ST. JOSEPH HEALTH QUEEN OF THE VALLEY

2017 Community Health Assessment Report

To provide feedback about this Community Health Needs Assessment, email Dana Codron at Dana.Codron@stjoe.org

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[1] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives:

a. Improves access to health services;
b. Enhances public health;
c. Advances increased general knowledge; and/or
d. Relieves government burden to improve health.

Community benefit includes both services to the poor and broader community.

[2] To be reported as a community benefit initiative or program, **community need must be demonstrated**. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

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ACKNOWLEDGEMENTS

It is with gratitude and great pride that we present St. Joseph Health Queen of the Valley Medical Center's Community Health Needs assessment to our community. In alignment with our mission and values, Queen of the Valley has a long history of extending care beyond our hospital walls. These community-based programs, services and partnerships are strategically implemented based on needs that are identified through a community health needs assessment that is conducted every three years.

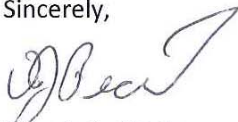
This report is the culmination of a formal community health needs assessment that reflects a year-long process including planning, data collection and analysis, and identification and prioritization of needs. It is designed to help us develop an informed understanding of the health gaps or needs that exist within communities served by Queen of the Valley.

The grounding framework throughout this process is to consider the social determinants of health. It is through this lens that we acknowledge the health impact of the conditions in which people are born, live, work, play and age. It is also through this lens that we are able to identify root causes of poor health and intervene in a preventive or "upstream" approach.

This comprehensive Community Health Needs Assessment would not be possible without the strategic foresight and leadership of the St. Joseph Health Community Partnerships Department as well as the expertise of The Olin Group, an Orange County firm providing process structure and data analysis. We are extremely grateful to On The Move, a longstanding community partner and expert at community outreach, recruitment and convening of diverse populations. Our gratitude also extends to our colleagues at Napa County Public Health and Health and Human Services who have collaborated with us on needs assessments for over a decade, and to Napa Junction Elementary School and Napa Valley Lutheran Church for providing meeting space for focus groups. We also want to thank all the community members and leaders who took the time to participate in focus groups and let their voice be heard.

It is my hope that that the findings in this document will help to develop a shared understanding of the needs in our community and spark collaborative engagement to improve the health and quality of life of the people in the communities we serve.

Sincerely,



Dennis Pedisich
Chair, Queen of the Valley Medical Center Community Benefit Committee

EXECUTIVE SUMMARY

St. Joseph Health, Queen of the Valley Medical Center (Queen of the Valley) is an acute-care hospital founded by the sisters of St. Joseph of Orange in 1958, located at Napa California. The facility has 208 licensed beds and a campus that is approximately 12.3 acres in size. Queen of the Valley has a staff of more than 1,280 and professional relationships with more than 300 local physicians. Major programs and services include cardiac care, cancer care, critical care, diagnostic imaging, neurosciences, orthopedics, rehabilitation services, urgent care, emergency medicine, obstetrics and a community medical fitness center.

With no county hospital, Queen of the Valley provides vital hospital and community services and addresses the needs of the uninsured and underinsured. In response to identified unmet health-related needs in this community needs assessment, during FY18-FY20 Queen of the Valley will focus on *mental health*, *substance use disorders*, and *economic and housing issues* for the broader and underserved members of the surrounding community.

OVERVIEW OF COMMUNITY HEALTH NEEDS ASSESSMENT

Community Benefit programs and services promote health and healing in response to identified community needs. In order to accurately define community needs, we conduct a Community Health Needs Assessment (CHNA) every three years. Queen of the Valley's CHNA process has rigor and follows a sound methodology to ensure that significant health needs identified by community-level data analysis (quantitative data) are validated through local resident and key stakeholder input (qualitative data). Queen of the Valley's Community Benefit Committee is involved throughout the CHNA process.

Conducting the needs assessment included four phases; CHNA initial design and planning beginning February of 2016, quantitative data collection and analysis beginning July of 2016, qualitative data collection and analysis beginning February 2017 and the identification, prioritization and selection of priority needs beginning April 2017.

Community-level data involved using the most recent data available and finding data at the smallest geographic region available such as zip code or city. Indicators were selected to provide as complete a picture of community health needs as possible, organized by demographic and five categories; health outcomes, health behaviors, clinical care, socioeconomic factors, and physical environment. This quantitative data was then shared with our community through a methodical and standardized series of group meetings designed to engage dialogue and unearth insights and observations about the community-level data findings.

The overall perspective throughout the CHNA process is grounded in the social determinant of health framework, with the understanding that 40% of what affects health are socioeconomic factors, 10% physical environment, 30% health behaviors, and only 20% of what affects health is clinical care. Within this framework, addressing the social determinants of health is the most

upstream and preventive approach to improve the health and also the quality of life of the people in the communities we serve.

COLLABORATING ORGANIZATIONS

This comprehensive Community Health Needs Assessment is made possible through the leadership and support from the SJH Community Partnerships Department and the expertise of the socially conscious consulting firm, The Olin Group. Queen of the Valley partnered with On the Move Bay Area (OTM) to support, recruit for, and host the focus groups and forums. OTM, a longstanding nonprofit community partner based in Napa has the mission to develop and sustain young people as leaders by building exceptional programs that challenge inequities in their communities. OTM works to unite communities and focus on the safety and inclusion of all people. Napa County Public Health has a long history of support and participation in Queen of the Valley's CHNA process sharing expertise, data and participating in the health need analysis, prioritization and planning processes.

COMMUNITY INPUT

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

The community resident focus groups were conducted in the two cities that demonstrated four of the five categorical indicators as moderately, as or much worse than that of the hospital's total service area; the city of American Canyon in Napa County and the city of Sonoma in Sonoma County. The Sonoma focus group was conducted in Spanish with 20 attendees and the American Canyon group was conducted in English with 16 attendees.

The government/nonprofit stakeholder group included 16 attendees including representatives from Napa County Health and Human Services Divisions of Public Health, Mental Health, Drug and Alcohol, Economic Self Sufficiency, and county Homeless Services. Other participating organizations included AMR ambulance, COPE Family Resource Center, Healthy Aging Planning Initiative, Housing Authority, Napa Community Health Initiative, Napa Police Department, Napa Valley Lutheran Church, On The Move, Parents CAN, Partnership Health Plan (managed Medicaid), St. John the Baptist Catholic Church, Up Valley Family Centers, and the mayor of American Canyon. Details regarding stakeholder group participants are in appendix 3b of the CHNA report. The community resident forum convened approximately 50 people from diverse backgrounds and experiences. Detailed demographics of the community resident focus groups and the community resident forum are in appendix 3a of the CHNA report.

SIGNIFICANT HEALTH NEEDS

After synthesis and analysis of community level data and community input, below is a list of the top 15 significant health needs.

Health Needs
Mental Health
Substance Abuse
Access to Care
Housing Concerns
Dental Care
Food and Nutrition
Obesity
Economic Issues
Cancer
Heart Disease
Diabetes
Immigration Status
Language Barriers
Asthma
Transportation and Traffic

PRIORITY HEALTH NEEDS

As a result of a prioritization process described in detail in the report, below is a list of the top three rank ordered significant health needs Queen of the Valley will address in FY 18-20.

Priority Health Needs
1. Mental Health
2. Substance Abuse
3. Housing Concerns/Economic Issues

INTRODUCTION

WHO WE ARE AND WHY WE EXIST

As a ministry founded by the Sisters of St. Joseph of Orange, St. Joseph Health Queen of the Valley Medical Center (Queen of the Valley) lives out the tradition and vision of community engagement set out hundreds of years ago. The Sisters of St. Joseph of Orange trace their roots back to 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 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, 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 59 years. Serving the communities of American Canyon, Napa, Yountville, St. Helena, and Sonoma/Boyes Hot Springs, Queen of the Valley is an acute care hospital that provides quality care in the areas of cardiac care, cancer care, critical care, diagnostic imaging, neurosciences, orthopedics, rehabilitation services, urgent care, emergency medicine and obstetrics. With over 1,280 employees committed to realizing the mission, Queen of the Valley is one of the largest employers in the region.

In total, for fiscal year 2016 Queen of the Valley contributed $16,804,981 in community benefit, excluding unreimbursed costs of Medicare. This investment helped care for vulnerable low-income persons, the uninsured and underinsured and the broader community. In addition, the unreimbursed cost of Medicare in FY 16 totaled $29,315,504.

Strategic Direction

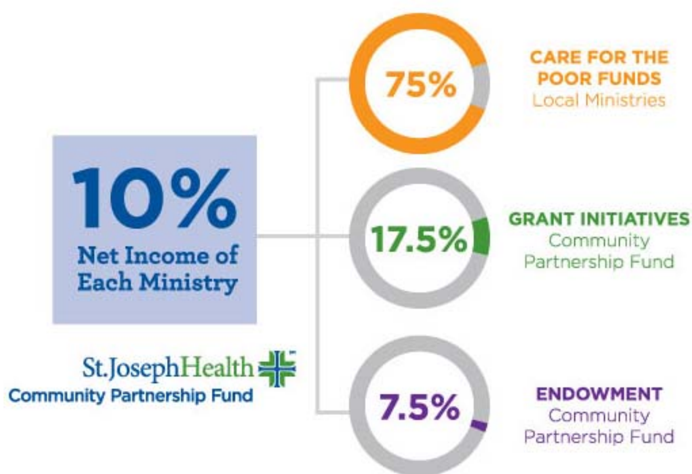
As we move into the future, Queen of the Valley is committed to furthering our mission and vision while transforming healthcare to a system that is health-promoting and preventive, accountable in its inevitable rationing decisions, integrated across a balanced network of care and financed according to its ability to pay. To make this a reality, over the next five years (FY 2018-2022) 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.

OUR COMMITMENT TO COMMUNITY

Organizational Commitment

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.

Figure 1. Fund distribution



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.

Each year Queen of the Valley allocates 10% of its net income (net unrealized gains and losses) to the St. Joseph Health Community Partnership Fund. (See Figure 1). 7.5% of the contributions are used to support local hospital Care for the Poor programs. 1.75% is used to support SJH Community Partnership Fund grant initiatives. The remaining .75% 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, Queen of the Valley will endorse local non-profit organization partners to apply for funding through the St. Joseph Health Community Partnership Fund. Local non-profits that receive funding provide specific services and resources to meet the identified needs of underserved communities throughout St. Joseph Health hospitals' service areas.

Community Benefit Governance

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 the Executive Director of Community Benefit 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 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 9 members of the Board of Trustees and 12 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 every two months.

Roles and Responsibilities

Senior Leadership

- CEO and other senior leaders are directly accountable for CB 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'.
- The committee 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.

OUR COMMUNITY

Community

Description of Community Served

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

Community Profile

Hospital Total Service Area

The community served by the Hospital is defined based on the geographic origins of the Hospital’s inpatients. The Hospital Total Service Area is the comprised of both the Primary Service Area (PSA) as well as the Secondary Service Area (SSA) and is established based on the following criteria:

- PSA: 70% of discharges (excluding normal newborns)
- SSA: 71%-85% of discharges (draw rates per ZIP code are considered and PSA/SSA are modified accordingly)
- Includes ZIP codes for continuity
- Natural boundaries are considered (i.e., freeways, mountain ranges, etc.)
- Cities are placed in PSA or SSA, but not both

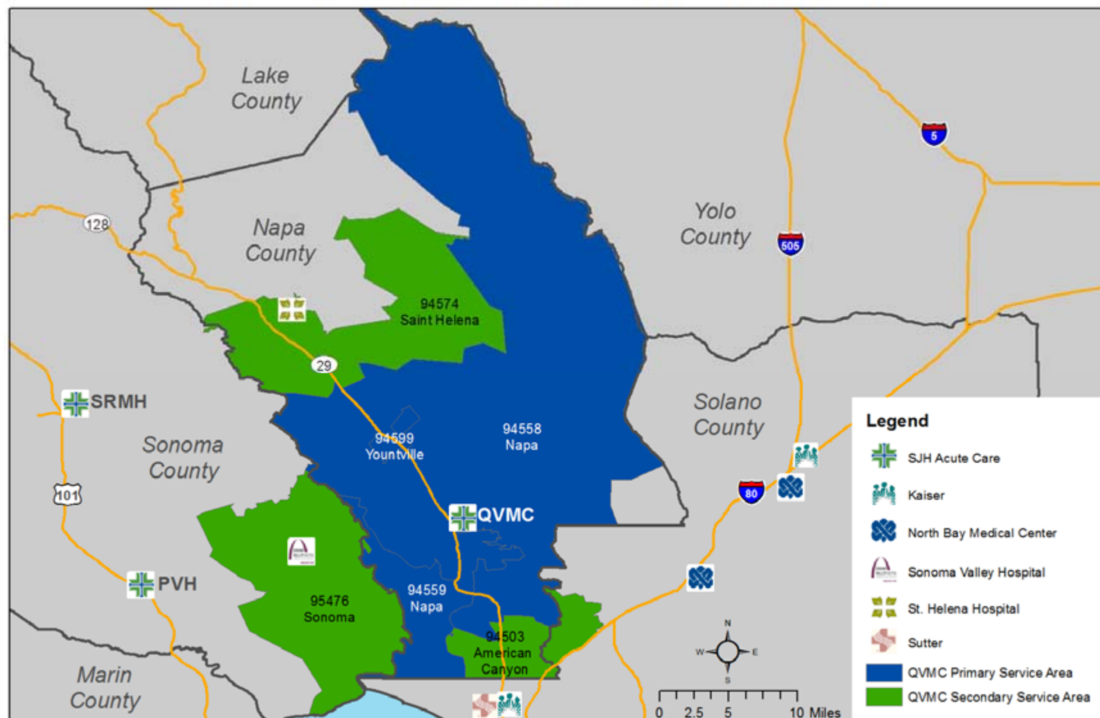
The Primary Service Area ("PSA") is the geographic area from which the majority of the Hospital's patients originate. The Secondary Service Area ("SSA") is where an additional population of the Hospital's inpatients reside. The PSA is comprised of the cities of Napa and Yountville. The SSA is comprised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

Table 1. Cities and ZIP codes

Cities/ Communities	ZIP Codes	PSA or SSA
Napa	94558, 94559	PSA
Yountville	94599	PSA
American Canyon	94503	SSA
St. Helena	94574	SSA
Sonoma/Boyes Hot Springs	95476	SSA

Figure 1 (below) depicts the Hospital's PSA and SSA. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

Figure 1. Queen of the Valley Hospital Total Service



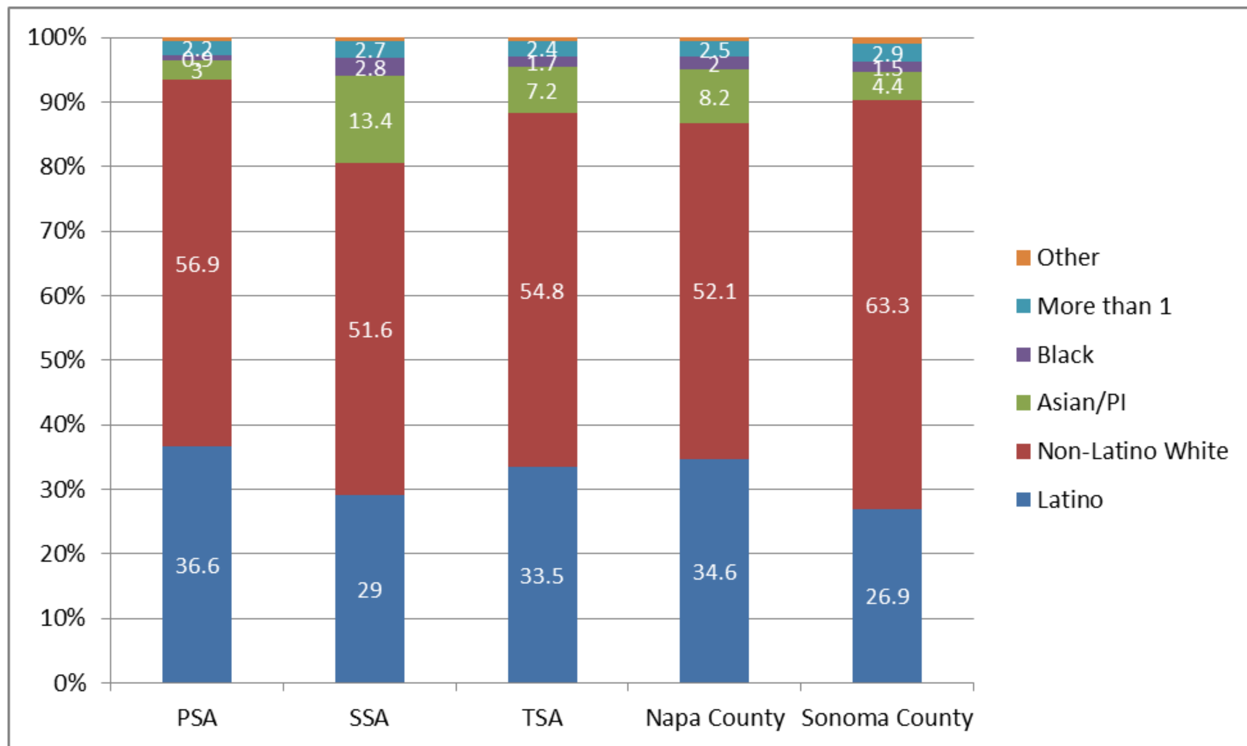
Community Profile

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

Service Area Demographic Overview

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

Race/Ethnicity



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

The Community Need Index (CNI) was developed by Dignity Health (formerly known as Catholic Healthcare West (CHW)) and Truven Health Analytics. The Community Needs Index (CNI) identifies the severity of health disparity for every zip code in the United States and demonstrates the link between community need, access to care, and preventable hospitalizations.

CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers):

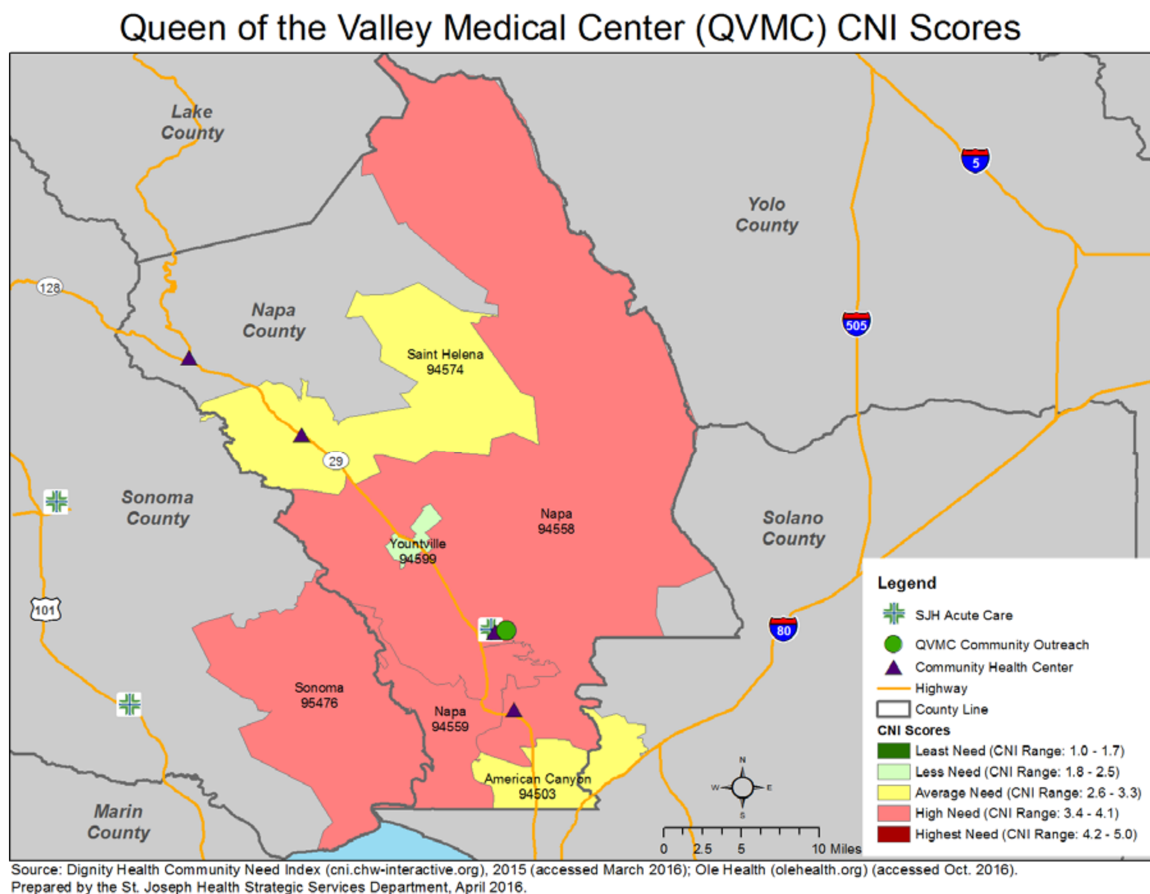
- Income Barriers (Elder poverty, child poverty and single parent poverty)
- Culture Barriers (non-Caucasian limited English);
- Educational Barriers (% population without HS diploma);
- Insurance Barriers (Insurance, unemployed and uninsured);
- Housing Barriers (Housing, renting percentage).

This objective measure is the combined effect of five socioeconomic barriers (income, culture, education, insurance and housing). A score of 1.0 indicates a zip code with the fewest socioeconomic barriers, while a score of 5.0 represents a zip code with the most socioeconomic barriers. Residents of communities with the highest CNI scores were shown to be twice as likely to experience preventable hospitalizations for manageable conditions such as ear infections, pneumonia or congestive heart failure compared to communities with the lowest CNI scores.

(*Ref* (*Roth R*, *Barsi E*., *Health Prog.* *2005 Jul-Aug; 86(4):32-8.)* The CNI is used to a draw attention to areas that need additional investigation so that health policy and planning experts can more strategically allocate resources. For example, the ZIP code 94558 on the CNI map is scored 3.4 - 4.1, making it a High Need community.

Figure 2 (below) depicts the Community Need Index for the ***hospital's geographic service area based on national need***. It also shows the location of the Hospital as well as the other hospitals in the area that are a part of St. Joseph Health.

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



See Appendix 1: Community Needs Index data

Health Professions Shortage Area – Mental, Dental, Other

The Federal Health Resources and Services Administration designates Health Professional Shortage Areas as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Although Queen of the Valley Medical Center is not located in a shortage area, large portions of the service area to the West and North of Queen of the Valley are designated as shortage areas.

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

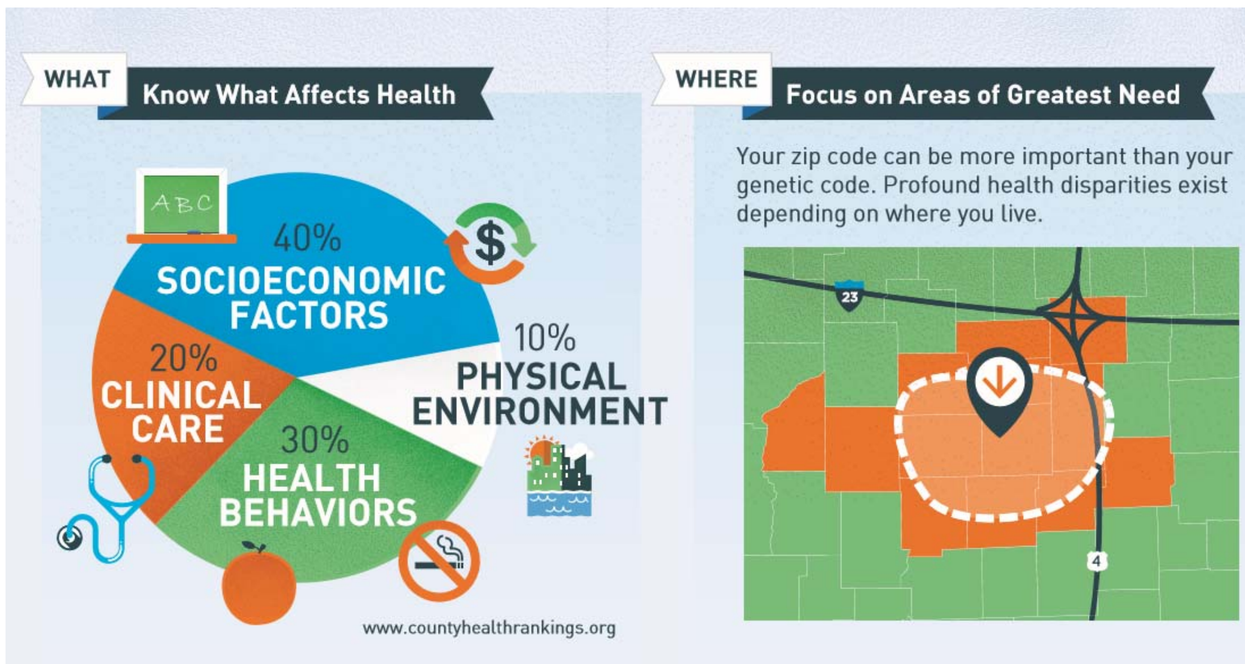
Queen of the Valley, along with the majority of the service area, is located in a Medically Underserved Area/Medically Underserved Populations area, signifying the importance of Queen of the Valley Medical Center to the community it serves.

OVERVIEW OF THE CHNA PROCESS

Overview and Summary of the Health Framework Guiding the CHNA

The CHNA process was guided by the fundamental understanding that much of a person's health is determined by the conditions in which they live. In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, health behaviors, and the availability of clinical care. This framework, depicted in the graphic below from County Health Rankings and Roadmaps, focuses attention on the social determinants of health to learn more about opportunities for intervention that will help people become and stay healthy within their community.

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



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

Socioeconomic Factors – income, poverty, education, and food insecurity

Physical Environment – crowded living situations, cost of rent relative to incomes, long commutes, and pollution burden

Health Behaviors – obesity, sugary drink consumption, physical exercise, smoking, and substance abuse

Clinical Care – uninsured, prenatal care, and the number of people per physician or mental health worker

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

Health Outcomes – overall health condition, asthma, diabetes, heart disease, cancer, and mental health

METHODOLOGY

Collaborative Partners

The Olin Group is a socially conscious consulting firm working across nonprofit, public, private, and philanthropic sectors to bring about community transformation. Based in Santa Ana, California, The Olin Group has 15 years of experience working on evaluation, planning,

assessment, fundraising, communication, and other services for nonprofit organizations, and had previously supported the CHNA process of multiple hospitals in the St. Joseph Health system. The Olin Group served as the lead consultant in the CHNA process, coordinating the quantitative and qualitative data collection processes and assisting in the prioritization and selection of health needs.

Community Partners:

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

Secondary Data/Publicly available data

Within the guiding health framework for the CHNA, publicly-available data was sought that would provide information about the communities and people within our service area. In addition, comparison data was gathered to show how the service area communities are faring compared to the county or state. Indicators were chosen if they were widely accepted as valid and appropriate measures and would readily communicate the health needs of the service area. Preference was given to data that was obtained in the last 5 years and was available at the zip code level. The data sources used are highly regarded as reliable sources of data (e.g., ESRI Business Analyst Online, US Census Bureau American FactFinder, and California Health Interview Survey). In total, 81 indicators were selected to describe the health needs in the hospital's service area. Appendix 2 includes a complete list of the indicators chosen, their sources, the year the data was collected, and details about how the information was gathered.

If an indicator had zip code level data available, data was pooled to develop indicator values for the Total Service Area (TSA), Primary Service Area (PSA), and Secondary Service Area (SSA) of the hospital. This enabled comparisons of zip code level data to the hospital service area and comparisons of the hospital service area to county and state measures.

After the data was gathered, the zip code level data was compared to the Total Service area values and color coded light pink to dark red depending on how much worse a zip code area was compared to the TSA value. This made it easier to visualize the geographic areas with greater health needs. The criteria for color-coding the zip code level data is explained in the spreadsheets in Appendix 2.

Community Input

The process of collecting qualitative community input took three main forms: Community Resident Focus Groups, a Nonprofit and Government Stakeholder Focus Group, and a Community Forum. Each group was designed to capture the collected knowledge and opinions of people who live and work in the communities served by Queen of the Valley Medical Center. We developed a protocol (noted in Appendix 3b) for each group to ensure consistency across individual focus groups, although the facilitators had some discretion on asking follow-up questions or probes as they saw fit. Invitation and recruitment procedures varied for each type of group. Appendix 3 includes a full report of the community input process and findings along with descriptions of the participants.

Resident Focus Groups

For Community Resident Groups, Community Benefit staff, in collaboration with their committees and the system office, identified geographic areas where data suggested there were significant health, physical environment, and socioeconomic concerns. This process also identified the language needs of the community, which determined the language in which each focus group was conducted. Community Benefit staff then partnered with community-based organizations that serve those areas to recruit for and host the focus groups. The community-based organization developed an invitation list using their contacts and knowledge of the area, and participants were promised a small incentive for their time. Two consultants staffed each focus group, serving as facilitators and note takers. These consultants were not directly affiliated with the ministry to ensure candor from the participants.

Nonprofit and Government Stakeholder Focus Group

For the Nonprofit and Government Stakeholder Focus Group, Community Benefit staff developed a list of leaders from organizations that serve diverse constituencies within the hospital's service area. Ministry staff sought to invite organizations with which they had existing relationships, but also used the focus group as an opportunity to build new relationships with stakeholders. Participants were not given a monetary incentive for attendance. As with the resident focus groups, this group was facilitated by outside consultants without a direct link to St. Joseph Health.

Resident Community Forum

Recruitment for the Community Resident Forum was much broader to encourage as many people as possible to attend the session. Community Benefit staff publicized the event through flyers and emails using their existing outreach networks, and also asked their partner organizations to invite and recruit participants. No formal invitation list was used for the

forums and anyone who wished to attend was welcomed. The forum was conducted by an outside consultant in English, with simultaneous Spanish language translation for anyone who requested it.

While the focus groups followed a similar protocol to each other in which five to six questions were asked of the group, the forum followed a different process. The lead facilitator shared the health needs that had emerged from the CHNA process so far and asked the participants to comment on them and add any other concerns. Once the discussion was complete, the participants engaged in a cumulative voting process using dots to indicate their greatest concerns. Through this process, the forum served as something of a "capstone" to the community input process.

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur.

- Not all desired data was readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance abuse.
- Data that is gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as rates of uninsured) and the most recent data available is not a good reflection of the current state.
- Zip code areas are the smallest geographic regions for which many indicators have data, but even within zip codes, there can be populations that are disproportionately worse off than neighboring communities and these do not show up in the data.
- Data for zip codes with small populations (below 2000) is often unreliable, especially when the data is estimated from a small sample of the population. There are no zip codes within the service area with a population of 2000 or less, although Yountville has just over 3000 people.
- Information gathered during focus groups and community forums is dependent on who was invited and who showed up for the event. Efforts were made to include people who could represent the broad interests of the community and/or were members of communities of greatest need.

- Fears about deportation kept many undocumented immigrants from participating in focus groups and community forums and made it more difficult for their voice to be heard.

Process for gathering comments on previous CHNA

The CHNA is posted and available for public review on Queen of the Valley's web site along with an email link to the Executive Director of Community Benefit encouraging feedback and comments.

Summary of any comments received

There were no comments or questions received on the previous CHNA.

SELECTED HEALTH INDICATORS: SECONDARY DATA

For each set of indicators shown below, there are two types of tables. The first table shows the values for the Primary Service Area (PSA), the Secondary Service Area (SSA), the Total Service Area (TSA), the counties that have communities in the service area, and California. The second table(s) shows the areas of greatest need by zip code. For the second table type, the cells are colored red, orange, yellow, or white based on how much worse the indicator value is for that zip code compared to the TSA. The specific definitions for the color coding are shown in the table below.

Indicator	Much Worse	Moderately Worse	Slightly Worse	Not Worse
Household Income	80% or more below the TSA median household income	80.1% - 90% below the TSA median household income	90.1%-95% below the TSA median household income	No color means the value is about the same as, or better than, the TSA
Any indicator shown as a percent	4.0 or more percentage points worse than the TSA value	2-3.9 percentage points worse than the TSA value	1-1.9 percentage points worse than the TSA value	
Pollution Burden	4 or more higher than the TSA value	2-3.999 higher than the TSA value	1-1.999 higher than the TSA value	
Violent Crime	40% or more above the value for the county in which the city is located	20%-39% above the value for the county in which the city is located	10%-19% above the value for the county in which the city is located	

Socioeconomic Indicators

While TSA and County data compares favorably to California averages, zip code level data shows there are several areas with socioeconomic challenges, including western Napa, American Canyon, and the city of Sonoma.

Indicator	PSA	SSA	TSA	Napa County	Sonoma County	California
Socioeconomic Indicators						
Median Household Income	$66,687	$71,096	$68,468	$69,936	$63,910	$62,554
Households below 100% of FPL	7.3%	8.1%	7.6%	7.3%	7.6%	12.3%
Households below 200% FPL	22.4%	21.7%	22.1%	21.7%	21.6%	29.8%
Children living below 100% FPL	14.9%	16.1%	15.4%	14.0%	15.1%	22.7%
Older adults living below 100% FPL	7.6%	6.4%	7.1%	7.1%	6.8%	10.2%
Age 25+ and no HS diploma	17.9%	15.4%	16.9%	17.2%	13.2%	18.5%
Enrolled in Medi-Cal	13.7%	13.5%	13.6%	13.7%	15.8%	20.3%
Low-income food insecurity	7.0%	5.3%	6.3%	6.7%	5.3%	8.1%

Areas of Greatest Concern – Cities/communities that are moderately or much worse than the Total Service Area average on at least one of these eight socioeconomic indicators.

Indicator	Napa	American Canyon	Sonoma
	94559	94503	95476
Median Household Income			
Households below 100% of FPL			
Households below 200% FPL			
Children living below 100% FPL			
Older adults living below 100% FPL			
Age 25+ and no HS diploma			
Enrolled in Medi-Cal			
Low-income food insecurity			

Physical Environment

The service area compares favorably to California on issues such as pollution, crime, rental costs, and overcrowding. While the city of Napa is somewhat worse on housing indicators and parts of Napa and American Canyon are worse on pollution indicators, these zip codes' values are still comparable to California averages. Although not shown in the tables, 50% of the workers in American Canyon commute 30 minutes or more, compared to only 32% in the TSA and Napa County.

Indicator	PSA	SSA	TSA	Napa County	Sonoma County	California
Physical Environment Indicators						
More than 1 occupant per room	6.6%	5.0%	6.0%	6.1%	4.9%	8.2%
Renters pay more than 30% of household income for rent	56.7%	54.4%	55.8%	55.4%	57.8%	57.2%
Pollution Burden	19.192	15.751	17.471	17.714	15.274	25.312
Violent crimes (rate per 100,000 inhabitants)	NA	NA	NA	383.5	370.3	397.8

Areas of Greatest Concern - Cities/communities that are moderately or much worse than the Total Service Area average on at least one of the physical environment indicators shown.

Indicator	Napa	Napa	American Canyon
	94558	94559	94503
More than 1 occupant per room			
Renters pay more than 30% of household income for rent			
Pollution Burden			
Violent Crime			

Health Outcomes

Asthma and heart disease rates are notably higher in the Service Area than California averages, although the older demographic may play a part in heart disease being more prevalent. Yountville, which is heavily influenced by the presence of the Veterans Home of California, has the highest rates in the TSA of people with disabilities and heart disease. Sonoma, American Canyon, and Saint Helena also are somewhat or moderately worse on at least one health outcome indicator.

Indicator	PSA	SSA	TSA	Napa County	Sonoma County	California
Health Outcome Indicators						
Fair or poor health (ages 0-17)	4.4%	4.8%	4.5%	NA	4.3%	5.2%
Fair or poor health (ages 18-64)	15.5%	17.4%	16.2%	16.0%	18.1%	19.2%
Fair or poor health (ages 65+)	15.4%	19.4%	17.1%	16.0%	20.4%	27.8%
Disabled population (all ages)	11.0%	10.4%	10.7%	11.2%	11.2%	10.3%
Asthma in children (ages 1-17)	15.7%	16.0%	15.8%	15.4%	16.4%	14.6%
Asthma in adults (ages 18+)	16.8%	16.0%	16.5%	17.1%	14.6%	13.9%
Diabetes in adults (ages 18+)	7.4%	9.3%	8.1%	7.5%	8.7%	8.8%
Heart disease (Ages 18+)	7.2%	7.7%	7.4%	7.2%	7.0%	5.9%
Serious psychological distress (ages 18+)	4.6%	5.9%	5.2%	4.7%	7.8%	8.1%

Areas of Greatest Concern - Cities/communities that are moderately or much worse than the Total Service Area average on at least one of the health outcome indicators shown.

Indicator	Yountville	American Canyon	Saint Helena	Sonoma
	94599	94503	94574	95476
Fair or poor health (ages 0-17)	NA	NA	NA	
Fair or poor health (ages 18-64)				
Fair or poor health (ages 65+)	NA	NA		

Indicator	Yountville	American Canyon	Saint Helena	Sonoma
Disabled population (all ages)				
Asthma in children (ages 1-17)	NA			
Asthma in adults (ages 18+)				
Diabetes in adults (ages 18+)				
Heart disease (Ages 18+)				
Serious psychological distress (ages 18+)				

Health Behaviors

The rates in the TSA for most health behavior indicators are very similar to or better than California averages, although both Napa and Sonoma Counties have higher rates of drug and alcohol use among teens. Western Napa generally had worse health outcomes, particularly around obesity at all ages and smoking. Obesity in adults is also an issue in the city of Sonoma.

Indicator	PSA	SSA	TSA	Napa County	Sonoma County	California
Health Behavior Indicators						
Overweight (ages 2-11)	13.8%	12.5%	13.3%	13.4%	12.5%	13.3%
Overweight or obese (ages 12-17)	35.4%	34.3%	35.0%	NA	32.2%	33.1%
Obese (ages 18+)	23.1%	23.7%	23.3%	22.4%	25.5%	25.8%
Sugary drink consumption (ages 18+)	13.8%	12.2%	13.2%	13.8%	12.6%	17.4%
Regular physical activity (ages 5-17)	19.7%	20.7%	20.1%	19.5%	23.9%	20.7%
Youth alcohol/ drug use in the past month (grades 7, 9, and 11)	NA	NA	NA	32.3%	34.7%	27.8%
Births per 1,000 teens (ages 15-19)	NA	NA	NA	17.8	13.6	23.2
Current smoker (ages 18+)	13.7%	10.4%	12.4%	13.5%	9.4%	12.6%

Areas of Greatest Concern - Cities/communities that are moderately or much worse than the Total Service Area average on at least one of the health outcome indicators shown.

Indicator	Napa	American Canyon	Sonoma
	94559	94503	95476
Overweight (ages 2-11)			
Overweight or obese (ages 12-17)			
Obese (ages 18+)			
Sugary drink consumption (ages 18+)			
Regular physical activity (ages 5-17)			
Current smoker (ages 18+)			

Clinical Care

Clinical Care indicators are generally better in Napa County and the service area than California averages; the data shows more access to insurance, prenatal care, and providers. The city of Sonoma has a much higher rate of uninsured adults compared to the TSA, but is still below the state average.

Indicator	PSA	SSA	TSA	Napa County	Sonoma County	California
Clinical Care Indicators						
Uninsured (ages 0-17)	2.2%	2.2%	2.2%	2.3%	NA	3.2%
Uninsured (ages 18-64)	7.9%	11.7%	9.4%	7.9%	14.3%	19.3%
First trimester prenatal care	86.9%	87.3%	87.0%	87.8%	84.6%	83.8%
# of people per primary care physician	NA	NA	NA	981:1	1,012:1	1,274:1
# of people per non-physician primary care provider	NA	NA	NA	2,179:1	2,120:1	2,192:1
# of people per dentist	NA	NA	NA	1,276:1	1,153:1	1,264:1
# of people per mental health provider	NA	NA	NA	240:1	268:1	356:1

Areas of Greatest Concern - City/community that is much worse than the Total Service Area average on at least one of the health outcome indicators shown.

Indicator	Sonoma
	95476
Uninsured (ages 0-17)	
Uninsured (ages 18-64)	
First trimester prenatal care	

See Appendix 2: Secondary Data /Publicly available data

SUMMARY OF COMMUNITY INPUT

To better understand the community's perspective, opinions, experiences, and knowledge, Queen of the Valley Medical Center held four sessions at which community members and nonprofit and government stakeholders discussed the issues and opportunities of the people, neighborhoods, and towns and cities of the service area. Below is a high-level summary of the findings of these sessions; full details on the protocols, findings, and attendees are available in Appendix 3. These sessions were scheduled as follows:

Type	Location	Date	Language	Attendees
Resident Focus Group	Sonoma	3/16/17	Spanish	20
Resident Focus Group	American Canyon	3/22/17	English	16
Stakeholder Focus Group	Napa	3/23/17	English	21
Community Resident Forum	Napa	3/27/17	English with simultaneous Spanish interpretation	~50

The following concerns were identified as important by both the community resident and nonprofit and government stakeholder focus groups:

Transportation and Traffic: Traffic was the major topic of conversation in American Canyon because it has become a major impediment, causing major delays, missed appointments, accidents, and stress. The pollution from cars may affect the air quality. Other groups raised transportation as an issue for many individuals, especially those living in the more rural areas, because it can impede access to medical care and other resources.

All of the sessions discussed **Housing Concerns** in the community, and their clear link with economic challenges. People were concerned about the lack of access to low-income housing and how the cost of housing places economic stress on everyone. Some people leave the area entirely, which causes a "brain drain," and also can isolate seniors when their children leave. Others stay within the area but away from the city of Napa, increasing traffic and commute times. Those on fixed incomes often have to make sacrifices in other areas to afford housing, and many low income individuals are at risk of homelessness.

Access to Care was a strong concern at all groups. Residents reported challenges in getting appointments, long waits at the doctor, a lack of local medical services, challenges in paying for services including co-pays and prescription costs, and a lack of medical insurance for undocumented individuals. There is a perceived shortage of doctors, mental health providers, nurses and other health care providers because the high cost of living and housing make recruiting them difficult. Finding specialists in the vicinity can be particularly challenging.

Mental Health was raised as an issue at all of the focus groups. The community usually discussed mental health in the context of what causes stress. The stakeholders focused on the need to destigmatize mental health challenges and discussed a shortage of services, particularly in Spanish or other languages.

Immigration Status was discussed as a serious issue because immigrants are living in a time of greater fear and stress. Undocumented immigrants cannot obtain health insurance through the ACA, leading them to delay seeking help until their health conditions have become very

serious. Others, whether undocumented or not, face discrimination, a toxic environment, and exploitation from landlords and employers.

Every group discussed **Food and Nutrition**. There was discussion about the difficulty for some to eat a healthy diet, either because healthier foods tend to be more expensive or cultural traditions that favor saltier or fattier foods. Because the service area is fairly spread out, some people who live in Sonoma or other locations outside the city of Napa have limited options to buy healthy foods and must travel far for supermarkets.

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

Participants at both resident focus groups noted the prevalence of **Obesity** among children, the growth in **Diabetes** among both children and adults, and the links between these issues and diet and nutrition. Other health conditions such as **Asthma, Heart Disease,** and **Cancer** were concerns as well.

Issues around **Dogs** were discussed in American Canyon. People reported being chased or harassed by unleashed dogs while exercising, particularly in parks, causing safety concerns. Also, participants complained about owners not cleaning up dog waste.

Water Quality was discussed as a major issue in American Canyon. Residents complained about perceived high levels of hazardous waste, an incident when the tap water was brown, and overall poor taste.

Domestic Violence was identified as a health concern in the Sonoma focus group.

Community Education was a discussion topic in American Canyon. Participants were eager to have more access to classes on cooking, nutrition, and fitness. While some knew about such classes being offered in Napa, traffic and time can be an obstacle.

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

While housing issues were discussed in all of the focus groups, the stakeholders closely linked housing to **Homelessness**. They discussed how the high cost of housing places many low-income people at risk of homelessness, and the severe health effects for unsheltered and chronically homeless individuals.

Substance Abuse was a topic in the stakeholder group, particularly in conjunction with Mental Health. Growing rates of drug and alcohol abuse increases the strain on the system, and there was a perception that fewer people are seeking support services despite their need. Prevention and education, especially in view of the recent legalization of marijuana was identified as a need.

Many immigrants also face **Language Barriers**. While Spanish is the most commonly spoken language (after English) in the area, there are native speakers of many different Asian languages, such as Tagalog, as well. There was recognition of the need for more in-language services for recent immigrants who may not be comfortable in English.

Economic Issues were also discussed more broadly in the stakeholder meeting because the high cost of living contributes to stress, traffic, housing concerns, food and nutrition deficits, and many other health needs. There was also concern that the federal standard for poverty was not appropriate for the area given the high cost of living.

The following concerns received the most support from the Community Forum. The concern listed here is how the idea was presented for the group voting process. In some cases, the idea has been reclassified or reworded into categories used for this report; this is noted in parentheses.

Mental health

Sidewalks, curbs, walkability, street lights

Poverty and economic stress

Dental care

Immigration status

Substance abuse

Language barriers

Lack of medical insurance/care (Access to Care)

Youth activities

See Appendix 3: Community Input

COMMUNITY ASSETS AND RESOURCES

Significant Health Need and Assets Summary

Communities with Disproportionate Unmet Health Needs (DUHN) are communities defined by zip codes where there is a higher prevalence or severity for a particular health concern than the general population within Queen of the Valley's 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 significant health needs and community resources/assets.

Significant Health Need	Target Population	Geographic Area (City, Zip Code, County)	Community Resources (Name of Organization(s)
Mental Health	*Low and middle income families, older adults*	*PSA, SSA*	*Napa County HHS: Mental Health Division, Mentis, Aldea, Progress Place, St. Helena Hospital, Buckelew, Parents CAN, Exodus*
Substance Use Disorders	*Low and middle income families, older adults, homeless, those with mental health component*	*PSA, SSA*	*Napa County HHS: Drug and Alcohol Division, Alternatives for Better Living, Wolfe Center, McAlister Institute, St. Helena Hospital*
Access to Care	*Uninsured, low and middle income adults*	*PSA, SSA*	*St. Joseph Health Queen of the Valley Medical Center, St. Helena Hospital, Kaiser Clinic, Ole Health, Collabria Care*
Housing	*Low and middle income adults, older adults, children and families*	*PSA, SSA*	*Napa County HHS: Whole Person Care, Abode Homeless Shelter and Housing Services, Housing Authority of the City of Napa, Napa Community Housing, Habitat for Humanity*
Dental Care	*Low income adults and older adults, uninsured*	*PSA, SSA*	*Sister Anne's FQHC Dental Clinic, SJH Queen of the Valley Mobile Dental Clinic*
Food & Nutrition	*Low income families, adults and older adults, 94559*	*PSA, SSA*	*Napa County HHS: WIC, SNAP, Community Action Napa Valley (CANV) Food Bank & Meals on Wheels, Congregate Meal Sites: The Table*
Economic Issues	*Low income- all*	*PSA, SSA*	*Napa County HHS: Self Sufficiency Division: CALWORKs (AFDC, Welfare or Cash Aid TANF), Section 8*
Obesity	*Low and middle income, Latino families, children and teenagers*	*PSA, SSA*	*St. Joseph Health Queen of the Valley Medical Center, St. Helena Hospital, Kaiser Clinic, Ole Health*

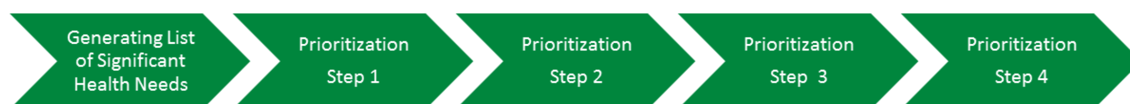
Significant Health Need	Target Population	Geographic Area (City, Zip Code, County)	Community Resources (Name of Organization(s)
Immigration Status	*Undocumented immigrants*	*PSA, SSA*	*North Bay Legal Aid, Puertas Abiertas Community Resource Center*
Cancer	*Low income un/underinsured*	*PSA, SSA*	*St. Joseph Health Queen of the Valley Medical Center, St. Helena Hospital, Kaiser Clinic, Ole Health*
Language Barrier	*Non English speaking*	*PSA, SSA*	*Puertas Abiertas Community Resource Center, Nonprofit, Public and Faith Based Organizations, Napa Valley College, Napa Valley Adult Education, Napa Valley Parent University*
Heart Disease	*Low income un/underinsured*	*PSA, SSA*	*St. Joseph Health Queen of the Valley Medical Center, St. Helena Hospital, Kaiser Clinic, Ole Health*
Diabetes	*Low income un/underinsured*	*PSA, SSA*	*St. Joseph Health Queen of the Valley Medical Center, St. Helena Hospital, Kaiser Clinic, Ole Health*
Asthma	*Low income un/underinsured*	*PSA, SSA*	*St. Joseph Health Queen of the Valley Medical Center, St. Helena Hospital, Kaiser Clinic, Ole Health*
Transportation and Traffic	*Broader community*	*PSA, SSA*	*Napa County Transportation and Planning Agency (NCTPA)*

Existing Health care Facilities in the Community

See Appendix 4: Existing Health care Facilities in the Community

SIGNIFICANT HEALTH NEEDS

The graphic below depicts both how the compiled data and community input were analyzed to generate the list of significant health needs, as well as the prioritization process that allowed the selection of 15 significant health needs around which Queen of the Valley Medical Center will build its implementation plan. Details of the selection and prioritization process are provided in the sections that follow and in Appendix 5.



Who	**2 external raters**	**2 external raters**	**Community Benefit Lead and internal Work group**	**Community Benefit Lead**	**Community Benefit Committee**
What	A comprehensive review of data & community input	Apply the following criteria per significant health need	Apply the following criteria per significant health need	Review through two filters	Review List of issues and narrow to 1-3 priority areas for FY18-FY20 CB Plan/ Implementation Strategy investment
Criteria	All sources were analyzed for severity of the problem and level of community concern.	1. Seriousness of the problem 2. Scope of the problem – # of people affected 3. Scope of the problem –compared to other areas 4. Health disparities among population groups 5. Importance to the community 6. Potential to affect multiple health issues (root cause) 7. Implications for not proceeding	1. Sustainability of impact 2. Opportunities for coordination/ partnership 3. Focus on prevention 4. Existing efforts on the problem 5. Organizational competencies	1. Is it aligned with the Mission of St. Joseph Health? 2. Does it adhere to the Catholic Ethical and Religious Directives?	1. Is the health need relevant to the ministry? 2. Is there potential to make meaningful progress on the issue? 3. Is there a meaningful role for the ministry on this issue? 4. Where do we want to invest our time and resources over the next three years?
Scale	**Multiple**	**1-5 scale**	**1-5 scale**	**Yes or No**	**CB Committee Dialogue**

Selection Criteria and Process

Evaluators from The Olin Group performed a rigorous review of the publicly-available data and community input to identify 15 significant health needs for Queen of the Valley Medical Center.

The selection process began with the development of a general list of potential health needs, derived from a broad review of the indicator data, focus group findings, and literature around health concerns and social determinants of health. The goal of the selection process was to analyze the wide variety and large quantity of information obtained through the quantitative and qualitative processes in a consistent manner. Each source of input was considered as follows:

- Quantitative Data: Weighting was based on how the service area compared to California and county averages and how individual cities and zip codes compared to the service area averages. Note that for some health needs, data was not readily available.
- Resident Focus Groups: Focus Group transcripts and notes were reviewed and considered both at the individual focus group level and collectively across focus groups. Weighting was related to how often and how extensively an issue was discussed by the participants.
- Stakeholder Focus Group: Weighting for the stakeholder group was based on how strongly the problem was discussed by the participants, and the extent of agreement among the participants about the problem.
- Community Resident Forum: The Community Forum was designed to measure the importance of an issue to attendees. Each forum ended with "dot voting" on significant health issues allowing all participants to have a voice in indicating which issues were most important to them. Issues that received more votes were considered to be more important to the community.

In developing the list of significant health needs, the quantitative data was given equal weight to the community input. After reviewing and rating all the available information, the list of potential health needs was ranked from greatest to lowest need for the ministry and the top 15 were recommended by The Olin Group for further consideration.

Before the final selection of significant health needs, two reviews took place. First, The Olin Group reviewed the list to determine if there were needs that were identified as priorities through the community process but not highlighted by the data, or for which no data was available. In some cases, a significant health need may have been added to the list due to this review. In the second review, the Community Benefit Lead examined the list, using her ministry-specific knowledge to determine if the significant health needs should be consolidated or added. Once the review was completed, the list was finalized and prioritized.

Prioritization Process and Criteria

To prioritize the list of significant health needs and ultimately select the three health need(s) to be addressed by Queen of the Valley Medical Center, a four-step process was followed that incorporated the experience, expertise, and perspective of both internal and external stakeholders of the ministry. The criteria and rating scales can be found in Appendix 5.

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

- Seriousness of the Problem: The degree to which the problem leads to death, disability, and impairs one's quality of life

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

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

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

The Community Benefit Staff participating in the working group also considered a fifth criteria:

- Organizational Competencies: The extent to which the ministry has or could develop the functional, technical, behavioral, and leadership competency skills to address the need.

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

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

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

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

Rank-ordered significant health needs

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

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

Definitions:

Mental Health: Covers all areas of emotional, behavioral, and social well-being for all ages. It includes issues of stress, depression, coping skills, as well as more serious health conditions such as mental illness and Adverse Childhood Experiences.

Substance Abuse: Pertains to the misuse of all drugs, including alcohol, marijuana, opiates, prescription medication, and other legal or illegal substances. It does not encompass cigarette smoking, which was considered separately and not identified as a significant health need.

Access to Care: Includes most barriers to accessing health care services and other necessary resources, such as cost, lack of insurance or underinsurance, a shortage of providers, particularly specialists, and resources being unavailable outside of working hours.

Housing Concerns: Includes affordability, availability, overcrowding, and quality of housing**.**

Dental Care: Includes knowledge of dental health and the availability of providers and dental insurance, as well as the cost of services.

Food and Nutrition: Concerns about healthy eating habits, nutrition knowledge, and challenges of cost and availability of healthy options.

Obesity: Primarily defined as the health condition in which individuals are sufficiently overweight as to have detrimental effects on their overall health. This does not include related health needs of exercise or food choices, which were considered separately.

Economic Issues: Identified as a root cause of other health issues, it covers the effects of poverty, difficulties around finding jobs that pay livable salaries, and the high cost of living and the concerns and stresses it creates.

Cancer: Covers the prevention, early detection, and treatment of cancer.

Heart Disease: Encompasses the incidence, prevention, and treatment of heart disease.

Diabetes: Specifically focused on the health condition of diabetes, and awareness and prevention of it.

Immigration Status: Individuals who are or are connected to undocumented immigrants feel afraid and stressed, which affects their health.

Language Barriers: The challenges with accessing services and feeling welcomed that are faced by non-English speakers or those from different cultures.

Asthma: Includes the prevalence, treatment, and management of asthma.

Transportation and Traffic: Issues around transportation such as services for the elderly to get to appointments, as well as concerns about long commutes and heavy traffic leading to increased stress, lack of time for other activities, reduced air quality, and increased risk of accidents.

PRIORITY HEALTH NEEDS

Queen of the Valley Medical Center will address the following priority areas as part of its FY18-FY20 CB Plan/Implementation Strategy Report:

- Mental Health
- Substance Abuse
- Housing Concerns and Economic Issues

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

Substance Abuse was also cited as an area of importance by several diverse sources. The data show that self-reported teen alcohol and drug use in both Napa (32%) and Sonoma (35%) Counties is more prevalent than California norms (28%). The stakeholder focus group talked about the importance of prevention and education, and the links between Substance Abuse and Mental Health. Substance Abuse was also extensively discussed in the community forum, and received the 6th most votes of any topic. It was ranked second after the first three steps of the prioritization process, for the same reasons as Mental Health. It was selected by the Community Benefit Committee because data analysis was significant, community input corroborated, and substance abuse links closely with mental health.

Housing Concerns and Economic Issues were combined by the Community Benefit Committee because they are closely linked to each other and either can exacerbate (or ameliorate) the other. Although the data does not show either as a clear problem in comparison to California, there are definite pockets of poverty within the service area that are hidden by the overall wealth of the Napa Valley, and housing costs can be a burden for almost everyone. This issue was a concern of all three focus groups, at which people discussed the various socioeconomic groups affected by housing costs: low-income, middle-income, youth, and seniors. "Poverty and Economic Stress" received the third most votes in the community forum. Homelessness and it's impacts on health was specifically discussed at the stakeholder focus group. After the first three steps of prioritization, Housing Concerns was the fourth highest concern and Economic Issues was eighth. These issues were selected by the Community Benefit Committee because when

considering the framework of the social determinants of health, housing/homelessness and economic issues such as poverty were identified as having a significant impact on overall health.

See Appendix 5: Prioritization protocol and criteria / worksheets

EVALUATION OF IMPACT ON FY15-FY17 CB PLAN/IMPLEMENTATION STRATEGY REPORT: FY16 ACCOMPLISHMENTS

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**[3] that provides free or discounted services to eligible patients.

One way, 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% 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. In FY16, Queen of the Valley, provided $1,563,739 free (charity care) and discounted care and 2,840 encounters.

For information on our Financial Assistance Program click here.

Medicaid (Medi-Cal) and Other Local Means-Tested Government Programs
St. Joseph Health Queen of the Valley provides access to the uninsured and underinsured by participating in Medicaid, also known as Medi-Cal in California, and other means-tested government programs. In FY16, St. Joseph Health Queen of the Valley, provided **$7,735,273** in Medicaid shortfall.

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[3] *Information about St. Joseph Health Queen of the Valley's Financial Assistance Program is available* Queen of the Valley's Financial Assistance Program.

Addressing the Needs of the Community: FY15 –17 Key Community Benefit Plan
FY16 Accomplishments

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 6 months to 26 years of age in Napa County, particularly those who are uninsured or underinsured

Outcome Measure	Baseline	FY16 Target	FY16 Result
Percentage of patients who demonstrate oral health status improvement at recall visit based on a set of clinical criteria	91.5%	92%	95% (Of 480 random chart audits, 95% of children had improved oral health status at follow up visit based on a set of clinical criteria)

Strategy(ies)	Strategy Measure	FY16 Result
Provide early oral health screening and education in preschools and kindergartens	Number of children provided early screening for oral health	438 children received early screening for oral health
Provide 6-month examinations and cleanings	Percentage of patients having seen a dentist within 6 months to one year following initial or last recall exam	96.5% of patients saw a dentist within 6 months to one year following initial examination or last recall exam (Of 480 random chart audits)

Strategy(ies)	Strategy Measure	FY16 Result
Provide patient / parent education on improving and maintaining oral health	Percentage of patient / parents reporting improved oral health behaviors	96% of patients /parents reported improved oral health behaviors (183 of 191 parent respondents to Professional Research Consultants, Inc./PRC survey report improved oral health behaviors of their children post dental clinic visit)
Provide Mobile Dental procedures as necessary and indicated	Percentage of those receiving procedures who have reduced caries at follow-up	86.5% of those receiving dental procedures who have reduced dental caries at follow-up (Of 480 random chart audits)

Key Community Partners: *Child Start/Head Start, First Five of Napa County, Sister Ann Dental Clinic, Napa Unified School District, St. Helena Unified School District, City of American Canyon, Puertas Abiertas Family Center*

Access to Dental Care

To address the identified community need of oral health, Queen of the Valley launched a **Children's Mobile Dental Clinic** in 2005. Currently as one of only two providers of dental care for low income or Medi-Cal eligible children in Napa County, Queen of the Valley strives to meet this continued community need.

FY16 Accomplishments:

This year our mobile dental clinic spanned 9 locations across Napa County serving **2,019** low-income children and providing **4737** clinic visits. In addition, 28 low income pre-school classes were provided free oral health screenings and fluoride varnish to over 438 children. Of these 438 children, 49 had no dental home and parents were assisted with referral to a dental home for treatment, education and continued preventive care.

Addressing the Needs of the Community: FY15 –17 Key Community Benefit Plan
FY16 Accomplishments

Initiative (community need being addressed): CARE Network Program. FY13 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	FY16 Target	FY16 Result
Percentage improvement in ED use of new clients at post – enrollment when compared to pre-enrollment	53% reduction (established FY15)	Maintain Baseline	74%

Strategy(ies)	Strategy Measure	FY16 Result
Provide Intensive Case Management Services to individuals at high medical and psychosocial acuity[i] level	Percentage improvement in hospitalizations for new clients enrolled in complex case management post enrollment compared to pre-enrollment	46% reduction in hospitalizations for new clients enrolled in complex case management
Provide 30 day Transitional Care from inpatient to outpatient for vulnerable high risk patients at high risk for readmission	Rate of hospital readmission at 30 days post hospitalization	7.5% hospital re-admission rate. (50 of 661 clients served)

Strategy(ies)	Strategy Measure	FY16 Result
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	95% (121of 127 clients served did not require higher level case management services)

Key Community Partners: OLE Health (Formerly Community Health Clinic Ole), Mentis (Formerly Family Services of Napa Valley), Napa County Health and Human Services (Substance Abuse Services, Mental Health Services, eligibility), Collabria Care (formerly Napa Valley Hospice), and Community Action Napa Valley (CANV) - Food Bank, Homeless Services, and Smoking Cessation.

Chronis Disease Care Management

CARE (Case Management, Advocacy, Resources, and Education) **Network** is a nationally recognized, award winning community based program that promotes chronic disease self-management utilizing an interdisciplinary RN, social work, behavioral health and spiritual approach. Services are provided in the clients' home or as needed in a health provider office or other community service location. The program is aimed at care coordination and improving disease management and quality of life while reducing overall healthcare costs.

FY16 Accomplishments:

In FY16 CARE Network served 539 clients, of those 275 were newly enrolled. For those newly enrolled clients, emergency room visits decreased by **74%** and hospitalizations decreased by **46%** as compared to one year prior to enrollment. To address improved access to critical medical and social supports and provide a community based safety net and continuum of care, in FY 15 Queen of the Valley expanded scope of services of the CARE Network to include transitional care, addressing the unique needs of patients recently discharged from inpatient care or at risk for hospitalization, particularly those patients with complex medical conditions as well as difficult socio-economic needs such as housing insecurity and basic needs deficits. The transitional care program served 661 individuals, targeting those most vulnerable regardless of diagnosis or insurance status with a program readmission rate of 7.47 percent.

SSI and SSDI/Outreach/Access/Recovery (**SOAR**): In collaboration with Ole Health, CANV homeless services, and county mental health, in January 2016 Queen of the Valley launched a SOAR program. SOAR is a national program designed to increase access to disability income benefits administered by the social security administration targeting adults who are experiencing or at risk of homeless and have mental illness, medical impairment and/or have a co-occurring substance abuse problem. October 20,2015 through April 30,2016 the SOAR program received a total of 23 referrals, interviewed 19 individuals, submitted 13 social security applications, have 8 applications pending. The approval rate for applications that have been determined by social security is 100% (5 of 5). Average length of time for social security determination is 36 days.

Addressing the Needs of the Community: FY15 –17 Key Community Benefit Plan
FY16 Accomplishments

Initiative (community needs 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	FY16 Target	FY16 Result
Percentage of clients who demonstrate a reduction in depression as measured through validated tools appropriate to the target population	90% (FY13)	91%	92% of clients (102 of 111)

Strategy(ies)	Strategy Measure	FY16 Result
Identify individuals with risk factors for depression using validated tools	Number of individuals identified with risk factors for depression using validated tools	1,619 individuals were identified at risk for depression
Provide interventions or refer individuals with positive screens to behavioral health services	Percentage of individuals with positive screens provided services or referrals	69% of individuals who have positive screening for mental or emotional health received services or referrals (185 of 267)

Key Community Partners: **Key Community Partners:** Mentis (formerly known as Family Services Napa Valley), Area Agency on Aging, Ole Health (Formerly Community Health Clinic Ole), St. Helena Women's Center, Adult Day Services, Napa County Mental Health, Napa County Alcohol and Drug Services, Napa County Public Health, and Comprehensive Services for Older Adults (CSOA).

FY16 Accomplishments:

92% of clients who completed behavioral health services demonstrated improvement in depression symptoms as measured by evidenced based tools. The total number of unduplicated clients served by The CARE Network, Healthy Minds Healthy Aging (HMHA), and the Perinatal Emotional Wellness Program was 245 with 1,611 therapy sessions provided in the client's home or office.

FY16 Other Community Benefit Program Accomplishments

Initiative (community need being addressed):	Community Benefit Category	Program	Description	FY16 Accomplishments
Addressing Social Determinants Of Health: Studies show health outcomes are directly related to social determinants of health such as poverty, academic success, access to healthy foods, and other environmental factors.	Community Health Improvement Services	Napa Valley Parent University (NVPU)	Napa Valley Parent University is an initiative in partnership with Napa Valley Unified School District and a local nonprofit, On the Move that creates a learning environment for parents to gain critical parenting and leadership skills to support their child's academic success. Classes are bilingual with a focus on schools with a high percentage of students receiving free and reduced lunch, and those schools with high number of English Second Language (ESL) students.	NVPU offered 106 different class topics at 6 elementary school sites with over 1,500 unduplicated parent participants. Altogether 205 classes were offered with over 11,400 parent participants (parents take multiple classes). Class topics include: becoming an effective school consumer, helping children with homework, computer literacy, becoming a school and community leader, becoming an effective volunteer in the school, raising a healthy child and accessing health services.

Initiative (community need being addressed):	Community Benefit Category	Program	Description	FY16 Accomplishments
Improve Wellness And Healthy Lifestyles through perinatal community health education	Community Health Improvement Services	Perinatal Education	Educational classes for pre and postnatal mothers, partners, and siblings including birth preparation, infant care, breastfeeding and infant safety	Queen of the Valley community benefit offers perinatal classes to all in our community, regardless of income or area hospital birthing choice. 156 classes were presented for 430 women. With women taking multiple classes, altogether there were over 2,000 class participants. An additional 1,053 class participants (duplicated) were provided specific to breast feeding support. In addition, low income women are also offered free perinatal exercise classes at Queen of the Valley's Medical Fitness Center. This year 236 perinatal exercise classes were offered ranging from perinatal yoga to water classes.
Improve Wellness And Healthy Lifestyles	Community Health Improvement Services	Cooking Matters	Cooking Matters is a series of cooking classes that empowers families with the skills to stretch	As part of the No Kid Hungry campaign to end childhood hunger in America, Share Our Strength's Cooking Matters

Initiative (community need being addressed):	Community Benefit Category	Program	Description	FY16 Accomplishments
through nutrition community health education			their food budgets and cook healthy meals at home for their children.	teaches participants to shop smarter, use nutrition information to make healthier choices and cook delicious, affordable meals. This year QVMC offered a total of 30 classes to 57 individuals totaling 302 encounters (participants take several classes). Four of the 5 six week series were offered in Spanish.
Access To Health Services And Supports through ensuring access to diagnostic, treatments and procedures for Napa's uninsured population.	Community Health Improvement Services	Operation Access (OA)	Operation Access is a nonprofit organization that coordinates volunteer medical services for the uninsured.	Through a collaborative effort of area hospitals (Queen of the Valley, St. Helena Hospital, Kaiser Permanente) and Ole Health (FQHC), OA continues in Napa this year serving 61 unique lives with 297 encounters and 206 specialty appointments.

Initiative (community need being addressed):	Community Benefit Category	Program	Description	FY16 Accomplishments
Address Social Determinants Of Health through ensuring food and shelter.	Cash and In-Kind Contribution	Food and Shelter Safety Net for the Poor	Food and shelter are essential basic needs. Queen of the Valley provides cash in kind donations to community partners who provide for basic needs such as food and shelter.	A community benefit contribution totaling $25,500 provided to five safety-net non-profit agencies in Napa County helped to secure food and housing for the poor. In addition, a community benefit contribution in total of $150,000.00 was provided to Catholic Charities in support of two housing programs; one targeting young mothers (Rainbow House) and another toward the development and implementation of medical respite for the homeless (Nightingale House)
Access To Health Services And Supports	Cash and In-Kind Contribution	Access to specialty care (HIV, Hepatitis C, and cancer) for the uninsured and under- insured	Uninsured and underinsured persons have difficulty accessing specialty care for complicated chronic conditions such as HIV, Hepatitis C, and Cancer.	This year Queen of the Valley provided a community benefit donation of $41,000 to Ole Health to bring HIV, Hepatitis C and cancer oncology specialty clinics directly to the FQHC site. Patients of these specialty clinics

Initiative (community need being addressed):	Community Benefit Category	Program	Description	FY16 Accomplishments
				are then followed by Queen of the Valley's CARE Network team for care coordination and case management. Clinics provided services to over 75 unduplicated patients for a total of 168 office visits.
Create and Strengthen Sustainable Partnerships: Services for Older Adults	Subsidized Health Services	Healthy Aging Population Initiative (HAPI)	HAPI is a coalition of over 40 organizations serving older adults in Napa County. HAPI assesses older adult needs, advocates for policy and develops collaborative strategies to address needs	Queen of the Valley contributed a community benefit donation in the amount of $32,400 to Area Agency on Aging in support of HAPI facilitation, strategic activities and evaluation. In FY 16, after completing an extensive survey of more than 1,000 older adults and providers, HAPI held two community summits to identify priorities for improving conditions for older adults in Napa County. The priorities identified for policy and program action included the following:

Initiative (community need being addressed):	Community Benefit Category	Program	Description	FY16 Accomplishments
				• Safe, affordable, appropriate **housing** at all stages of life and income levels. • Outreach, Education and Links to Services • Affordable and accessible **transportation** and mobility • A continuum of quality, **comprehensive healthcare** that meets individual needs. • Building an aging friendly county Each priority area has a subcommittee and outcomes and implementation strategies identified. HAPI continues to promote the mental health, transportation and information and assistance strategies begun more than 10

Initiative (community need being addressed):	Community Benefit Category	Program	Description	FY16 Accomplishments
				years ago. The Committee has grown from 20 members to more than 40 organizations and has forged close relationships with the County and policymakers.
Access to Health Services and Supports through community wide collaborative to reduce death from sudden cardiac arrest	Cash and In-Kind Contribution	Heart Safe Program	Queen of the Valley and The Via Heart Project through a cooperative effort with the Napa Fire Department, EMS/911, Napa County of Education, Napa County Health and Human Services, and community members have joined forces to ensure existing Automatic External Defibrillators (AEDs) are maintained and registered to a database, and that AEDs are placed in high risk areas at a low cost or provided through	In FY 16 a community benefit donation in the amount of $20,000 supported 21 CPR/AED training events for a total of 4,402 persons trained. There are now a total of 75 AEDs in Heart Safe Program throughout Napa county. In part due to the efforts of the Heart Safe Program, the City of Napa is now designated as a HeartSafe Community.

Initiative (community need being addressed):	Community Benefit Category	Program	Description	FY16 Accomplishments
			donated funding, and there is free AED training along with CPR available to all Napa County residents.	
Access to Health Service and Supports through community health screenings	Community Health Improvement Services	Health screening for migrant farmworkers and the homeless	An ongoing partnership with Ole Health FQHC to provide health screenings to migrant farmworkers and the homeless. Screenings include cholesterol and blood sugar testing in addition to health education in prevention of diabetes, hypertension, heart disease and obesity. Participants are assisted for ongoing care through Ole Health	Provided 4 health screenings, three targeted migrant farmworkers and one the homeless population screening a total of 281 individuals. Queen of the Valley contributed a community benefit of $4,121 toward health fair supplies as well as in kind staffing including RN, Social Work, and Community Health Workers.

GOVERNANCE APPROVAL

This FY17 Community Health Needs Assessment Report was approved at the June 22, 2017 meeting of the Queen of the Valley Medical Center's Community Benefit Committee a sub-Committee of the Board of Trustees.

Community Benefit Committee Chair's Signature confirming approval of Queen of the Valley Medical Center's FY17 Community Health Needs Assessment Report

Date

See Appendix 6: Ministry Community Benefit Committee

Appendix 1: Community Needs Index data

Community Need Index (CNI) Scores

Queen of the Valley Medical Center Hospital Total Service Area (HTSA)

ZIP Code[1]	Service Area[2]	CNI Score[3]	Population	City	County	State
94559	PSA	4.0	28,263	Napa	Napa	California
94558	PSA	3.8	68,278	Napa	Napa	California
95476	SSA	3.6	36,167	Sonoma	Sonoma	California
94503	SSA	3.0	22,602	American Canyon	Napa	California
94574	SSA	3.0	8,742	Saint Helena	Napa	California
94599	PSA	2.4	3,091	Yountville	Napa	California
94581	PSA	PO Box	N/A	Napa	Napa	California

1. CNI scores are not calculated for non-populated ZIP codes, including such areas as PO boxes, national parks, public spaces, state prisons, and large unoccupied buildings.
2. PSA = primary service area; SSA = secondary service area.
3. CNI scores are sorted from highest to lowest. A CNI score of 1 represents the lowest need nationally, while a score of 5 indicates the highest need nationally.

Source: Dignity Health Community Need Index (cni.chw-interactive.org), 2015; Accessed March 2016.

Appendix 2A: Secondary Data /Publicly available data

http://www.thequeen.org/For-Community/Community-Benefit.aspx

Appendix 2B: Secondary Data /Publicly available data Appendix\

http://www.thequeen.org/For-Community/Community-Benefit.aspx

Appendix 3: Community Input

Public Health Representative

Name	Title	Organization
Dr. Karen Relucio	Napa County Chief Public Health Officer	Napa County Health and Human Services Agency (HHSA)
Jennifer Henn, PhD	Napa County Public Health Epidemiologist	Napa County Health and Human Services Agency (HHSA)
Howard Himes	Director	Napa County Health and Human Services Agency (HHSA)

Appendix 3a: Focus Group and Community Forum Participants

Residents who participated in focus groups and community forums completed an anonymous survey to allow reporting on demographics of the participants. In the table below, the number and percentages are shown for the focus groups, community forums, and then for all participants in both the focus groups and community forums. Percentages were calculated using the number of respondents for each question, which may be fewer than the total number of respondents because people could choose to leave a question unanswered.

Queen of the Valley Hospital	Resident Focus Groups	Community Forum Participants	ALL Community Members	Resident Focus Groups	Community Forum Participants	ALL Community Members
Number of Respondents	30	35	65	30	35	65
Gender						
Female	25	28	53	83%	82%	83%
Male	5	6	11	17%	18%	17%
Race/Ethnicity*						
Hispanic/Latino	21	25	46	70%	74%	72%
Non-Latino White	4	9	13	13%	26%	20%
Asian or Pacific Islander: Filipino	3	0	3	10%	0%	5%
Black/African American	2	0	2	7%	0%	3%
Native American	0	1	1	0%	3%	2%
Chronic Conditions						
Person with chronic conditions or a leader or representative of individuals with chronic conditions	5	10	15	22%	31%	27%
Age						
0-17 years	0	0	0	0%	0%	0%
18-44 years	18	22	40	62%	67%	65%
45-64 years	7	9	16	24%	27%	26%
65-74 years	2	2	4	7%	6%	6%
75 years or older	2	0	2	7%	0%	3%
Total Household Income before Taxes						
Less than $20,000	5	3	8	25%	9%	15%
$20,000 to $34,999	4	12	16	20%	35%	30%
$35,000 to $49,999	2	9	11	10%	26%	20%
$50,000 to $74,999	5	6	11	25%	18%	20%
$75,000 to $99,999	0	3	3	0%	9%	6%
$100,000 or more	4	1	5	20%	3%	9%
Decline to answer	6	1	7	Decline to Answer responses were not included in the calculation of percentages		
Number of People in Household						
Average	4.1	4.4	4.3	NA	NA	NA
Median	4.5	4	4	NA	NA	NA
Range	1-7	1-8	1-8	NA	NA	NA

*The percentages for race/ethnicity may add up to more than 100% because people could select more than one race/ethnicity.

Appendix 3b. List of Stakeholder Focus Group Participants and Organizations

The Non-profit/Government Stakeholder Focus Group was held on March 23, 2017 in Napa. The list of participants is presented in the table below, along with information about their organizations and the population they serve.

Name	Title	Organization	Public Health Department	The population served by the organization includes people who have or represent:			
				Chronic Condition	Diverse Community	Medically Underserved	Low Income
Bruce Lee	General Manager	AMR Napa; EMS		X	X	X	X
Jason Bond	Operations Manager	AMR Napa; EMS		X	X	X	X
Leon Garcia	Mayor	City of American Canyon			X	X	X
Joelle Gallegher	Executive Director	COPE (Child or Parent Emergency) FRC			X	X	X
Michele Grupe	Assistant Ex. Dir.	COPE FRC			X	X	X
Kathy Tabor	Co - Chair	HAPI (Healthy Aging Planning Initiative)		X	X	X	X
Lark Ferrell	Housing Manager	Housing Authority; City of Napa		X	X	X	X
Elba Gonzalez-Mares	Executive Director	Napa Community Health Initiative		X	X	X	X
Nui Bezaire		Napa County HHSA		X	X	X	X
Jacqueline Connors	Deputy Director	HHSA: Alcohol + Other Drugs		X	X	X	X
Howard Himes	Director HHS	Napa County HHSA	X	X	X	X	X
Jennifer Henn	PhD Epidemiologist Public Health	Napa County HHSA	X	X	X	X	X
Jennifer Swift	Diversity and Inclusion	Napa County HHSA		X	X	X	X
Karen Relucio	MD; Chief Public Health Officer	Napa County HHSA	X	X	X	X	X
Steve Potter	Chief of Police	Napa Police Department			X	X	X
Maren Rocca-Hunt	Executive Director Elementary Education	Napa Valley Unified School District			X	X	X
Alissa Gentile	Executive Director	On The Move			X	X	X
Chris Roth	Development Director	ParentsCAN		X	X	X	X
Jim Cotter	MD; Regional Medical Director	Partnership Health Plan; Managed Medi-Cal		X	X	X	X
Eustura Velazquez	Parishioner, Wife of Deacon	St. John The Baptist Catholic Church		X	X	X	X
Jenny Ocon	Executive Director	Up Valley Family Centers			X	X	X

Appendix 3c. Focus Group and Community Forum Report

Community Focus Groups

Queen of the Valley Medical Center held two Community Resident Focus Groups, one in Sonoma in Spanish, and one in American Canyon in English. The focus group in Sonoma was held in collaboration with Santa Rosa Medical Center because the city of Sonoma is also in their service area. In total, 36 individuals participated in the Community Resident Focus Groups.

Location	Date and Time	Language	Attendees
Sonoma	3/16/17, 9:00 AM	Spanish	20
American Canyon	3/22/17, 7:00 PM	English	16

The Community Resident Focus Group attendees were 83% female and 17% male. 70% of attendees identified as Hispanic/Latino, 13% as non-Latino White, 10% as Filipino, and 7% as Black/African-American. Of those who responded, 45% said they earned less than $35,000 annually; the American Canyon group was considerably more affluent than the group in Sonoma. More detailed demographic information is listed in Appendix 3a.

Resident participants were engaged and appreciated the opportunity to share their thoughts, as well as learn from others in the room. The Sonoma session was scheduled as part of an English as a Second Language class, so participants already had a rapport with each other. Many individuals in the American Canyon group also knew each other, leading to a positive group dynamic. There were two main groups of people at this group—one from the local school and one from a nearby church — but there was not a divide between the two constituencies. Attendees seemed to understand the purpose of the sessions, with most open to sharing their experiences and networking with one another to learn about available programs and services.

Identified Health Challenges

Traffic was the major topic of conversation in American Canyon. With the growth of the city and the number of people who use its roads to travel to Napa or cities south of the county, traffic has become a major impediment. Those who travel locally to schools, churches, or jobs often get caught in traffic, causing major delays, missed appointments, and stress. Commute times can often be close to an hour for trips that are only 10 miles. Some felt the roads are poorly designed, increasing the risk for accidents. Others felt that the pollution from cars is affecting the air quality. There was also concern that the continued growth in the community is going to worsen the problem, since there are limitations (including community opposition) to how many new roads can be built.

Both focus groups discussed challenges in the community with **Housing**, although due to the demographic differences, they had different approaches to the issue. In Sonoma, people were concerned about the high cost of housing and lack of access to low-income housing. In American Canyon, the discussion was also focused on housing costs, but with the perspective that housing costs in the city of Napa lead people to move further away, causing traffic problems and long commutes.

Access to Care was a strong concern at the Sonoma group, where residents reported challenges in getting appointments, long waits at the doctor, a lack of local medical services, challenges in paying for services including co-pays and prescription costs, and a lack of medical insurance for undocumented individuals. The group in American Canyon did not spend as much time talking about this issue; some participants even mentioned how good their insurance was. However, there was discussion about how some services are in the city of Napa, which can be a barrier due to traffic and commute times. The lack of **Dental** coverage and cost of care was also discussed extensively in the Sonoma focus group and was considered a major challenge to staying healthy in the community.

The challenges faced by the **Undocumented Immigrant Community** were discussed at Sonoma. Because they are ineligible for insurance, undocumented immigrants wait until their health concern is very serious before seeking help due to the cost of care and fear of being reported. They also noted that undocumented immigrants are afraid to report substandard housing conditions because they fear being evicted or deported. Some participants said they felt that clinic and hospital staff discriminate against them because of their race.

Participants at both focus groups noted the prevalence of **Obesity** among children, its link to **Food choices and Nutrition**, and the growth in **Diabetes** among both children and adults. In Sonoma, participants said they had to leave town to find affordable food in nearby towns such as Santa Rosa, Rohnert Park, and Petaluma. In American Canyon, there are local supermarkets but people questioned the availability of healthy food options in schools and other institutions.

Mental Health was raised as an issue at both focus groups, although it was usually discussed in the context of what causes stress. In American Canyon, traffic was identified as a major cause of stress. In Sonoma, participants noted the stress in the immigrant community associated with fears of deportation and disruption of their families.

Issues around **Dogs** were discussed in American Canyon. People reported being chased or harassed by unleashed dogs while exercising, particularly in parks. As a result, people are concerned about their safety and are less likely to use the parks for exercise. Also, participants complained about owners not cleaning up dog waste. While there may be stray dogs in the area, for the most part this was identified as a problem of owners not being responsible with their pets.

Water Quality was discussed as a major issue in American Canyon. Residents perceived high levels of hazardous waste and an incident where the water coming out of the taps was brown, perhaps due to the city back-flushing the system. There was concern from some that pesticides and fertilizers used in the wine industry are seeping into the water supply. Also, people complained that the water usually tasted bad. Many residents reported that they only drink bottled water as a result of these issues.

Domestic Violence was identified as a health concern in the Sonoma focus group, but it was not discussed in American Canyon. The general topic of crime was not discussed in either group.

Asthma was discussed as a concern in both groups, by participants who were suffering from it. In American Canyon, some wondered if allergens or pollutants in the air are causing or contributing to asthma. **Heart**

Disease, high blood pressure, strokes, and high cholesterol also were discussed in the focus groups as concerns.

Cancer was identified as a concern in both focus groups. In American Canyon, several participants shared their experiences with cancer, from the lens of either being a cancer survivor or having family and friends who had cancer. There was a perception that cancer is unusually prevalent in the city, and speculation about what might cause it. Sonoma's group also talked about breast cancer and cancer in children as pressing concerns.

Community Education was a discussion topic in American Canyon because people were eager to have more access to classes on cooking, nutrition, and fitness. While some knew about such classes being offered in Napa, traffic and time can be an obstacle. As a positive, some participants provided information about community education offered by the Parent University program in American Canyon.

Community Assets and Advantages

In addition to asking about issues facing the community, the facilitators explored what helps people stay healthy in the community. Participants at both focus groups had a number of positive things to say about their community. They spoke about the availability of parks, even in low-income areas, and paths for walking, which encourage being active and staying healthy. With the nearby farmland, there is an abundance of fresh produce at the markets and restaurants and local farmers' markets. There are community services to support families and residents, such as the Family Resource Center (El Verano) and Food Bank in Sonoma, the library, gyms, recreation centers, and pools.

Stakeholder Focus Group

The Stakeholder Focus Group was held on March 23, 2017 in Napa at the Napa County Health and Human Services offices. There were 21 participants representing community and government organizations (a complete list of participants is available in Appendix 3b). Many of the participants knew one another prior to the focus group, and were eager to discuss the health issues and opportunities of the area.

Identified Health Challenges

The stakeholders were savvy about the various health concerns in the community. They were primarily focused on the root causes of health conditions, such as housing, homelessness, and socioeconomic issues. They were not just concerned with the individual health issues, but also the compounding effect of one or more of these diseases for individuals.

The major topic of conversation in the focus group was **Housing**. Housing can be expensive for everyone, and can be particularly challenging for those in lower income brackets or with fixed incomes. Housing costs can drive people out of the community when they search for more affordable locations. For lower income individuals, affordable housing is hard to come by, so many people are in unstable situations and are at risk of homelessness. Seniors often cannot afford to pay for housing and other basic needs, especially if they need supportive housing. There also was concern that when young people leave because of housing costs, their senior citizen parents are deprived of their local family networks.

Homelessness is closely linked to Housing Concerns. While the stakeholders said that the extent of the problem was similar to the rest of the state, for the unsheltered and chronically homeless individuals, there is clearly a significant impact on their health.

Much of the focus group discussion was about **Mental Health.** Stakeholders reported a lack of psychiatric beds and other mental health services (especially those in Spanish). There was a sense that mental health issues are getting worse, particularly stress among youth, low-income individuals, and the immigrant and LBGTQ communities. The need to destigmatize the issue for everyone was also highlighted. **Substance Abuse** was often discussed in conjunction with Mental Health, as growing rates of drug and alcohol abuse increases the strain on the system. There was a perception that fewer people are seeking support services despite their need. The importance of prevention and education, beginning in schools, was stressed. With the legalization of marijuana, it is particularly important to educate about its effects on adolescent development.

Immigration Status was discussed as a serious issue. Immigrants are living in a time of greater fear and stress. Undocumented immigrants cannot obtain health insurance through the ACA, complicating their access to health care and leading them to often delay seeking help until their health conditions have become very serious. Others, whether undocumented or not, face discrimination and a toxic environment. Many immigrants also face **Language Barriers**. Some participants reported that there are not enough Spanish or Tagalog language services in the area. In addition, because there are dozens of languages being spoken in the area, it is difficult to support every resident's language needs.

Access to Resource issues also were extensively discussed at the focus group. Participants spoke about shortages of doctors, mental health providers, nurses and other health care providers, and the difficulties in recruiting them due to the high cost of living and housing. They noted difficulties residents have getting appointments and that people often need to leave the area to receive specialized care. While the percentage of people with insurance is relatively high, some who recently received insurance may not understand how to use it. **Transportation** can also be an issue for many individuals, especially those living in the more rural areas.

Economic Issues were also discussed, because there are concerns about how hard people have to work to earn enough to live in the area, which contributes to stress. The high cost of living makes it difficult for people to live near their jobs, leading to excess traffic. There was also concern that the federal definition of poverty was not appropriate given the high cost of living. Costs also place a burden on senior citizens; roughly one-third do not have enough income to pay for their essential needs.

The stakeholder group delved into issues of **Food and Nutrition** as well. There was discussion about the difficulty for some to eat a healthy diet, either because of economic reasons (because healthier foods tend to be more expensive), or cultural traditions around saltier or fattier foods. Because the service area is fairly spread out, some people who live outside of the city of Napa are in food deserts in which their options to buy healthy foods are limited. However, there is also an opportunity as an agricultural community because there may be a way to reduce waste by food gleaning or other programs.

Community Assets and Advantages

The stakeholder focus group also was asked what helps people stay healthy in the communities, and had many positives to contribute, starting with the natural beauty of the area, with clean water and air, and a climate that allows for exercise. The nonprofit community collaborates effectively, providing support for the community and programming such as the Live Healthy Napa County initiative. The philanthropic and government stakeholders also support wellness and health initiatives.

There is also a great deal and variety of programming that supports communities, such as recreational programming in parks, prevention programs in the schools and beyond, active Family Resource Centers in the elementary schools, wellness centers in the middle schools, and the children's dental van.

Community Forum

One community forum was held in Napa at the Napa Valley Lutheran Church. There were approximately 50 participants, most of whom were residents of Napa. The forum was conducted in English with interpretation services available for participants in Spanish; between 15 and 20 people required translation.

At the beginning of the forum, the participants viewed a short PowerPoint presentation with an overview of the CHNA framework, the hospital service area, and the health needs that had emerged from the data and preceding focus groups. The health needs also were written on poster paper taped to the walls of the room. Both the PowerPoint and the health needs were in English and Spanish. After the presentation, participants were invited to share their perspectives on the health needs in the community – to confirm, clarify, or add to items on the list. New items and clarifications were written on the poster paper. After the discussion, each person was given four adhesive dots and asked to place their dots on the health needs of greatest concern to them, applying only one dot per health need.

The discussion at the forum raised some of the same issues as the focus groups, although participants noted that issues such as traffic and water quality were specific to American Canyon and not as relevant to the city of Napa. Mental health, economic stress, walkability, lack of access to care, and substance abuse were all frequent discussion points. There was also some discussion about the political system of the city and county because some felt there is a disconnect between those who work in government, and even some nonprofits, and the experiences of the people in lower income communities. Some felt unable to access services and support, and even resented that a stakeholder meeting that was not open to the general public had been held the previous week. The facilitator and other participants tried to assuage those concerns, saying that the Community Health Needs Assessment process itself was intended to be a participatory process open to everyone, and that the implementation of any programming was designed to be inclusive and not top-down.

Below are the categories that received at least three votes in the forum. The labels provided are the English language headings that were listed on flip chart paper. Spanish language translations were provided next to the English language labels, to allow those who were not comfortable in English to easily vote.

Health Need	# of Votes
Mental health	19
Sidewalks, curbs, walkability, street lights	17
Poverty and economic stress	13
Dental care	11
Immigration status	10
Substance abuse	9
Language barriers	8
Lack of medical insurance/care	7
Youth activities	5
Community engagement	4
Education and prevention	3

Appendix 3d: Focus Group and Community Forum Protocols and Demographic Survey

Community Resident Focus Group Protocol

Introduction:

Hello everyone and thank you for agreeing to be part of this focus group. We appreciate your time and willingness to participate.

We are doing this focus group as part of Queen of the Valley Medical Center Community Health Needs Assessment. This is an every three years process in which non-profit hospitals such as Queen of the Valley explore community needs with input from the local community to better respond to the unmet needs. My name is ___________ and I'll be running the focus group along with my colleague _________. We do not work for the hospital as they wanted to have an outside partner to help run the process. This focus group is one of many that Queen of the Valley Medical Center is holding to hear directly from its communities' residents.

A focus group is a great way to get information and to capture people's ideas, opinions, and experiences. It's a structured conversation where we have some scripted questions and look to you to respond and take the discussion where it needs to go.

We need your input and want you to share your honest and open thoughts with us. Your responses will be anonymous. While we will be reporting in broad terms what is said during this focus group, we will not be attributing it to any person or organization. And we ask the same of you—that if you discuss this focus group outside of this room, you do not connect anyone to anything specific that was said.

Ground Rules:

1. There are no right or wrong answers. It's ok to respectfully disagree with someone else's opinion as that leads to dialogue and a better understanding of everyone's position and thoughts. Every opinion counts, and it is perfectly fine to have a different opinion than others in the group, and you are encouraged to share your opinion even if it is different.

2. We have a list of questions to ask, but we want YOU to do the talking. We would like everyone to participate, so we may call on people who have been particularly quiet.
3. We would like to record our conversation. Our note taker will be taking notes so that we remember what people have to say, but we'd also like to record the conversation to ensure we have the most accurate information possible. Is that okay?

This session should take 90 minutes. If you need to get up to use the restroom or grab refreshments, feel free to do so.

Any questions before we begin?

OK, then a couple other things before we get into the questions. First of all, can we please go around the room and introduce ourselves and say where we live and say something you like about your community.

Focus Group Questions

1. What are the biggest health issues affecting you, your family and friends in the community?
    a. Prompt – health issues refers to specific health conditions like heart problems, diabetes, obesity, cancer, asthma, or depression, and health behaviors refers to exercising, smoking, unhealthy eating, and drug use

Now, I'd like to ask you to look at the graphic that we're handing out right now. This was made by the United States Center for Disease Control and Prevention, a federal agency whose mission it is to help our country be healthy. The visual shows the many things that contribute to community health. Note that this graphic, and your own introductions, show that there is a lot more to "health" than just medical concerns. Let's keep that in mind as we go to our next questions.

2. What are the things in your community that help you stay healthy?
    a. Prompt – if you were to tell a friend about some of the good things in this community that help people live a good life here, what would you tell them?
    b. Prompt – This could include safe places to walk, clean air, enough doctors, easy access to health care, caring community, affordable housing, good-paying jobs, etc.
3. What are some of the challenges to staying healthy in this community?
    a. Prompt – if you were to tell a friend about some of the things that make it difficult to live a good life here, what would you tell them?
    b. Prompt – This could include no nearby grocery stores with fresh produce, no place to get exercise, overcrowded housing, low incomes, no doctors that take your insurance, poor air quality, gangs, etc.
4. Thinking about all the concerns discussed today, which do you think are the biggest concerns needing the most immediate attention?
5. What would you like to see in the communities to address these top concerns? How can some of the positive aspects of your community help?

Closing:

I wanted to thank you on behalf of the hospital for spending your time with us and sharing your wisdom and experiences. I wanted to stress that this meeting has been one very important part of the Needs Assessment process for Queen of the Valley Medical Center. I also wanted to be clear that everything that was said today will be recorded, reported, and considered. But some of what was said may not find its way into the final plan, because the hospital has to pull together everything they've learned in the process and make decisions about priorities. What I can say is that the final plan will be publicly available, and if you read it, you should see the key themes from today's meeting in there. Thank you again, and have a good evening.

Government/Non-Profit Stakeholders Focus Group

Hello everyone and thank you for agreeing to be part of this focus group. We appreciate your willingness to participate.

We are doing this focus group as part of Queen of the Valley Medical Center Community Health Needs Assessment. This is an every three years process in which non-profit hospitals such as Queen of the Valley study their communities' needs in order to become even better at serving those needs. My name is ___________ and I'll be running the focus group along with my colleague _________. We do not work for the hospital as they wanted to have an outside partner to help run the process. This focus group is one of other focus groups that are being conducted with community residents.

A focus group is a great way to get information and to capture people's ideas, opinions, and experiences. It's a structured conversation where we have some scripted questions and look to you to respond and inform the discussion to where it needs to go.

We need your input and want you to share your honest and open thoughts with us. Your responses will be anonymous. While we will be reporting in broad terms what is said here today, we will not be attributing it to any person or organization. And we ask the same of you—that if you discuss this focus group outside of this room, you do not connect anyone to anything specific that was said.

Ground Rules:

1. We have a list of questions to ask, but we want YOU to do the talking. We would like everyone to participate, so we may call on people who have been particularly quiet. But answering any question is optional.
2. There are no right or wrong answers. It's ok to respectfully disagree with someone else's opinion. In fact, we encourage it because it leads to dialogue and a better understanding of everyone's position and thoughts.
3. ______________ will be taking notes, but we also will be recording the group in order to capture everything you have to say. We are doing this for our own notes and reporting, but again, we won't share the recording or identify anyone by name in our report. You will remain anonymous.

Facilitator shows presentation focusing on high level findings from quantitative data. During the presentation, use the BARHII visual as an icebreaker to get people to talk about what factors influence a community's health, while answering the question "Please tell us your name, organization, and referring to the visual (provided in the PowerPoint), which area does your organization focus on or address in the upstream or downstream factors that influence community health?

After concluding the presentation, ask the following questions:

1. What are the biggest health issues facing our community?
    a. Prompt – health issues refers to specific health conditions like heart problems, diabetes, obesity, cancer, asthma, or depression, and health behaviors refers to exercising, smoking, unhealthy eating, and drug use

2. What helps our community stay healthy?
    a. Prompt – if you were to tell a friend or colleague about some of the good things in this community that help people live a good life here, what would you tell them?
    b. Prompt – This could include safe places to walk, clean air, enough doctors, easy access to health care, caring community, affordable housing, good-paying jobs, etc.

3. What are the challenges to staying healthy in our community?
    a. Prompt – if you were to tell a friend or colleague about some of the things that make it difficult for people to live a good life here, what would you tell them?
    b. Prompt – This could include no nearby grocery stores with fresh produce, no place to get exercise, overcrowded housing, low incomes, no doctors that take residents' insurance, poor air quality, gangs, etc.
4. What are the opportunities in our community to improve and maintain health?

5. What are the biggest health concerns needing immediate attention?

Closing: Thank the participants and talk about next steps.

Community Resident Forum Process/Protocol:

Hello everyone and thank you for agreeing to be part of this forum. We appreciate your willingness to participate.

We are doing this forum as part of Queen of the Valley Medical Center Community Health Needs Assessment. This is an every three years process in which hospitals such as Queen of the Valley study their communities' needs in order to become even better at serving those needs. My name is ___________ and I'll be running the focus group along with my colleague _________. We do not work for the hospital as they wanted to have an outside partner to help run the process. This forum is one of many that Queen of the Valley Medical Center is holding to hear directly from its community residents.

The purpose of this forum is to get a sense of what you think are the needs, issues, and opportunities in your communities. We need your input and want you to share your honest and open thoughts with us. Your responses will be anonymous. While we will be reporting in broad terms what is said to the hospital, we will not be attributing comments made to any person or organization.

Ground Rules:

1. We have a process in mind today, but it will only be as successful as you all make it; this session is for you. So please, feel free to be candid. Answering any question is optional; we won't be calling on anyone.
2. There are no right or wrong answers. It's ok to respectfully disagree with someone else's opinion.

3. ______________ will be taking notes, but we also will be recording the group in order to capture everything you have to say. We are doing this for our own notes and reporting, but again, we won't share the recording or identify anyone by name in our report. You will remain anonymous

Provide context: Facilitator: Be sure to provide context and how the information will be used up front

1. There will be two 5-10 minute presentations of findings from the community-based data and focus groups with questions in between. One presentation will focus on socioeconomic factors and physical environment; the other on health outcomes, health behaviors, and clinical care.
2. Point out the poster paper headings around the room, on which we list the areas of concern we have already seen on socioeconomic and physical environment and health needs that were identified through the quantitative data and qualitative process
3. After the first presentation on context and socioeconomic factors and physical environment, ask the following questions:
    a. Do you have any questions about the information you just saw or the poster paper headings?
    b. What did you see that matches with what you know about your community?
    c. What surprised you?
    d. What's missing? What's happening in your community that was not mentioned in the presentations?

4. After the second presentation on health outcomes, health behaviors and clinical care:

    a. Do you have any questions about the information you just saw or the poster paper headings?
    b. What did you see that matches with what you know about your community?
    c. What surprised you?
    d. What's missing? What's happening in your community that was not mentioned in the presentations?

5. Write down issues that are new or not already represented on the poster paper
6. Add explanation to the poster paper issues as provided from participants
7. Keep a parking lot for issues that are important but not necessarily related to the task at hand
8. Explain the process that participants will use to identify the most pressing areas of concern. Each participant will receive 4 dots to specify what they view as the most significant health issues; no more than one dot may be assigned to a health issue. Allow 10-15 minutes to complete this process
9. Review the results and facilitate discussion about the results – ask for more input on why some issues received more dots than others
10. Explain what will happen next with this information
11. Thank everyone for their time

Demographic Survey

Thank you for taking time to participate in our focus group today. Please take a few moments to complete the demographic survey below. Your identity will be kept confidential and anonymous. We'd like to gather some demographic data to reflect the individuals who participated in the focus groups or community forums. Please complete the survey and submit to the facilitator. Thank you for your time.

1. **Please check the box next to the description that best describes you:**
   - ☐ Community Member who does not work for a local health or social services provider (skip to question 3)
   - ☐ Community Member employed by:
     - ☐ Community-based Org/Nonprofit
     - ☐ County/Government Agency
     - ☐ Foundation/Funder
     - ☐ Health Care/Hospital/Clinic
     - ☐ University
     - ☐ Other (please provide): ____________________

2. **If applicable, please check the box next to the role that most closely matches your position/role within the organization:**
   - ☐ Administrative Staff
   - ☐ Board Member
   - ☐ Executive Director
   - ☐ Medical Professional
   - ☐ Program Manager/Staff
   - ☐ University/Faculty/Researcher
   - ☐ Volunteer
   - ☐ Other (please provide): ____________________

3. **Please check the box next to your current gender identity:**
   - ☐ Female
   - ☐ Male
   - ☐ Other (please provide): ____________________
   - ☐ Decline to answer

4. **What race/ethnicity do you identify as (Please select all that apply)**
   - ☐ Black/African American
   - ☐ Non-Latino White
   - ☐ Asian or Pacific Islander:
     - ☐ Vietnamese
     - ☐ Filipino
     - ☐ Chinese
     - ☐ Japanese
     - ☐ Korean
     - ☐ Indian
     - ☐ Native Hawaiian or Pacific Islander
     - ☐ Other: ____________________
   - ☐ Hispanic/Latino
   - ☐ Native American

5. **Do you identify as a person with chronic conditions, or a leader or representative of individuals with chronic conditions (such as diabetes, arthritis, or cancer)?**
   - ☐ Yes
   - ☐ No
   - ☐ Decline to answer

6. **What is your age group?**
   - ☐ 0 - 17 years
   - ☐ 18 - 44 years
   - ☐ 45 – 64 years
   - ☐ 65 - 74 years
   - ☐ 75 years or older

7. **How much total combined money did all members of your HOUSEHOLD earn last year before taxes?**
   - ☐ Less than $20,000
   - ☐ $20,000 to $34,999
   - ☐ $35,000 to $49,999
   - ☐ $50,000 to $74,999
   - ☐ $75,000 to $99,999
   - ☐ $100,000 or more
   - ☐ Decline to answer

8. **How many people live in your household, including you?** Please enter a number ____________________

Appendix 4: Existing Health care Facilities in the Community

Name	Address	Description of Services Provided
Ole Health, FQHC	1141 Pear Tree Lane, Napa	Primary Medical Care Behavioral Health Dental Care Pharmacy
Kaiser Permanente Clinic	3285 Claremont Way, Napa	Primary Medical Care Specialty Services Pharmacy
Napa County Health and Human Services	2751 Napa Valley Corporate Drive, Napa	Mental Health Public Health Alcohol and Drug Services
St. Joseph Health Queen of the Valley Medical Center	1000 Trancas Street, Napa	Acute Care Hospital Specialty Services Outpatient Services Community Benefit Services Mobile Dental Services
St. Helena Hospital	10 Woodland Rd, St. Helena	Acute care hospital Outpatient Services Inpatient/Outpatient Behavioral Health Inpatient/Outpatients Substance Abuse
Veterans Home of California	100 California Drive, Yountville	Residential Care Intermediate Care Skilled Nursing Care Memory Care Center

Appendix 5: Prioritization Protocol Worksheets

Step 1 Criteria and Score Definitions

#	Criteria	Criteria Definition	Score Definitions				
Step 1			1	2	3	4	5
1	**Seriousness of the problem**	Degree to which the problem leads to death, disability, and impairs one's quality of life.	For most people with the problem, the consequences are mild and not life threatening		Most people with the problem have some impairment of their quality of life; only some people die from the problem		For most people with the problem, the consequences are lethal or extremely debilitating
2	**Scope of the problem - Part 1**	Number of persons affected	Affects very few people		Affects about half the population		Affects much of the population
3	**Scope of the problem - Part 2**	Take into account the variance between regional benchmark data and targets and/or statewide averages. (for example, the prevalence of the problem in the primary service area compared to Target 2020 goals and/or prevalence in the county or state.)	The region is doing much better than targets or county/statewide averages		The region is on par with targets or county/statewide averages		The region is doing much worse than targets or county/statewide averages
4	**Health disparities**	Degree to which specific groups are affected by the problem	There are no differences in prevalence or severity of the problem across demographic or socioeconomic groups		One or more demographic or socioeconomic groups are doing moderately worse than the average in the service area		One or more demographic or socioeconomic groups are doing much worse on the health problem than the average in the service area
5	**Importance to the community**	Community members recognize this as a problem; it is important to diverse community stakeholders	Community input did not identify this area as a problem		Community input showed a moderate amount of concern about this problem		Community input showed a high level of concern about this problem
6	**Potential to affect multiple health issues**	Affects residents' overall health status; addressing this issue would impact multiple health issues.	Addressing this issue would not affect any other health issue		Addressing this issue would affect a few other health issues		Addressing this issue would impact many health issues - it is a root problem
7	**Implications for not proceeding**	Risks associated with exacerbation of problem if not addressed at the earliest opportunity	There is no risk that this problem will get worse if we don't address it now		There is a moderate risk that the problem will get worse if we don't address it now		This problem will definitely get worse if we don't address it now

These criteria were applied by raters from The Olin Group Evaluation Team to all identified health needs.

Step 2 Criteria and Score Definitions

#	Criteria	Criteria Definition	Score Definitions				
Step 2			1	2	3	4	5
8	**Sustainability of impact**	The ministry's involvement over next 3 years would add significant momentum or impact that would remain even if funding or ministry emphasis were to cease	Ministry involvement would likely yield little to no momentum or impact that would remain after 3 years of funding		Ministry involvement would likely yield moderate momentum or impact that would remain after 3 years of funding		Ministry involvement would likely yield significant momentum or impact that would remain after 3 years of funding
9	**Opportunities for coordination/ partnership**	Ability to be part of collaborative efforts	There is not much opportunity for the ministry to be part of collaborative efforts		There is some opportunity for the ministry to be part of collaborative efforts		There are many opportunities for the ministry to be part of collaborative efforts
10	**Focus on prevention**	Effective and feasible primary and/or secondary prevention is possible	There are no or few effective and feasible prevention strategies with which the ministry could be involved		There are a moderate number of effective and feasible prevention strategies with which the ministry could be involved		There are many effective and feasible prevention strategies with which the ministry could be involved
11	**Existing efforts on the problem**	Ability to enhance existing efforts in the community	There is so much work being done on this problem that our contribution would be meaningless		The problem is already being addressed by others and our contribution would be only moderately meaningful		We could make a very meaningful contribution to enhance the work of others in addressing this problem
12	**Organizational competencies (only CB Staff complete)**	Ministry has or could develop the functional/technical, behavioral (relationship building) and leadership competency skills to address significant health need	The ministry does not have and could not develop the competencies to address the issue		The ministry has some of the competencies or could develop them to address the issue		The ministry has or could easily develop strong organizational competencies to address the issue

These criteria were applied by raters from the Queen of the Valley Medical Center Health Needs Assessment Prioritization Working Group to all identified health needs.

Step 3 Criteria

Criteria	Criteria Definition	Responses		
Step 3		**Yes**		**No**
Relevance to Mission of St. Joseph Health	Is this area relevant or aligned with the Mission of St. Joseph Health?	Proceed to the next set of criteria		No further consideration of this health problem is necessary
Adheres to ERD's	Does this area adhere to the Catholic Ethical and Religious Directives?	Proceed to the next set of criteria		No further consideration of this health problem is necessary

These criteria were applied by the Community Benefit Staff of Queen of the Valley Medical Center to all identified health needs.

Appendix 6: Ministry Community Benefit Committee

Name	Title	Affiliation or Organization
Dorothy Arata	Retired Business Owner	Community Member
Jenna Bolyarde	Homeless Advocate	Community Member
Larry Coomes	Hospital CEO, Trustee	SJH, Queen of the Valley
Zack Curren	Battalion Chief	Napa Fire Department
Ed Farver	Board Chair	SJH, Queen of the Valley
Eva Garcia	Realtor/American Canyon Advocate	Community Member
Tim Herman	Board Trustee	SJH, Queen of the Valley
Dr. Donald Hitchcock, M.D.	Retired Community Physician, Medical Advisor Community Outreach Department	SJH, Queen of the Valley Community Member
Jose Hurtado	Retired / Education	Community Member Napa Valley Community College
Pam Kindig	Board Trustee	SJH, Queen of the Valley
Gerardo Martin	Founder Latino Leader Roundtable, Financial Advisor	Community Member
Sr. Nadine McGuinness, CSJ	Sister of St. Joseph of Orange, Board Trustee	Sisters of St. Joseph of Orange
Dennis Pedisich	Board Trustee, Chair Community Benefit Committee	SJH, Queen of the Valley

Name	Title	Affiliation or Organization
Reverend Linda Powers	Director of County Shelter Services	Community Action Napa Valley
Ron Profili	Board Trustee	SJH, Queen of the Valley
Dr. Karen Relucio	Chief Public Health Officer	Napa County Public Health/HHSA
Sr. Christine Schleich, CSJ	Sister of St. Joseph of Orange, Board Trustee	Sisters of St. Joseph of Orange
Ian Stanley	Director LGBTQ Connection	On The Move
Dr. Colleen Townsend	Physician	Ole Health, FQHC
Sr. Lisa Turay, CSJ	Sister of St. Joseph of Orange, Board Trustee	Sisters of St. Joseph of Orange
Rob Weiss	Executive Director	Mentis Mental Health Services
Dana Codron	Committee Staff, Executive Director Community Benefit	SJH, Queen of the Valley
Liz Alessio	Committee Staff, Community Benefit Coordinator	SJH, Queen of the Valley
Daniel Dwyer	Committee Staff, VP Mission Integration	SJH, Queen of the Valley

Appendix 7: Napa County Community Health Needs Assessment

http://www.countyofnapa.org/LHNC/

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