity, Access to Dental Care, Continuum of Care, Access to Behavioral Health Services for the underserved disadvantaged members of the surrounding community and to some degree the broader community population.

To address the childhood obesity problem in Napa County, SJH Queen of the Valley will continue the Healthy for Life Program at 17 local schools. Healthy for Life (HFL) is a school-based obesity prevention program designed to emphasize lifelong fitness and healthy eating behaviors among children and adolescents. The program incorporates the following strategies: (1) School-based obesity prevention; (2) Intervention with at-risk children; (3) Community/ parent education; and, (4) Community and school policy advocacy.

As one of only three providers of dental care for low income or Medi-Cal eligible children in Napa County, SJH Queen of the Valley will provide comprehensive oral health services to 2,200 children annually through the Queen's Mobile Dental Clinic. Services targeted toward children living at or below 200 percent of the Federal Poverty level and are provided regardless of ability to pay. The program provides mobile clinic services at eight school and neighborhood sites as well as serving up to 1000 preschool and kindergarten children within the preschool premises.

To address improved access to critical medical and social supports for low-income residents and provide a continuum of care from hospital to outpatient settings, SJH Queen of the Valley will expand scope of services of the CARE Network program. CARE Network will provide intensive, community-based disease case management, transitional care and brief care coordination for 350-500 clients. Services address the unique needs of Medi-Cal enrolled and uninsured 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. The program is aimed at improving disease management and quality of life while reducing overall healthcare costs.

Access to low cost mental health services was ranked as a top priority in the past several community health needs assessments for Napa County. To address this need, SJH Queen of the Valley will continue to implement a multipronged approach with three integrated mental health programs that promote screening of targeted populations for depression, offer brief therapeutic interventions (1-10 sessions) and/or referrals to more intensive services and navigate clients to other community support services and groups. Program beneficiaries include postpartum mothers, CARE Network intensive case management clients and underserved older adults at risk for behavioral or cognitive health issues. Services are bilingual Spanish/English and link clients to community resources and services.

In addition, SJH Queen of the Valley will participate as a partner as well as support collaborative work to address the social determinants of health through the Parent University, a program to assist parents to participate in their child's education by providing classes in low income school settings and providing opportunities for engagement.

As resources allow, community benefit donations will be provided to organizations addressing the safety net needs of residents living in poverty including food access, housing, and caregiving.

SJH Queen of the Valley also will continue to provide an array of perinatal educational opportunities aimed at promoting healthy pregnancies and births with a focused outreach to the low-income population.

Live Healthy Napa County (LHNC) is a public-private partnership bringing together 80 agencies to collaboratively conduct Napa's CHNA and develop a comprehensive Community Health Improvement Plan (CHIP). To support and build the capacity of the community to address and prevent health problems through this community-wide partnership, SJH Queen of the Valley will include community benefit programs as an integral component of the CHIP and serve on LHNC Core Team guiding the CHIP over time.

Due to the fast pace at which the community and health care industry change, SJH Queen of the Valley anticipates that implementation strategies may evolve and therefore, a flexible approach is best suited for the development of its response to the SJH Queen of the Valley Community Health Needs Assessment (CHNA). On an annual basis SJH Queen of the Valley evaluates its CB Plan, specifically its strategies and resources; and makes adjustments needed to achieve its goals/outcome measures, and, to adapt to changes in resource availability.

Organizational Commitment

In 1986, St. Joseph Health created a plan and began an effort to further its commitment to neighbors in need. With a vision of reaching beyond the walls of health care facilities and transcending traditional efforts of providing financial assistance for those in need of acute care services, St. Joseph Health created the St. Joseph Health Community Partnership Fund (formerly known as the St. Joseph Health System Foundation) to improve the health of low-income individuals residing in local communities.

Each year SJH Queen of the Valley allocates 10 percent of its net income (net realized gains and losses) to the St. Joseph Health Community Partnership Fund. 7.5 percent of the contributions are used to support local hospital Care for the Poor programs. 1.75 percent is used to support SJH Community Partnership Fund grant initiatives. The remaining .75 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, SJH Queen of the Valley will endorse local non-profit organization partners to apply for funding through the St. Joseph Health Community Partnership Fund. Local nonprofits that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout St. Joseph Health hospitals' service areas.

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 (SJH-QV) lives out the tradition and vision of community engagement set out hundreds of years ago. The Sisters of St. Joseph of Orange trace their roots back to 17th century France and the unique vision of a Jesuit Priest named Jean-Pierre Medaille. Father Medaille sought to organize an order of religious women who, rather than remaining cloistered in a convent, ventured out into the community to seek out "the Dear Neighbors" and minister to their needs. The congregation managed to survive the turbulence of the French Revolution and eventually expanded not only throughout France but also throughout the world. In 1912, a small group of the Sisters of St. Joseph traveled to Eureka, California, at the invitation of the local Bishop, to establish a school. A few years later, the great influenza epidemic of 1918 caused the sisters to temporarily set aside their education efforts to care for the ill. They realized immediately that the small community desperately needed a hospital. Through bold faith, foresight and flexibility, in 1920, the Sisters opened the 28-bed St. Joseph Hospital Eureka and the first St. Joseph Health ministry.

Mission, Vision and Values and Strategic Direction

Our Mission

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

Our Vision

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

Our Values

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

St. Joseph Health, Queen of the Valley has been meeting the health and quality of life needs of the local community for over 50 years. Serving communities including American Canyon, Napa, Yountville, St. Helena, Calistoga, Angwin, Pope Valley and Lake Berryessa, SJH Queen of the Valley is an acute care hospital that provides quality care as the county's only Level III Trauma Center and neonatal intensive care unit. SJH-QV is committed to community wellness and is one of the first acute care providers to successfully develop and implement a medical fitness center, Synergy, in the Wellness Center on the medical center campus. Other medical specialties include: Robotic Surgery, a Cancer Center, Heart Center, Maternity/Infant Care, Neurosciences, Orthopedics, Rehabilitation Services, Women's Services, Imaging Services, and Wound Care Clinic. With over 1,368 employees committed to realizing the mission, SJH Queen of the Valley is one of the largest employers in the region.

Strategic Direction

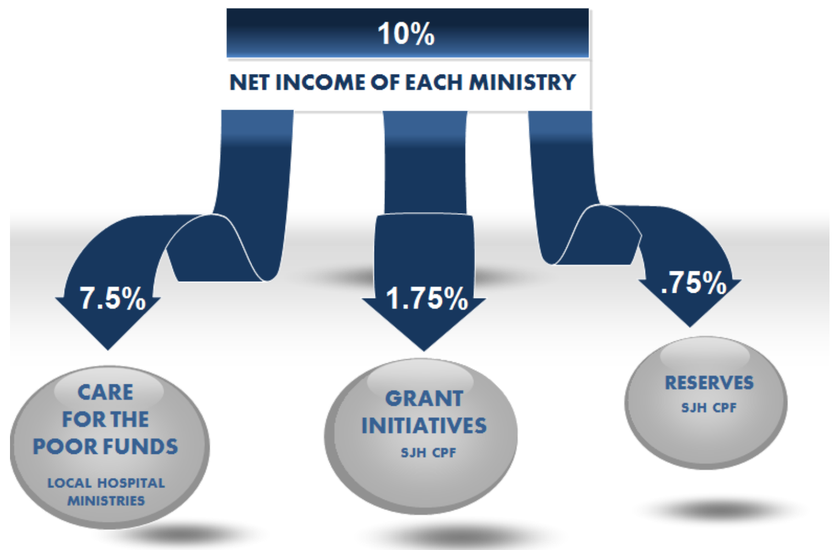
As we move into the future, SJH Queen of the Valley is committed to furthering our mission and vision while transforming healthcare to a system that is health-promoting and preventive, accountable in its inevitable rationing decisions, integrated across a balanced network of care and financed according to its ability to pay. To make this a reality, over the next five years (FY14-18) St. Joseph Health and Queen of the Valley are strategically focused on two key areas to which the Community Benefit (CB) Plan strongly align: population health management and network of care.

ORGANIZATIONAL COMMITMENT

SJH 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 health of low-income individuals residing in local communities served by SJH hospitals.

Figure 1. Fund distribution



Each year SJH Queen of the Valley allocates 10 percent of its net income (net realized gains and losses) to the St. Joseph Health Community Partnership Fund (See Figure 1). 7.5 percent of the contributions are used to support local hospital Care for the Poor programs. 1.75 percent is used to support SJH Community Partnership Fund grant initiatives. The remaining .75 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.

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Community Benefit Governance and Management Structure

SJH Queen of the Valley further 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, Community Outreach SJH Queen of the Valley are responsible for coordinating implementation of California Senate Bill 697 (provisions and Federal 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 the Community Benefit Plan.

The Community Benefit (CB) Management Team provides orientation for all new Hospital employees on Community Benefit programs and activities, including opportunities for community participation.

A charter approved in 2007 establishes the formulation of the SJH Queen of the Valley Community Benefit Committee. The role of the Community Benefit Committee is to support the Board of Trustees in overseeing community benefit issues. The Committee acts in accordance with a Board-approved charter. The Community Benefit Committee is charged with developing policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and

implementation of the Community Health Needs Assessment and Community Benefit Plan/Implementation Strategy Reports, and overseeing and directing the Community Benefit activities.

The Community Benefit Committee has a minimum of eight members including three members of the Board of Trustees. Current membership includes 11 of the Board of Trustees and nine community members. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Community Benefit Committee generally meets monthly.

Roles and Responsibilities

Senior Leadership

- CEO and other senior leaders are directly accountable for Community Benefit performance.

Community Benefit Committee (CBC)

- CBC serves as an extension of trustees to provide direct oversight for all charitable program activities and ensure program alignment with *Advancing the State of the Art of Community Benefit (ASACB) Five Core Principles*. It includes diverse community stakeholders. Trustee members on CBC serve as 'board level champions'.
- CBC provides recommendations to the Board of Trustees regarding budget, program targeting and program continuation or revision.

Community Benefit (CB) Department

- Manages CB efforts and coordination between CB and Finance departments on reporting and planning.
- Manages data collection, program tracking tools and evaluation.
- Develops specific outreach strategies to access identified Disproportionate Unmet Health Needs (DUHN) populations.
- Coordinates with clinical departments to reduce inappropriate ER utilization.
- Advocates for CB to senior leadership and invests in programs to reduce health disparities.

Local Community

- Partnership to implement and sustain collaborative activities.
- Formal links with community partners.
- Provide community input to identify community health issues.
- Engagement of local government officials in strategic planning and advocacy on health related issues on a city, county, or regional level.

COMMUNITY

Community Served
SJH Queen of the Valley provides the Napa County and surrounding communities with access to advanced care and advanced caring. With no county hospital, SJH Queen of the Valley, serves as the primary source of charity care. In total, for fiscal year 2013 SJH-QV contributed $17,091,507 in community benefit, excluding unreimbursed costs of Medicare. This amount helped care for the poor, vulnerable, low-income persons, the uninsured and underinsured.

Located 50 miles northeast of the San Francisco Bay Area, Napa is one of the most renowned agricultural as well as premium wine-producing regions in the world with a population of approximately 136,484 people (2010 Census), an increase of 9.8 percent from the 2000 Census. Napa County's Latino population grew by 50 percent from 2000 to 2010. The wine, agricultural, and hospitality industries are the county's largest and responsible for nearly 40,000 jobs. Immigrants have worked in Napa's vineyards, wineries, and hospitality sector for decades and are overrepresented in the County's workforce; however, Latino men have relatively low earnings compared to other county workers, mostly as a result of lower educational attainment and limited English proficiency. Latinos have become the largest demographic group of school children. Close to half (45 percent) of all children enrolled in Napa County's public schools were English Language Learners (ELL's) in 2008-09. In some areas of the county 30-50 percent of those over 25 years of age do not have a high school diploma. The academic achievement gap is high among children who are economically disadvantaged and/ children who are not.

The cost of living in Napa County is high with a family of four needing between $65,000 and $77,000 to meet their family's basic needs for food, shelter, childcare and healthcare. (Insight Center for Community Economic Development). Among Latinos, 51 percent live below the self-sufficiency level. Forty-one percent of Latino immigrant households in the county that rented were living in crowded conditions (Source: Profile of Immigrants in Napa County, 2012).

While Napa is not considered a "poor" county relative to other counties, including those with large agricultural areas, about 12 percent of children (3,670) and 7.2 percent of seniors age 65+ live below the poverty level and 26.4 percent live below 200 percent of poverty including 10,000 children. Due to the high cost of living in Napa County, 43 percent of families with children live below the family self-sufficiency level. (Source: Insight Center for Community Economic Development) Thirty-five percent of households speak a language other than English at home; 25 percent speak Spanish.

An estimated 15,246 residents are not U.S. citizens; this can swell during the growing season. With 15 percent of the population over 65 years of age, Napa County has a higher proportion of older adults compared to California as a whole and the third highest proportion of those 75 and older. Twenty-two percent of the population is 17 years of age and younger. According to the 2010 US Census, 56.4 percent of the population is White, 32.2 percent are Latino, 6.8 percent are Asian, 4.2 percent are two or more races, 2 percent are African American, 1.1 percent are other. (Source: American Community Survey, US Census 2010) Other social factors affecting Napa residents are lack of affordable housing, high cost of food and limited access to transportation for those without automobiles and growing academic achievement gap. The leading causes of death are cancers, coronary health disease, Alzheimer's disease and cerebrovascular disease. Chronic diseases such as heart disease and diabetes are on the rise as are correlating factors such as obesity and overweight. For a complete copy of SJH Queen of the Valley's FY14 CHNA click here: http://www.thequeen.org.

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 percent of discharges (excluding normal newborns)
- SSA: 71 percent-85 percent 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

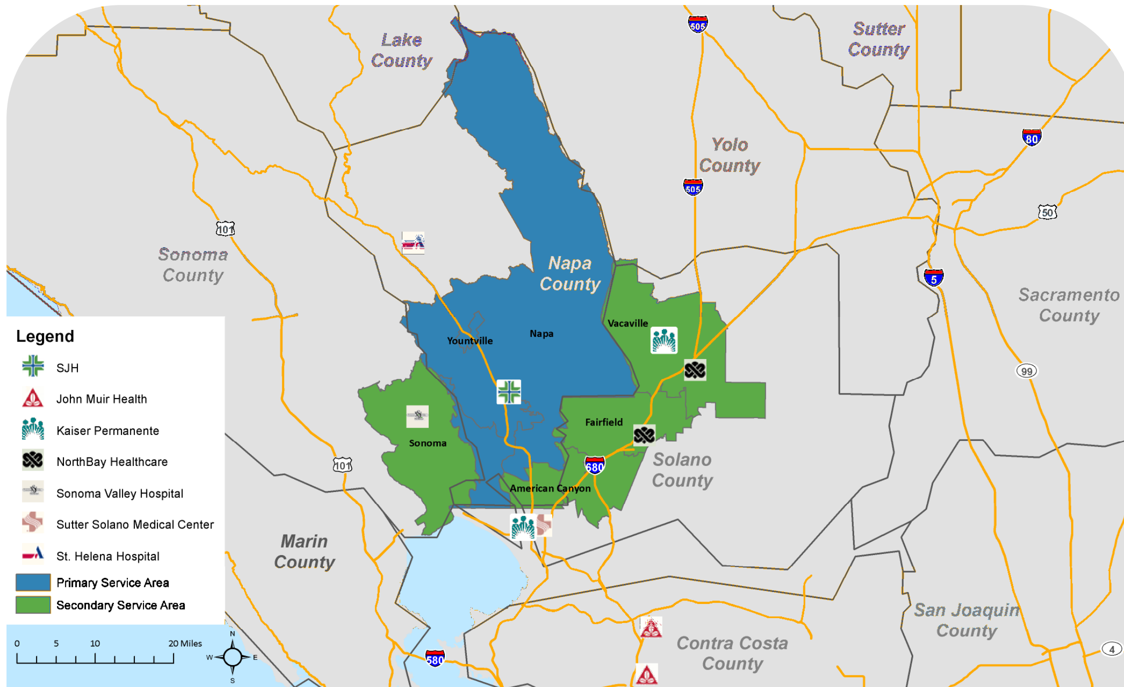
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients resides. The hospital's PSA is comprised of the cities of Napa and Yountville. The hospital's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

Table 1. Cities and ZIP codes

Cities	ZIP Codes
Napa/Lake Berryessa	94558, 94559
Yountville	94599
American Canyon	94503
Vacaville	95688, 95687
Sonoma	95476
Fairfield	94533, 94534

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.

Figure 1. SJH Queen of the Valley Medical Center Total Service Area



Community Need Index (Zip Code Level) Based on National Need
Dignity Health (formerly known as Catholic Healthcare West (CHW)) and Truven Health Analytics developed the Community Need Index (CNI). 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):

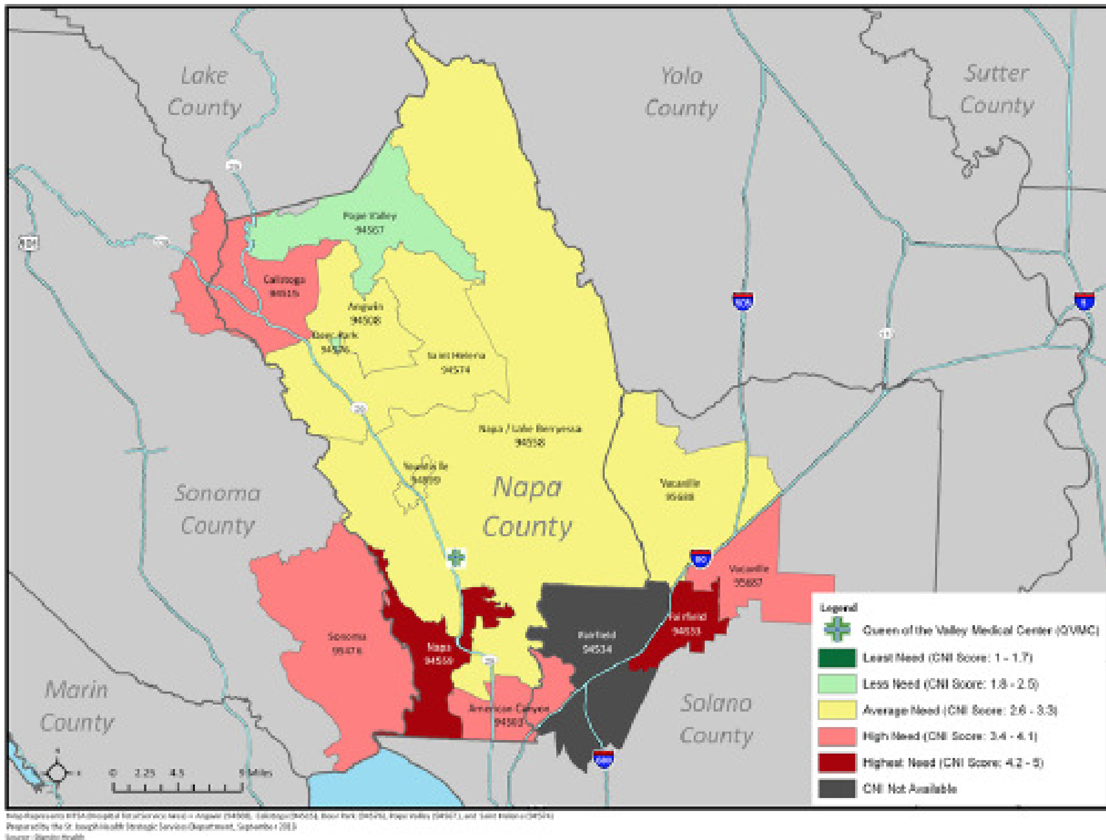
- Income Barriers (Elder poverty, child poverty and single parent poverty)
- Culture Barriers (non-Caucasian limited English);
- Educational Barriers (percent population without HS diploma);
- Insurance Barriers (Insurance, unemployed and uninsured);
- Housing Barriers (Housing, renting percentage).

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 94559 on the CNI map is scored 4.2 - 5, 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.

Figure 2. SJH Queen of the Valley Community Need Index (Zip Code Level)



Intercity Hardship Index (Block group level) Based Geographic Need

The Intercity Hardship Index (IHI) was developed in 1976 by the Urban and Metropolitan Studies Program of the Nelson A. Rockefeller Institute of Government to reflect the economic condition of cities and allow comparison across cities and across time. The IHI ranges from 0-100, with a higher number indicating greater hardship. The IHI was used by St. Joseph Health to identify block groups with the greatest need**.**

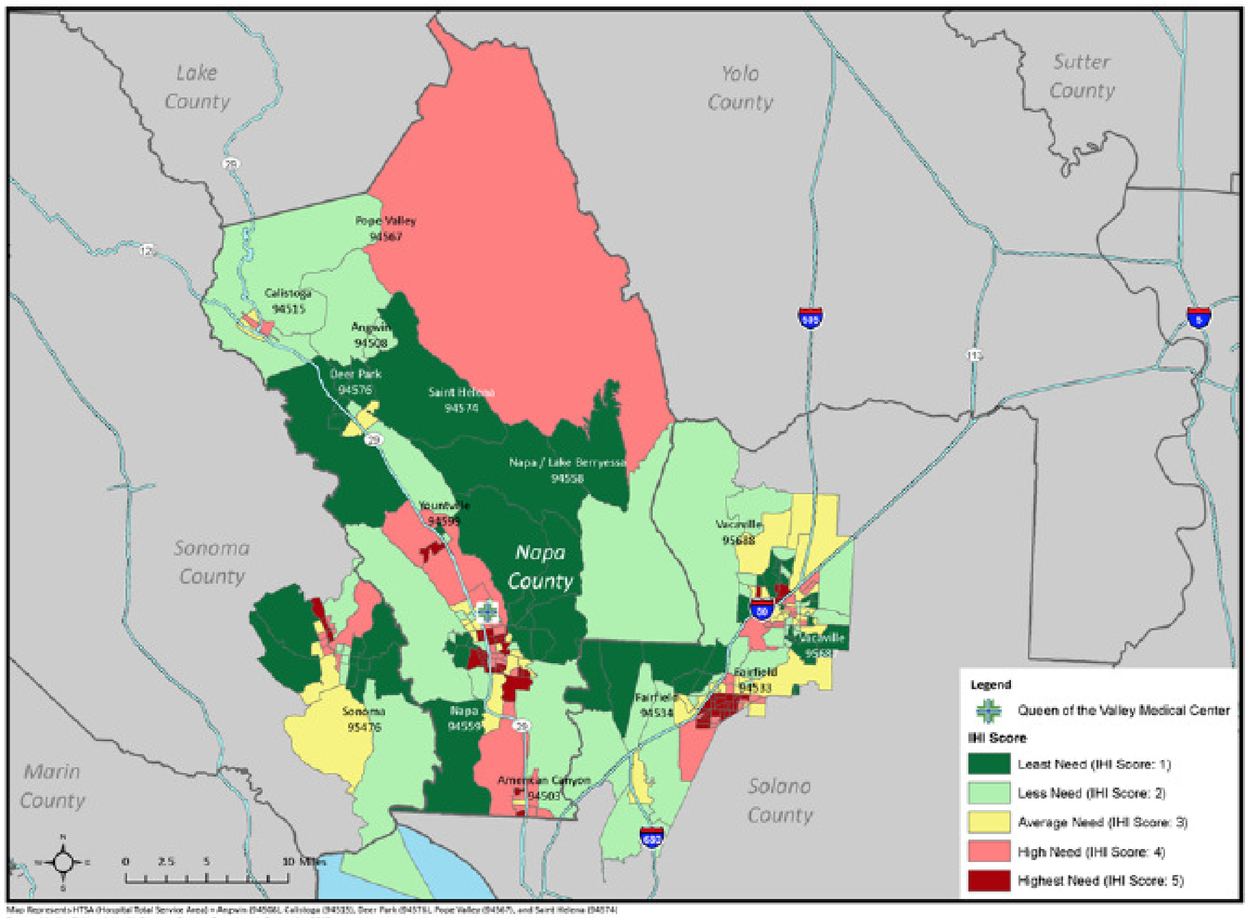
The IHI combines six key social determinants that are often associated with health outcomes:

1) Unemployment (the percent of the population over age 16 that is unemployed)
2) Dependency (the percent of the population under the age of 18 or over the age of 64)
3) Education (the percent of the population over age 25 who have less than a high school education)
4) Income level (per capita income)
5) Crowded housing (percent of households with seven or more people)
6) Poverty (the percent of people living below the federal poverty level)

Based on the IHI, each block group was assigned a score from 1 (lowest IHI, lowest level of hardship/need) to 5 (highest IHI, highest level of hardship/need). The IHI is based on ***relative need within a geographic area***, allowing for comparison across areas. Similar to what is seen with the Community Need Index; the highest need areas in Napa County are in the cities of Napa and Yountville.

Figure 3 (below) depicts the **Intercity Hardship Index** for the hospital's geographic service area and demonstrates *relative need.*

Figure 3. SJH Queen of the Valley Intercity Hardship Index (Block group Level)



COMMUNITY NEEDS AND ASSESSMENT PROCESS

Summary of Community Needs Assessment Process

SJH Queen of the Valley completed a needs assessment in 2013 year in partnership with Napa County Public Health, Kaiser Permanente, St. Helena Hospital, Napa Valley Coalition of Nonprofit Agencies and Community Clinic Ole. This new collaborative, Live Healthy Napa County (LHNC) is composed of a public-private partnership bringing together, among others, representatives not just from health and healthcare organizations, but also from business, public safety, education, government and the general public to develop a shared understanding and vision of a healthier Napa County. The collaborative process cast a wide net to include three different comprehensive needs assessments and a larger and more diverse stakeholder representative group to reach further into the community.

As part of this comprehensive CHNA, three community assessments strategies were employed.

1. The Community Themes, Strengths, and Forces of Change Assessment included the following qualitative information gathering processes:
   a) An online and paper survey of 2,383 residents (356 in Spanish) included a series of 28 multiple-choice questions that asked respondents to consider quality of life in Napa County, which health issues they felt were most pressing for County residents, how and where they accessed health care and social services, what barriers they faced in accessing services, how they viewed economic and housing conditions in the County, and types of recreational and volunteer activities.
   b) In addition to the survey, 300 residents and other stakeholders participated in 28 workshops. Workshop participants mapped community assets, prioritized key challenges and developed a vision for a healthy Napa County.
   c) In 16 stakeholder interviews leaders were asked to describe a healthy Napa County; identify the most important health factors and issues; identify populations that are adversely affected by health problems; and identify assets, strengths, and challenges that affect health throughout Napa County.
2. A Local Public Health System Assessment collected data for the Local Public Health System (the system) using the National Public Health Performance Standards Program's (NPHPSP) local instrument. The instrument reviews the "10 Essential Public Health Services (EPHS)" - core public health functions that should be undertaken in every community - as a framework to evaluate the system's performance and environmental and individual factors to create conditions for improved health and wellbeing in a community.
3. The Community Health Status Assessment included a comprehensive review of secondary data sources to obtain the most current and reliable data for the CHSA. Secondary data sources and resources included, but were not limited to, the U.S. Census, the American Community Survey, the California Department of Public Health (CDPH), the California Department of Education (CDE), the California Health Interview Survey (CHIS), the California Healthy Kids Survey (CHKS), the Behavioral Risk Factor Surveillance System (BRFSS), the CDC National Center for Health Statistics, the California Department of Justice, Healthy People 2020 (HP 2020), and the 2012 County Health Rankings and Roadmaps. Data collected through the Napa County Public Health Vital Statistics Office and the Public Health Communicable Disease Control program is also utilized.

Identification and Selection of DUHN Communities

Communities with Disproportionate Unmet Health-Related Needs (DUHN) are communities defined by ZIP codes and census tracts where there is a higher prevalence or severity for a particular health concern than the general population within our ministry Service Area.

Communities with DUHN generally meet one of two criteria: *either* there is a high prevalence or severity for a particular health concern to be addressed by a program activity, or there is evidence that community residents are faced with multiple health problems and have limited access to timely, high quality health care. The following table lists the DUHN communities/groups and identified community needs and assets.

DUHN GROUPS AND KEY COMMUNITY NEEDS AND ASSETS SUMMARY TABLE		
DUHN Population Group	**Key Community Needs**	**Key Community Assets**
Low income children **Latino children and their families**	Continued access to affordable, quality oral health services including preventive services and education	SJH-QV Mobile Dental Van Sister Anne's Dental Clinic Head Start WIC
	Prevention and early intervention to improve nutrition, physical activity and prevent obesity	Children& Weight Coalition SJH-QV Healthy for Life Program Schools SJH-QV Wellness Center Parent University Family Resource Centers
	Reduce educational opportunity gap (social determinant of health): Increase parental involvement in schools	Title I schools - NVSD Parent University On the Move
Low income pregnant women particularly women who do not speak English	Access to prenatal education to improve birth outcomes, encourage breastfeeding including number of low birth weight infants	SJH-QV bilingual perinatal education classes Healthy Moms and Babies Linkage to clinical care programs for pregnant women Breastfeeding Coalition
	Access to screening and early intervention for perinatal depression	SJH-QV Perinatal Mood Disorders program Prenatal providers
Low income adults, including Spanish-speaking adults	Chronic disease management: Access to care, support, education and mental health services to improve quality of life and disease management	SJH-QV Care Network SJH-QV (hospital) Community Health Clinic Ole Family Service of Napa Valley SJH-QV Wellness Center Adult Day Services
	Access to affordable, community-based behavioral health services for depression and other behavioral health issues	Family Service of Napa Valley Clinic Health Ole County Mental Health Services

	Access to affordable dental care	Sister Anne's Dental Clinic
	Access to affordable health care	Community Health Clinic Ole SJH-QV Napa County HHS
Low income seniors	Access to affordable, quality dental care	Sister Anne's Dental Clinic; FQHC
	Access to affordable mental health services including preventive programs	Family Services of Napa Valley Area Agency on Aging Adult Day Services County Services for Older Adults
	Chronic disease management	SJH-QV CARE Network Adult Day Services SJH-QV Community Health Clinic Ole Family Service of Napa Valley SJH-QV Wellness Center
	Access to community-based supports for independent living	Area Agency on Aging Community Action Napa Valley County Services for Older Adults In Home Supportive Services Senior Centers Home Health care agencies

More listings of community assets can be found at *http://napa.networkofcare.org/ph/services/index.aspx*

PRIORITIZED COMMUNITY HEALTH NEEDS

The Needs Assessment Collaborative agreed that an important opportunity exists in Napa County for all health partners—regardless of their own organization's mission and priorities—to focus on the following 4 priority areas in no particular ranked order:

COMMUNITY HEALTH PRIORITIES
• Improve Wellness and Healthy Lifestyles o Physical health improved o Mental health improved o Prevention resources • Address Social Determinant of Health o Social and physical environments promote good health for all o Equitable educational and economic opportunities • Create and Strengthen Sustainable Partnerships for Collective Impact o Public health system collaboration o Community engagement and leadership o New systems and strategic alliances to focus on policies and practices to address local issues • Ensure Access High Quality Health Services and Social Support o All ages will have access to care to achieve optimal health and reach fullest potential o Health services and social supported are integrated o Prevention services available to all high risk individuals and families

COMMUNITY BENEFIT PLAN

Summary of Community Benefit Planning Process
The FY15-17 CB Plan was developed in response to findings from the SJH-QV FY14 Community Health Needs Assessment and is guided by the following five core principles:

- **Disproportionate Unmet Health-Related Needs:** Seek to accommodate the needs to communities with disproportionate unmet health-related needs.
- **Primary Prevention:** Address the underlying causes of persistent health problem.
- **Seamless Continuum of Care:** Emphasis evidence-based approaches by establishing operational between clinical services and community health improvement activities.
- **Build Community Capacity:** Target charitable resources to mobilize and build the capacity of existing community assets.
- **Collaborative Governance:** Engage diverse community stakeholders in the selection, design, implementation, and evaluation of program activities.

The SJH-QV Community Benefit Committee (a cross section of community leaders, nonprofit sector providers, community members and SJH-QV leadership) discussed and agreed upon specific criteria to be used in ranking health priorities as follows:

CRITERIA
• Builds upon and aligns current programs with identified priority community health needs (Live Healthy Napa Valley) and SJH-QV strategic priorities particularly related to population health and networks of care. • Focuses on most vulnerable and addresses health disparities • Has potential for high impact on issue/individuals • Works upstream: prevention and early intervention • Committed partners and opportunities for linkages with other organizations, institutions and stakeholders • Competency • Engages and empowers those to be served • Important to the community to be served • Is feasible with sufficient resources available to address adequately • Measurable • Align with ASACB Core Principles

Ranking Health Priorities
The SJH-QV Community Benefit Committee had a lengthy discussion of the findings from the Community Health Needs Assessment and the strategic initiatives of the hospital. Following this discussion, members of the SJH Queen of the Valley Community Benefit Committee rank ordered the four health priorities developed by the LHNC CHNA Steering Committee. Each member of the committee ranked each priority area as #1 through #4 with #1 as the highest priority. Items ranked #1 received 4 points, #2 equaled 3 points, #3 equaled 2 points and #4 equaled 1 point. Weighted scores for each need were calculated by adding the number of points received. The result of this ranking process is as follows:

PRIORITY HEALTH NEED	POINTS
#1 Priority: Improve Wellness and Healthy Lifestyles	61
#2 Priority: Ensure Access to High Quality Health Services and Supports	55
#3 Priority: Address Social Determinants of Health	54
#4 Create and Strengthen Sustainable Partnerships for Collective Impact	35

Summary of Community Benefit Planning Process
Following the full Community Benefit Committee ranking of priority areas, the Community Benefit Committee convened a representative Planning Committee including staff, community members, professionals and hospital trustees to review the findings and determine how best to align the community benefits efforts of the SJH Queen of the Valley over the next three years with the health priority areas above and address unmet needs in the community.

The Planning Committee convened in three meetings over eight hours to develop a recommended implementation framework (initiatives and programs) for the FY15-17 Community Benefit plan in alignment with the health priorities and the criteria above.

The processes included reviewing and discussing:

- SB697 guidelines and core principles
- The Ministry Goals
- Past and current community benefit activities including charity care contribution
- Community Health Needs Assessment
- Communities and populations where disproportionate health needs exist
- Criteria for selection of priority initiatives for SJH Queen of the Valley investment.

To determine priority initiatives and programs the committee identified:

- Key health issues for consideration, current trends/community context and common themes
- Findings that were unexpected and surprising as well as assumptions that were supported by the needs assessment data
- Opportunities, challenges and barriers to addressing issues
- Specific opportunities for SJH Queen of the Valley to contribute to improving community health in Napa County, particularly for those with disproportionate need.

Prior to the convening of the Planning Committee, Community Outreach staff conducted a comprehensive evaluation of current programs in order to assess alignment with needs identified in the current CHNA, effectiveness and efficiency of the services provided, and leveraging of community resources. Following staff evaluation, the Planning Committee also reviewed these existing community benefit programs and evaluated the value of these programs in addressing DUHN communities and identified health priorities.

The Strategic Planning Committee identified the following health issues under the four health priorities. The issues were placed in two categories: ongoing health issues and emerging issues. Following discussion and review, the health issues were ranked using a scaled ranking process. Scores were aggregated for each health issue and rank ordered by score. Items are listed in rank order:

Ongoing Health Needs	Emerging Issues
1. Chronic Diseases (Healthcare Access) 2. Mental and Emotional Health (Healthcare Access) 3. Childhood Obesity (Wellness) 4. Dental Care (Healthcare Access) 5. Community Health Partnerships (Sustainable Partnerships) 6. Perinatal Education (Wellness) 7. Educational Opportunity Gap (SDoH)* 8. Safety Net (SDoH)*	1. Continuum of Care for uninsured (Healthcare Access) 2. Living Wage; Family Self-sufficiency (SDoH)* 3. Accessibility to social supports and services (SDoH)* 4. Immigration (SDoH)*

* Social determinants of health

Building upon and leveraging existing programs and partnerships and critical gaps, the Planning Committee identified key initiatives, programs and strategies to address the specific health needs above to design a framework for the Community Benefit efforts in FY 15-17. The Community Benefit Committee reviewed and approved the implementation framework.

Based on this review of prioritized significant health needs and a thoughtful priority setting process, SJH Queen of the Valley will address the following four priority areas with specific initiatives or programs as part of its FY15-17 CB Plan:

1. **Improve Wellness and Healthy Lifestyles/Childhood Obesity: Healthy for Life Program**

SJH Queen of the Valley will continue to implement the Healthy for Life Program, currently at 17 local schools. Healthy for Life (HFL) is a school-based obesity prevention program designed to emphasize lifelong fitness and healthy eating behaviors among children and adolescents. The program incorporates the following strategies: (1) School-based obesity prevention; (2) Intervention with at-risk children; (3) Community/ parent education, and, (4) Community and school policy advocacy. Curriculum components depending on age level appropriateness may include nutrition, aerobic exercise, and resistance training. The SJH QV Healthy for Life Program focuses on children at risk for obesity and their families in Napa County, particularly those in low-income neighborhoods and schools. HFL will focus risk assessments, nutrition programming and physical activity training at elementary schools with a preponderance of children from low income or diverse families. Three nutrition sessions and a summer teacher training that would emphasize lifelong fitness will be provided for all levels (elementary, middle and high schools). Additionally, a dietician will provide individualized family counseling for elementary students identified as obese (95 percentile or above).

2. **Improve Access to quality health services and supports/Continuum of Care: CARE Network**

CARE Network implements intensive disease case management, transitional care and brief care coordination services addressing the unique needs of Medi-Cal enrolled and uninsured 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. The program is aimed at improving disease management and quality of life while reducing overall healthcare costs. Upon referral from the hospital, primary care or other partners, a multi-disciplinary team comprised of an SW intake specialist, an RN case manager, an MSW case manager, an LCSW behavioral health specialist, and a community care aide develop and implement an individualized care plan with the client based on level and type of care requited. Intensive case management clients receive a comprehensive assessment of medical, psychosocial, economic needs. Case managers work directly with hospital social work, health care providers, community resources staff and Napa County Social Services, Mental Health and Alcohol and Drug Services to address each client's unique needs.

3. **Improve Access to Quality Health Services and Supports/Dental Care: Children's Mobile Dental**

QVMC's Mobile Dental Clinic provides a comprehensive array of dental services targeted toward children living at or below 200 percent of the Federal Poverty level. Services are provided regardless of ability to pay. The program is a primary provider of services to low-income Napa County children serving more than 2200 children annually at 8 school and neighborhood sites and up to 1000 preschool and kindergarten children at their school sites. SJH, QV Mobile Dental Program Strategies includes (1) Oral health screening in preschools and kindergartens serving low income children; (2) Mobile Dental Clinic 6-month examinations and cleaning; (3) Patient and parent/caregiver education at examinations and, (4) Mobile Dental clinical procedures as determined by patient guidelines and needs including fillings, extractions, pulpotomy, root canals, crowns, scaling and root planning, and space maintainers. In addition, for children requiring sedation, the Mobile Dental Clinic director may provide surgical procedures at the medical center.

4. **Improve Access to Quality Health Services and Supports/Behavioral Health: Healthy Aging-Healthy Minds, CARE Network Behavioral Health Integration, Perinatal Mood Disorder**

Access to low cost mental health services ranked as a top priority in the past three community health needs assessments for Napa County. To address this ongoing need, SJH Queen of the Valley will continue to implement a multipronged approach with three mental health programs that promote screening of targeted populations for depression, offer brief therapeutic interventions (1-10 sessions) and/or referrals to more intensive services and navigate clients to other community support services and groups. These programs target 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. The perinatal emotional wellness program provides free counseling and referral services for pregnant and postpartum women experiencing depression and other behavioral health concerns. CARE Network Integrated Behavioral Health provides free mental health services to low-income chronically ill clients. Services include cognitive and behavioral health assessments, case management, therapy sessions, as well as community presentations, provider education and caregiver training and support.

Addressing the Needs of the Community: Healthy for Life Program
FY15 –17 Key Community Benefit Plan

Initiative (community need being addressed): Level of childhood obesity among Napa children is very high, particularly among Latino children. According to the California Department of Education prevalence in overweight and obesity among 5th, 7th and 9th grade students in Napa is 40 percent, up 6.1 percent from 2005 to 2010; this is the largest increase among Bay Area counties. Nearly 50 percent of economically disadvantaged students were overweight or obese.

Goal (anticipated impact): Reduce risk factors for obesity among at risk children participating in Healthy for Life Program

Outcome Measure	Baseline	FY15 Target	FY17 Target
Percentage of children participating in the program assessed as overweight and obese (100-150) re-classifying to a lower weight category by the end of the school year	*9.5 percent (average of FY 12 and 13)*	*10 percent*	*12 percent*

Strategy(ies)	Strategy Measure	Baseline	FY15 Target
1.Implement school-based physical activity and healthy eating program	1. Number/Percent of children participating in HFL program that improve healthy lifestyle choices	TBD	Establish baseline and target
2. Refer children at the 95 percent or above BMI percentile and their families to nutirition counseling	2. Number of children referred for interventions	TBD	Establish baseline and target

Key Community Partners: Napa Valley Unified School District, 17 schools, QVMC Wellness Center, Community Clinic Ole, pediatricians, Children and Weight Coalition, Kaiser Permanente

Addressing the Needs of the Community: Healthy for Life Program
FY15 –17 Key Community Benefit Plan

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Goal (anticipated impact): Reduce risk factors for obesity among at risk children participating in Healthy for Life Program

Outcome Measure
Percentage of children participating in the program assessed as overweight and obese (100-150) re-classifying to a lower weight category by the end of the school year

Strategy(ies)
1.Implement school-based physical activity and healthy eating program
2. Refer children at the 95 percent or above BMI percentile and their families to nutirition counseling

Addressing the Needs of the Community: CARE Network
FY15 –17 Key Community Benefit Plan

Initiative (community need being addressed): FY 13 *Community health needs assessment showed access to health services and supports for underserved communities as a key community need along with high rates of chronic conditions including heart disease and diabetes.*

Goal (anticipated impact): *Improve disease management and quality of life of low-income adults and older adults with acute to moderate medical conditions, chronic diseases and/or comorbidities, and complex socio-economic needs*

Outcome Measure	Baseline	FY15 Target	FY17 Target
Percentage improvement in ED visits among new clients post-enrollment compared to pre-enrollment	*TBD*	*Baseline and target is established*	*TBD*

Strategy(ies)	Strategy Measure	Baseline	FY15 Target
1. Provide Intensive Case Management Services to individuals at high medical and psychosocial acuity level	3. Percentage improvement in hospitalizations for new clients post enrollment compared to pre-enrollment	TBD	Defined baseline and target
2. Provide 30 day Transitional Care from inpatient to outpatient for patients at high risk for readmission	4. Rate of hospital readmission at 30 days post hospitalization	TBD	Define baseline and target
3. Provide Brief Care Coordination for individuals at moderate to low acuity level needing brief support	5. Percentage of clients not requiring higher level case management services	TBD	Define baseline and target

Key Community Partners: *Community Clinic Ole, Napa County Health and Social Services (Substance Abuse Services, Mental Health Services, eligibility, Stakeholder Committee, Family Service of Napa Valley, County Probation, Food Bank, QVMC Inpatient Social Work, Homeless and Housing providers.*

Addressing the Needs of the Community: CARE Network
FY15 –17 Key Community Benefit Plan

Initiative (community need being addressed): FY 13 *Community health needs assessment showed access to health services and supports for underserved communities as a key community need along with high rates of chronic conditions including heart disease and diabetes.*

Goal (anticipated impact): *Improve disease management and quality of life of low-income adults and older adults with acute to moderate medical conditions, chronic diseases and/or comorbidities, and complex socio-economic needs*

Outcome Measure
Percentage improvement in ED visits among new clients post-enrollment compared to pre-enrollment

Strategy(ies)
1. Provide Intensive Case Management Services to individuals at high medical and psychosocial acuity level
2. Provide 30 day Transitional Care from impatient to outpatient for patients at high risk for readmission
3. Provide Brief Care Coordination for individuals at moderate to low acuity level needing brief support

Key Community Partners: *Community Clinic Ole, Napa County Healthy and Social Services (Substance Abuse Services, Mental Health Services, eligibility, Stakeholder Committee, Family Service of Napa Valley, County Probation, Food Bank, QVMC Inpatient Social Work, Homeless and Housing providers.*

Addressing the Needs of the Community: Children's Mobile Dental
FY15 –17 Key Community Benefit Plan

Initiative (community need being addressed): *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.*

Goal (anticipated impact): *To improve oral health status of 2200 children annually 6 months to 21 years of age in Napa County, particularly those who are uninsured or underinsured*

Outcome Measure	Baseline	FY15 Target	FY17 Target
Percentage of patients who demonstrate oral health status improvement at recall visit based on a set of clinical criteria	***91.5 percent***	***92 percent***	***93 percent***

Strategy(ies)	Strategy Measure	Baseline	FY15 Target
1. Provide early oral health screening and education in preschools and kindergartens	1. Number of children provided early screening for oral health problems	600	600
2. Provide mobile dental 6-months examinations and cleanings	2. Percentage of patients in random case review having seen a dentist within 6 months to one year following initial exam	81 percent	82 percent
3. Provide patient/parent education on oral health	3. Percentage of patients/parents reporting improved oral health behaviors	97 percent	98 percent

Key Community Partners: Preschools, schools and community sites (WIC, Family Resource Centers, Girls and Boys Club, etc.) SJH-QV, Sister Ann's Dental and local dental specialists.

Addressing the Needs of the Community: Children's Mobile Dental
FY15 –17 Key Community Benefit Plan

Initiative (community need being addressed): *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.*

Goal (anticipated impact): *To improve oral health status of 2200 children annually 6 months to 21 years of age in Napa County, particularly those who are uninsured or underinsured*

Outcome Measure
Percentage of patients who demonstrate oral health status improvement at recall visit based on a set of clinical criteria

Strategy(ies)
1. Provide early oral health screening and education in preschools and kindergartens
2. Provide mobile dental 6-months examinations and cleanings
3. Provide patient/parent education on oral health

Key Community Partners: Preschools, schools and community sites (WIC, Family Resource Centers, Girls and Boys Club, etc.) SJH - QV, Sister Ann's Dental and local dental specialists.

Addressing the Needs of the Community: Behavioral Health
FY15 –17 Key Community Benefit Plan

Initiative (community need being addressed): *Mental and emotional health services, particularly for low income, Spanish-speakers and uninsured adults, older adults and pregnant women was identified in FY13 Needs Assessment as a critical gap in access to health services and support.*

Goal (anticipated impact): Reduce depression among low-income older adults, individuals with chronic disease and pregnant and postpartum women.

Outcome Measure	Baseline	FY15 Target	FY17 Target
Percentage of clients that improve depression as measured through validated tools appropriate to the target population	90% (FY13)	91%	92%

Strategy(ies)	**Strategy Measure**	**Baseline**	**FY15 Target**
1. Identify individuals with risk factors for depression using validated tools	1. Number of individuals identified with risk factors for depression	1380 (FY13)	1385 (FY13)
2. Provide interventions or refer individuals with positive screens to behavioral health services	2. Percentage of individuals with positive screens provided services or referrals	TBD	Set baseline

Key Community Partners: Family Service of Napa Valley, Ob-Gyns, Pediatricians, Community Clinic Ole, Older Adult providers, Area Agency on Aging, Adult Day Services, Napa County Health and Human Services,

Addressing the Needs of the Community: Behavioral Health

Initiative (community need being addressed): *Mental and emotional health services, particularly for low income, Spanish-speakers and uninsured adults, older adults and pregnant women was identified in FY13 Needs Assessment as a critical gap in access to health services and support.*

Goal (anticipated impact): Reduce depression among low-income older adults, individuals with chronic disease and pregnant and postpartum women.

Outcome Measure
Percentage of clients that improve depression as measured through validated tools appropriate to the target population

Strategy(ies)
3. Identify individuals with risk factors for depression using validated tools
4. Provide interventions or refer individuals with positive screens to behavioral health services

Key Community Partners: Family Service of Napa Valley, Ob-Gyns, Pediatricians, Community Clinic Ole, Older Adult providers, Area Agency on Aging, Adult Day Services, Napa County Health and Human Services

Planning for the Uninsured and Underinsured

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 we have a **Patient Financial Assistance Program**[1] that provides free or discounted services to eligible patients.

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

Medicaid and Other Local Means-Tested Government Programs

SJH Queen of the Valley provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California, and other local means-tested government programs.

[1] *Information about SJH Queen of the Valley Medical Center's Financial Assistance Program is available www.thequeen.org/For-Patients/Billing-Information*

Other Community Benefit

In addition to the preceding priority areas, SJH Queen of the Valley plans to provide other community benefit programs responsive to the health needs identified in the 2014 CHNA. Community Benefit programs listed below only includes additional Community Services for the Low-income and Broader Community that have not been previously covered in this CB Plan/Implementation Strategy Report.

Initiative (community need being addressed):	Program	Description	Target Population (Low Income or Broader community)
1. Social Determinants Of Health	Parent University	Core curriculum and workshops provided at low income schools to assist parents to become actively engaged in children's school	Low Income
2. Improve Wellness And Healthy Lifestyles	Perinatal Education	Perinatal classes on birth preparation, infant care, breastfeeding and safety	Broader community
3. Address Social Determinants Of Health	Safety Net/Basic Needs	Small donation to community partners to provide for basic needs such as food, shelter and caregiving	Low Income
4. Access To Health Services And Supports	Continuum of Care/Operation access	Collaborative funding to implement access to diagnostic screening, procedures and surgeries for the uninsured	Low income
5. Access To Health Services And Supports	Continuum of Care	Cancer and HIV clinic support at FQHC Community Health Clinic Ole	Low income
6. Create & strengthen Sustainable Partnerships	Partnerships for Community Health	Live Healthy Napa County/Community Health Improvement Plan	Broader community
7. Create & strengthen Sustainable Partnerships	Healthy Aging Population Initiative (HAPI)	HAPI is a coalition of 20-30 older adult serving organizations. HAPI assesses older adult needs and advocates policy and develops collaborative strategies to address needs	Broader community

Needs Beyond the Hospital's Service Program

Although no health care facility can address all of the health needs present in its community, we are committed to continue our Mission through community benefit efforts and by funding other non-profits through the St. Joseph Community Partnership Fund.

The following community health needs identified in the ministry CHNA will not be directly addressed through programming. An explanation is provided below:

Basic Needs (specifically housing, income equality, public transportation system, environmental): The hospital does not directly address affordable housing, living wage, public transportation, and public environmental issues. However, we partner with several organizations that provide these services including Napa Valley Community Housing, Legal Aid, Napa County Self Sufficiency, Napa County Transportation Planning Agency, and Community Action Napa Valley (CANV) homeless shelters. In addition, we support and endorse grant applications to the St. Joseph Health Community Partnership Fund for Community Action Napa Valley (CANV), the largest provider of food and shelter to the poor in the community. Without this funding these services would not be able to sustain and / or further their work.

Drug and Alcohol: The hospital does not directly address community-based drug and alcohol abuse prevention and treatment; however, we partner with Napa County Drug and Alcohol, Catalyst Coalition, CANV Tobacco Cessation, and McAllister Institute residential drug treatment center.

Countywide Communication/Data Systems: The LHNC collaborative identified that the overarching Local Public Health System has challenges coordinating communication and data systems across Napa County organizations. Although the hospital does not directly address this need, we partner with LHNC as a key Core Support Team member in seeking resources to further LHNC and CHIP efforts of a coordinated continuum of care for the Napa community.

Dental Services for Older Adults: The hospital does not directly provide dental services for older adults; however, we do partner with our FQHC, Sr. Anne's Dental Clinic, through a shared dental clinic director to enhance capacity and coordination of dental services for the low-income and uninsured population.

Governance Approval

This Community Benefit Plan/Implementation Strategy Report was approved at the May 22, 2014 meeting of the St. Joseph Health, Queen of the Valley's Community Benefit Committee of the Board of Trustees.

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Chair's Signature confirming approval of the FY15-17 Community Benefit Plan

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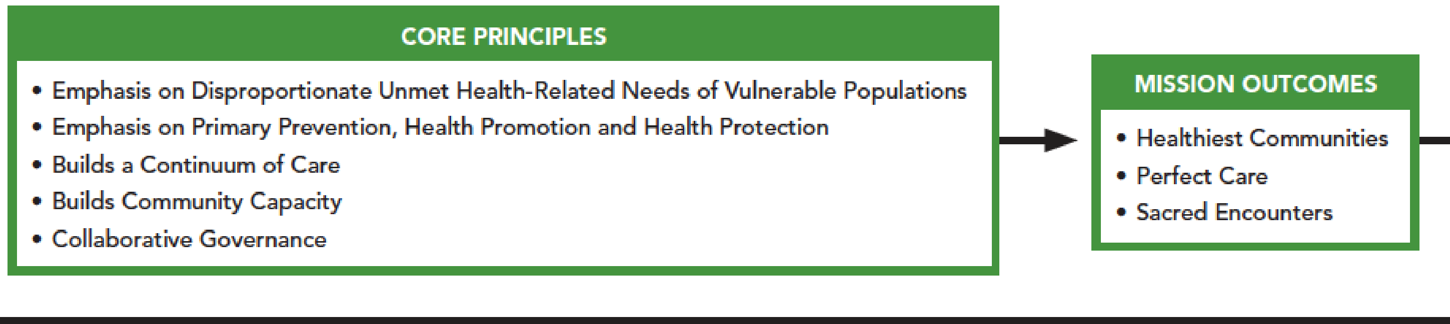
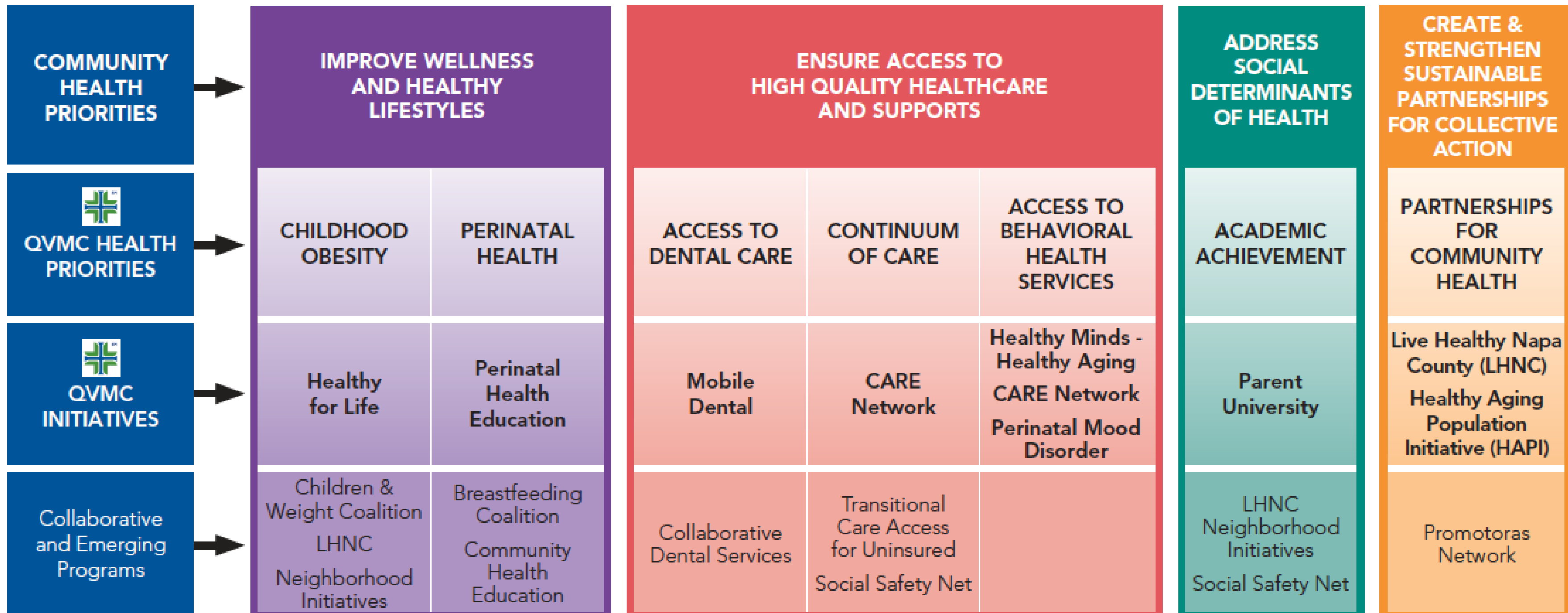
Date

Community Benefit Implementation Framework FY 15-17





ACCESS TO HIGH QUALITY HEALTHCARE & SUPPORTS: DENTAL CARE: CHILDREN'S MOBILE DENTAL

GOAL	To improve oral health status of 2200 children 6 months to 21 years of age in Napa County, particularly those who are uninsured or underinsured

OUTCOME MEASURE	Percentage of patients who demonstrate oral health status improvement at recall visit based on a set of clinical criteria

STRATEGY 1	STRATEGY MEASURE	ACTIVITY	ACTIVITY MEASURE
Provide early oral health screening and education in preschools and kindergartens	Number of children provided early screening for oral health problems	Provide onsite screenings at schools	Number of schools
		Refer children w/o dental home to a dental home	Number of children referred

STRATEGY 2	STRATEGY MEASURE	ACTIVITY	ACTIVITY MEASURE
Provide 6-months examinations and cleanings	Percentage of patients having seen a dentist within 6 months to one year following initial or last recall exam conducted at Mobile Dental	Provide regular exams and cleaning for existing patients	Number of existing patients receiving cleaning and examinations
		Provide examinations and cleanings for new patients	Number of new patients receiving cleaning and examinations

ACCESS TO HIGH QUALITY HEALTHCARE & SUPPORTS: DENTAL CARE: CHILDREN'S MOBILE DENTAL

GOAL	To improve oral health status of children 6 months to 21 years of age in Napa County, particularly those who are uninsured or underinsured

OUTCOME MEASURE	Percentage of patients who demonstrate oral health status improvement at recall visit based on a set of clinical criteria

STRATEGY 3	STRATEGY MEASURE	ACTIVITY	ACTIVITY MEASURE
Provide patient/parent education on improving and maintaining oral health	Percentage of patient/parents reporting improved oral health behaviors	Instruct children and families on proper brushing, flossing and nutrition at examinations	Number of patients instructed

STRATEGY 4	STRATEGY MEASURE	ACTIVITY	ACTIVITY MEASURE
Provide Mobile Dental procedures as necessary and indicated	Percentage of those receiving procedures who have reduced caries at follow-up	Address caries through fillings, crowns, extractions, primary tooth root canals in new and existing patients	Number of procedures
			Number of patients

ACCESS TO HIGH QULTIY HEALTHCARE & SUPPORTS: CONTINUUM OF CARE: CARE Network

GOAL	*Improve disease management and quality of life of low-income adults and older adults with acute to moderate medical conditions, chronic diseases and/or comorbidities, and complex socio-economic needs*

OUTCOME MEASURE	*Percentage improvement in ED use of new clients at post- enrollment when compared to pre-enrollment*

STRATEGY 1	STRATEGY MEASURE	ACTIVITY	ACTIVITY MEASURE
Provide intensive case management to reduce medical acuity, improve disease management and quality of life	*Percentage improvement in hospitalizations for new clients post enrollment compared to one year pre-enrollment*	RN assess gaps in medical care and disease management	Number of new clients assessed
		RN medical care and disease management interventions and supports	Number of medical and supports provided
			Percentage of clients demonstrating Improvement on self-management scale
		SW interventions based on assessed need to improve quality of life	Number of psychosocial supports provided
			Percentage improvement in quality of life among new clients at 3 months as measured by SF12

STRATEGY 2	STRATEGY MEASURE	ACTIVITY	ACTIVITY MEASURE
Provide 30 day Transitional Care from impatient to outpatient for patients at high risk for readmission	*Rate of readmission of new clients to hospital at 30 days*	RN telephonic or home visit support	Number of clients/number of contacts
		Medical resources referral or provision	Number of resources or referrals provided

STRATEGY 3	STRATEGY MEASURE	ACTIVITY	ACTIVITY MEASURE
Provide Brief Care Coordination for individuals at moderate to low acuity level needing brief support	*Percentage of clients not requiring higher level case management services*	SW telephonic support or home visit	Number of clients/number of contacts
		Referrals and linkages to needed supports	Number of resources or referrals provided

ACCESS TO HIGH QUALITY HEALTHCARE & SUPPORTS: BEHAVIORAL HEATLH

GOAL	*Reduce depression among low income older adults, those with chronic disease and pregnant and postpartum women*

OUTCOME MEASURE	*Percentage of clients that improve depression as measured through validated tools appropriate to the target population*

STRATEGY 1	STRATEGY MEASURE	ACTIVITY	ACTIVITY MEASURE
Identify individuals with risk factors for depression using validated tools	Number of individuals identified with risk factors for depression	Screen individuals for risk factors using validated tools	Number of individuals screened
			Number of individuals with positive screens

STRATEGY 2	STRATEGY MEASURE	ACTIVITY	ACTIVITY MEASURE
Provide interventions or refer individuals with positive screens behavioral health services	Percentage of individuals with positive screens provided services or referrals	Therapists provide therapeutic interventions	Number of clients provided interventions
			Number of intervention sessions
		Therapists refer individuals to external services as appropriate	Number of individuals referred for external services
		Therapists refer discharged clients to outside BH services upon discharge as needed	Number of clients referred for outside services upon discharge

IMPROVE WELLNESS & HEALTHY LIFESTYLES: CHILDHOOD OBESITY: HEALTHY FOR LIFE

GOAL	*Reduce risk factors for obesity among at risk children participating in Healthy for Life Program*

OUTCOME MEASURE	*Percentage of children participating in the program assessed as overweight and obese (100-150) re-classifying to a lower weight category by the end of the school year*

STRATEGY 1	STRATEGY MEASURE	ACTIVITY	ACTIVITY MEASURES
Implement school-based physical activity and healthy eating program to improve healthy lifestyles	Percent of children participating in HFL program that report improved healthy lifestyle choices	Train teachers at designated schools to implement classroom curriculum	Number of teachers trained
			Number of schools
		Provide nutrition classes in schools	Number of sessions of nutrition education provided
			Number students reached (duplicated)
		Provide physical activity classes at participating schools	Number of physical activity sessions provided
			Number of students reached

STRATEGY 2	STRATEGY MEASURE	ACTIVITY	ACTIVITY MEASURES
Refer children at the 95% or above BMI percentile and their families to nutirition counseling	Percentage of children/families referred for interventions that participate in 2 or more sessions	Assess children for overweight or obesity	Number of children assessed
		Provide nutrition counseling to families	Number of sessions provided/number of families