



Queen of the Valley Medical Center

FY 09 – FY 11 Community Benefit Plan

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FY 09- FY 11 Community Benefit Plan**

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EXECUTIVE SUMMARY

Napa County's 2006 population of 134,326 is becoming increasingly diverse and will continue that trend in the coming years. About one-quarter of the overall population identifies as Hispanic or Latino, while among children age 0-5 the proportion is closer to half. Napa County reflects dramatic socio-economic contrasts. Known as a world-class wine-producing region, yet amid the affluence, there are populations with disproportionate unmet health needs. While Napa is not considered a "poor" county relative to other counties, including those with large agricultural areas, about 10.6% of children and 6% of seniors age 65+—close to 11,000 individuals—live below the poverty level. Many more are live below 200% of poverty. With a peak agricultural labor force of approximately 6,000 farm workers (California Employment Development Department, 2005), approximately one of every 22 Napa County residents is a farmworker.

Queen of the Valley Community Benefit Program will target the following unmet health needs through program services and collaborative community partnerships:

1. **Dental Care for low-income children** and community capacity-building to expand dental care to low-income older adults
2. **Chronic Disease Management** for low-income chronically ill adults and older adults
3. **Obesity prevention** among at-risk low-income children through a model school-based program
4. **Behavioral Health Services** for low income and underserved adults, seniors and children
5. **Women's Health** including bilingual perinatal education, postpartum depression screening and intervention and cancer screening for low income women
6. **Access to Health insurance** for uninsured children
7. **Childhood asthma prevention policies** that address environmental risk factors for childhood asthma, particularly indoor air quality in schools, homes and community settings
8. **Wellness and Prevention** including bilingual community health education (nutrition, physical activity, car seats, bicycle helmets, asthma), health literacy, screening events, car seats/ installation, healthy aging efforts, and information and referral.

A. COMMUNITY PROFILE

The Queen of the Valley Medical Center (QVMC) community is defined by the geographic boundaries of Napa County and is divided into five regions: American Canyon, Calistoga, the City of Napa, St. Helena and Yountville. While nearly six in 10 county residents live in the City of Napa, the nearby City of American Canyon bordering Solano County, grew 34.5% between 2000 and 2004, and is projected to grow at a faster rate than other Napa County cities.

Mirroring California, Napa County's 2006 population of 134,326 is becoming increasingly diverse and will continue that trend in the coming years. About one-quarter of the overall population identifies as Hispanic or Latino, while among children age 0-5 the proportion is closer to half.

Napa County's older adult population is rising at a faster rate than California as whole. Population projections through 2030 for older residents show an increase of 99% for the age group 65-80. The over-85 population is also growing at a significantly faster rate than the total county population. The anticipated significant growth in these age groups will put a larger burden on the health care system and local economy, which may not have sufficient community services or tax base to support it.

Napa County reflects dramatic socio-economic contrasts. Known as a world-class wine-producing region, yet amid the affluence, there are populations of disproportionate unmet health needs. While Napa is not considered a "poor" county relative to other counties, including those with large agricultural areas, about 10.6% of children and 6% of seniors age 65+—close to 11,000 individuals—live below the poverty level. Many more are live below 200% of poverty. Despite a low unemployment rate of 3.6% in 2007, many low-income individuals and families are employed in low-paying jobs in the service (such as hospitality), retail and agricultural sectors. Service and retail jobs account for about 44% of total employment, while agriculture accounts for approximately 8%. With a peak agricultural labor force of approximately 6,000 farm workers (California Employment Development Department, 2005), approximately one of every 22 Napa County residents is a farmworker.

B. COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS

In 2007, QVMC participated in a collaborative effort to conduct a community health needs assessment. Public and private health and philanthropic organizations and institutions joined together to assess the health needs of the entire county. The needs assessment process included qualitative and quantitative data collection methods. The full report is attached.

The qualitative and quantitative assessment methods for this study included an "environmental scan" and the collection and analysis of primary and secondary data. The focus of data collection aimed at physical and mental health concerns and targeted issues for underserved populations.

Environmental scanning and needs assessment data provide the necessary information to inform decision makers and funders about the challenges they face in improving community health, and the priority areas where support is most needed.

Secondary Data: County-Level Statistics and Document Review

Existing data were collected from available data sources including government agencies (California Department of Finance, Office of Statewide Health Planning and Development, California Department of Health Services) and other institutions. These data included demographics, health status indicators and service capacity/availability.

Relevant information about the community, health status, where health services are obtained, and gaps in services was obtained through a review of reports and other records including documents and records of facilities such as data from local clinics and state government, reports from earlier needs assessments conducted related to health and reports about specific health programs or services

Primary Data

A questionnaire and community focus groups provided data from community residents and stakeholders. The questionnaire was developed in English and Spanish for the general public that inquired about most-important health needs and ideas for responsive solutions (See Appendix 2 of the attached Needs Assessment).

Community focus groups aimed at gather input of community residents were conducted in three locations (Napa, Calistoga, and American Canyon) chosen to ensure geographic representation and four more community focus groups were conducted at sites intended to draw populations that typically gathered there. Key community-based host organizations and housing complexes in those locations were identified by the Collaborative.

Provider Input

A focus group was conducted with healthcare professionals, including mostly community outreach workers, to gain their perspective about high-priority health needs, barriers to access and recommendations for community support. The forum was open to all providers.

Key Informant Interviews

In-depth telephone interviews using a structured set of questions were conducted, primarily individually, with a representative group of 21 individuals whose perceptions and experience were intended to inform the assessment (Appendix 5). The interviews provided an informed perspective from those working "in the trenches," increased awareness about agencies and services, offered input about gaps and possible duplications in service, and solicited ideas about recommended strategies and solutions. The interviews also focused the needs assessment on particular issues of concern where individuals with particular expertise could confirm or dispute patterns in the data and identify data and other studies the Collaborative might not otherwise be aware.

Disproportionate Unmet Health Needs Identified

The unmet health needs ranked highest/most often by all participants were:

- Lifestyle related/preventive health (obesity, nutrition, exercise, wellness)
- Mental health (gaps in service, depression, social/cultural isolation)
- Chronic disease (diabetes, cancer, allergies)
- Lack of insurance, provider not accepting Medi-Cal/Medicare, etc. Dental services for children, adults, seniors
- Drug and alcohol related problems
- Lack of bicultural/bilingual health care workers
- Lack of awareness of type/location/eligibility for services
- Transportation problems

Needs Assessment Priority Setting

After the assessment data were compiled and analyzed, the Needs Assessment Collaborative partners reviewed the draft assessment report and engaged in an informal discussion that led to recommended priorities for funding. The process included listing key issues and common themes; identifying findings that were unexpected and surprising as well as assumptions that were supported by the data; recognizing challenges and barriers; and determining opportunities with long-term benefit for improving community health in Napa County.

After evaluating the data collected from the needs assessment process, the Needs Assessment Collaborative agreed that an important opportunity exists in Napa County for health partners to focus efforts on four key areas:

- *Prevention and “healthy living” and wellness* to produce a long-term impact on health improvement, including comprehensive efforts that address nutrition, exercise and tobacco cessation
- *Community-based mental health services*
- *Affordable, community-based dental services* that focus on low-income seniors and children
- Efforts that address *alcohol abuse and underage drinking* using evidence-based community intervention strategies

Community assets and challenges were also identified.

Assets

- Unusually high degree of collaboration among community organizations
- Minimal turf issues
- Existence of highly regarded Clinic Ole as a critical safety net provider
- Presence of local, generous funders supportive of health
- Consistent desire among organizations to serve high-need groups (e.g., Latinos, seniors)

Challenges

- High cost of living in the area
- Aura of wealth that camouflages poverty
- A high proportion of an aging population
- Relatively high numbers of agricultural workers, many with unique needs
- Inadequate public sector resources for health education/health promotion and chronic disease prevention
- Geographic barriers due to distance and spread between cities/towns

C. IDENTIFICATION AND SELECTION OF DUHN COMMUNITIES

Communities of disproportionate unmet need in Napa County include low-income children in need of dental care, access to health care, prevention of asthma, obesity, and healthy birth outcomes; low income seniors at risk of mental health problems, prevention and management of chronic disease, access to critical services and dental care, youth and adults at risk of alcohol abuse.

DUHN Communities

The chart below describes the extent of key DUHN populations and health needs identified in the needs assessment:

1. Low income children including Latino children and their families where English is limited and access to information is difficult
 - a. Expand access to affordable, quality oral health services including preventive services and education
 - b. Child and family health and wellness education and early intervention to improve nutrition, physical activity and prevent obesity
 - c. Community education and advocacy to reduce indicators for asthma
2. Low income pregnant women particularly those who do not speak English
 - a. Access to prenatal care, support and education to improve birth outcomes including number of low birth weight infants
3. Low income uninsured women
 - a. Access to screening for cancer
4. Low income, chronically ill adults
 - a. Access to care, support, education and mental health services to improve quality of life and disease management
5. Low income seniors
 - a. Access to affordable, quality dental care
 - b. Access to mental health services
6. Low income adults at risk for mental health problems including suicide, depression, and other psychological problems

- a. Access to affordable, community-based mental health services for depression and other behavioral health issues
7. Youth and adults at risk of abuse of alcohol, tobacco and other drugs
- a. Community awareness to reduce high rates of underage drinking
 - b. Community interventions

DUHN Groups and Key Community Needs and Assets Summary Table		
DUHN Population Group	Key Community Needs	Key Community Assets
Low income children Latino children and their families	Expand access to affordable, quality oral health services including preventive services and education	QVMC Mobile Dental Van Sister Anne's Dental Clinic Family Resource Centers
	Child and family education and early intervention to improve nutrition, physical activity and prevent obesity	Established bilingual community education program Schools QVMC Wellness Center Children & Weight Coalition
	Access to education and support to improve outcomes for children with asthma	Asthma Coalition of community agencies and members
Low income pregnant women particularly women who do not speak English	Access to prenatal care, support and education to improve birth outcomes including number of low birth weight infants	QVMC Workshops Healthy Moms and Babies Linkage to clinical care programs for pregnant women
Low income un or underinsured women	Improve utilization of screening for cancer	Community Clinic Ole QVMC cancer services
Low income, chronically ill adults	Access to care, support, education and mental health services to improve quality of life and disease management	Care Network QVMC Community Clinic Ole Family Service of Napa Valley Wellness Center
Low income seniors	Access to affordable, quality dental care	Sister Anne's Dental Clinic Healthy Aging Population Initiative
	Access to affordable mental health services including preventive programs	Healthy Aging Population Initiative collaborative partners
Low income adults and older adults	Access to affordable, community-based mental health services for	FSA Clinic Ole

including Spanish-speaking adults	depression and other behavioral health issues	County Mental Health Services
Youth at risk of abuse of alcohol, tobacco and other drugs	Community awareness and interventions to reduce high rates of underage drinking and other drug use	Schools County Substance Abuse Services Wolfe Center

Targeted DUHN Communities

The following DUHN communities and Health Needs will be the major target in the next three years. Selection of these communities reflects resource considerations, expertise/ability to impact the issue and availability of existing community resources that are better positioned to undertake the issue.

D. INITIATIVE PRIORITIZATION PROCESS

The Community Benefit Committee convened a representative Planning Committee including staff, community members and hospital trustees to review the community needs assessment and determine how best to align the community benefits efforts of the Queen of the Valley over the next three years to address the unmet needs in the community. The Planning Committee convened in two meetings over 6 hours and developed criteria for selection of priorities and prioritized health needs using these criteria. The processes included listing key issues and common themes; identifying findings that were unexpected and surprising as well as assumptions that were supported by the data; recognizing challenges and barriers; and determining specific opportunities for Queen of the Valley to contribute to improving community health in Napa County. Additionally, the Planning Committee reviewed existing community benefit programs addressing DUHN communities and identified health priorities.

They discussed and agreed upon specific initiatives and strategies to address the unmet health needs based on the criteria below. Recommendations from the Planning Committee were presented to the Community Benefits Committee in the form of a logic model. This Community Benefits plan framework was approved prior to the development of this plan.

The Planning Committee utilized the following criteria to select priority health initiatives. The proposed initiatives were developed through an individual ranking and then consensus process.

Initiative Selection Criteria
<p>The Initiative should:</p> <ul style="list-style-type: none"> • Align with ASACB Core Principles • Build upon and align current programs with identified priority community health needs • Be appropriate to our mission, goals and expertise • Serve most vulnerable • Leverage and align with hospital resources and goals • Provide opportunities for linkages with other organizations, institutions and stakeholders • Have potential for high impact on issue/individuals

- Be cost effective
- Be able to be implemented utilizing best practices and innovation
- Be Measurable
- Address multiple factors: environmental, individual, root causes

E. COMMUNITY BENEFIT PLAN: HEALTH ISSUES AND INITIATIVES

The Community Benefit Committee approved the following recommendations from the following recommendations from the Planning Committee. The Planning Committee recommendations included strengthening the data collection strategies, linkages throughout the community outreach programs the medical center, adopting collaborative approaches to health and wellness activities and providing a continuum of care from one initiative to the others. For example, linking dental care to nutrition education and patients to community resources. These program enhancements will be built into ongoing programs as well as new efforts.

The central vision for the next three years is to: Build QVMC strength as a trusted community partner and expert working in coordination and collaboration with community stakeholders and providers. Expand integration throughout our own system. With our partners, construct sustainable community infrastructure to plan, implement and address priority community health needs. Assure that our existing programs are stronger, more cost effective and have a greater impact on priority health issues. Utilize targeted approaches to prevent problems at the earliest possible stage. We provide our most vulnerable population with the information and tools to prevent health problems and access health care. We have identified key community indicators and track initiative progress based on those indicators. We are leveraging our encounters to provide a continuum of care –providing follow-up to expand learning and impact multiple health priorities. The work of Community Outreach supports and expands the impact of the hospital’s provision of healthcare for the poor and Charity Care.

Two core assumptions guided selection of the initiatives:

- Target resources to identified priorities and build new initiatives through collaboration and specific partnerships rather than a community grantmaking process
- Build from current successful initiatives that address priority health needs

Selected Health Issues and Initiatives

1. Dental Care

- a. Expand dental care for low-income children through the mobile dental van
- b. Develop community capacity to expand care to low-income older adults as resources are available (Develop strategy over 3 years)

This initiative includes participation from local community agencies in coordinating access to the dental van for children in the community. Coordinated planning with

community stakeholder and organizations will be used to identifying potential resources and opportunities for expanding dental services for older adults.

2. Chronic Disease Management

- a. Continue to provide comprehensive chronic disease management for low-income chronically ill adults and older adults
- b. Continue to support free HIV specialty clinic
- c. Explore model program that provides short term case management support for patients with chronic disease following hospitalization to promote disease self-management (Develop strategy over 3 years)

This initiative targets a significant focus on DUHN populations, building a continuum of care from clinical services to community health support. The Care Network links with multiple community partners to provide chronic disease management and support for self-management.

3. Obesity

- a. Prevent obesity among at-risk low-income children through a model school-based program piloted in one school
- b. Provide referral of high risk children to QVMC Wellness Center for comprehensive support
- c. Expand model program over 3 years to additional schools as feasible

The model program will be completed with participation of multiple community partners who are currently meeting to establish the first program in a low-income school. This program is linked to a continuum of community education, clinical services and policy development.

4. Behavioral Health

- a. In coordination with community partners, increase access to a coordinated, continuum of behavioral health services and programs for low income and underserved adults, seniors and children. Program opportunities will be research and involvement defined in during the remainder of 2008. Implementation of programs with community partners will begin in FY 2009 as appropriate to funding and community timing.
- b. Expand psychiatric consultation at community clinic
- c. Continue to integrate behavioral health services to CARE Network patients.

5. Women's Health

- a. Continue and expand access to a full scope of perinatal education programs for low-income underserved women
- b. Continue to provide leadership and services to identify and address postpartum

- depression for all women
- c. Continue to provide support for cancer screening for un or underinsured women
- 6. Access to Health Care**
- a. Continue to assist uninsured children to enroll and maintain enrollment in health insurance.
- 7. Asthma**
- a. With community partners, advocate for policies and practices that address environmental risk factors for childhood asthma, particularly indoor air quality in schools, homes and community settings
- b. Conduct classroom assessments at local schools.
- c. Provide community education regarding childhood asthma prevention.
- 8. Healthy Communities – Wellness and Prevention**
- a. Transition/realign Healthy Communities program to improve health education/health literacy and access focused on the Latino community, support/expand Bi-National Health activities, and align with Community Outreach health education priorities. (Transfer coordination of Latino School Parent Groups to schools over the next year)
- b. Continue to support Healthy Aging Population Initiative in collaboratively addressing health, mental health and access to care and services for low income older adults
- c. Continue to support The Community Outreach Network of outreach workers throughout the county
- d. Provide free car seats and bicycle helmets for low-income families and children
- e. Continue to conduct Community Health Education series in Spanish and English (obesity, asthma, car seat safety, drug and alcohol abuse)
- f. Look for opportunities with health partners to increase community awareness about underage drinking

F. MINISTRY’S GOVERNANCE AND MANAGEMENT STRUCTURE

Senior Leadership

- CEO and other senior leaders are directly accountable for CB performance and Integrating ASACB Core Principles into hospital-wide practices.

Community Benefit Committee (CBC)

- CBC serves as an extension of trustees to provide direct oversight for all charitable activities and ensure program alignment with ASACB Core Principles. It includes diverse community stakeholders. Trustee members on CBC serve as ‘board level champions’

Community Benefit Department

- Manage community benefits programs and initiatives. Coordination between CB and finance departments on reporting and planning.

- Data collection, program tracking tools and evaluation.
- Develop specific outreach strategies to access identified DUHN populations.
- Coordinate with clinical departments to reduce inappropriate ER utilization.
- Advocate for CB to senior leadership.
- Investment in programs to reduce health disparities.

Medical Center/Organization

- Integrates ASACB Core Principles in CB and organizational strategic planning
- Physicians engaged in program development, implementation and evaluation.
- Coordination of hospital departments in case management strategy to reduce inappropriate (frequent flier') visits to ED due to chronic health conditions.
- Seamless continuum of care between physician and community services.

Community

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

INITIATIVE LEVEL
Template for Key DUHN Community Benefit Initiatives

Initiative: DENTAL CARE FOR CHILDREN

Activity/Program Name(s):

1. Preventive and restorative dental services to children ages 6 months-13 years through mobile dental van
2. *Family education: oral health and nutrition*
3. *Information and referral to community services for at risk children*

Outcome Measure (if available): Measurable increase in # of children with regular oral health care

DUHN Target group: Low income children

Activity 1: Content category of activity/program: Community Health Services **Sub-content category of activity/program: A2 Community-based Clinic**

Activity 2: Content category of activity/program: Community Health Services **Sub-content category of activity/program: A1 Community Health Education**

Activity 3: Content category of activity/program: Community Health Services **Sub-content category of activity/program: A1 Community Health Education**

How does this initiative fit with the identified DUHN needs and assets?

Dental care for low-income children was a high priority for community members and providers. The mobile van brings access to high quality dental care to families where dental care is unavailable or of limited availability. Nearly 40% of children with no insurance have untreated decay compared with 21% of children with private insurance. Children from poor families suffer twice as much dental disease as middle-class children and their disease is more likely to remain untreated. Applying the statewide assessment data above to poverty-level children age 0-19 in Napa County, at least 6,680 children have decay requiring treatment, an estimate that is probably conservative.

How many unduplicated persons do you target to serve in this initiative in FY 09? 300 new patients and 950 active patients

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
<p>To expand access to affordable, quality oral health services including preventive services and education and resource and referral for low income children</p>	<ol style="list-style-type: none"> 1. Provide preventative and restorative oral health services to children ages 6 months-13 years of age through mobile dental services located at schools and community locations with low income population 2. Provide education program to complement mobile dental services: preventive care, nutrition 3. Link with community-based providers and refer for follow-up children with risk factors for food security, mental health concerns, or other psychosocial issues 	<p><i>Strategy 1 –</i></p> <ul style="list-style-type: none"> • <i>Measure:</i> # of children on waiting list • # of children seen daily/# of services provided • % of children returning for regular check-ups • % of reduction in fillings or extractions related to decay among returning children <p><i>Strategy 2 –</i></p> <ul style="list-style-type: none"> • Increase in oral health behaviors reported at recall visit • % of parent demonstrating knowledge regarding oral health • % of families reporting healthy eating <p><i>Strategy 3 –</i></p> <ul style="list-style-type: none"> • % of families/children with perceived problem receive follow-up and assessment

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
<p>To improve fitness and health behaviors for underserved children at risk for obesity</p>	<ol style="list-style-type: none"> 1. Increase access to early intervention programs to improve fitness and nutrition: Pilot program in elementary school with high rate of children on free or reduced lunch and expand as resources are available 2. Increase child and family education on physical fitness, nutrition and health promotion 3. Provide referrals for higher risk children to QVMC Wellness Center for comprehensive support. 4. Increase availability of community education related to nutrition, physical activity and obesity 	<p><i>Strategy 1 –</i></p> <ul style="list-style-type: none"> • # of children participating • Improved skills that correlate with physical fitness • Improved in self-esteem on validated self-esteem scales • Increase in regular physical activity at appropriate levels for health and weight management: pre/post behavior survey of children and parents • Improvement on areas of the 5th grade CA Department of Education Fitness Test • Improved access to physical activity within the school setting <p><i>Strategy 2</i></p> <ul style="list-style-type: none"> • Families parents participating • Number of workshops presented • Evidence of family support through encouragement, provision of healthy foods and modeling/participation <p><i>Strategy 3 - –</i></p> <ul style="list-style-type: none"> • Number of workshops • Number of participants • Increase in knowledge of participants about nutrition, physical activity, healthy behaviors

INITIATIVE LEVEL

Initiative: CHRONIC DISEASE MANAGEMENT

Activity/Program Name(s):

1. _____ CARE Network
2. _____ HIV Clinic_____

Outcome Measure (if available): Reduced ER visits and Hospitalizations among clients

DUHN Target group: Low income chronically ill adults_____

Activity 1: Content category of activity/program: Community Health Services **Sub-content category of activity/program:** A2 Community-based clinical services

Activity 2: Content category of activity/program: Community Health Services **Sub-content category of activity/program:** A2 Community-based clinical services

How does this initiative fit with the identified DUHN needs and assets? Chronic disease is an expanding problem as Napa County’s overall population is increasingly “old”. Management of chronic diseases among the poor who are more likely to have greater psychosocial impacts on quality of life and co-morbidities related to their disease is cost effective in reducing hospitalizations and ER visits and improves quality of life. This initiative expands a continuum of care from hospital and clinical services to community-based services.

How many unduplicated persons do you target to serve in this initiative in FY 09? 315

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
<p>To improve outcomes and quality of life for adults with chronic illness</p>	<ol style="list-style-type: none"> 1. Increase access to comprehensive chronic disease case management for impacted low income patients including access to home-based and site-based mental health assessments, interventions and consultation for chronic disease patients 2. Increase access to HIV specialty care for HIV specialty care 	<p><i>Strategy 1 - Measure:</i></p> <ul style="list-style-type: none"> • Number of assessments • # of services • Number of hospitalizations/re visits • Number of resources and referrals • % of patient s reporting increased quality of life • % of patients reporting increased ability to manage disease <p><i>Strategy 2 - Measure:</i></p> <ul style="list-style-type: none"> • # of patients seen • % of patient s reporting increased quality of life • % of patients reporting increased ability to manage disease

INITIATIVE LEVEL
Template for Key DUHN Community Benefit Initiatives

Initiative: BEHAVIORAL HEALTH

Activity/Program Name(s): 1. CARE Network Behavioral Health Integration
2. Psychiatric Consultation in Community clinic
3. Collaborative planning to expand community-based mental health services

Outcome Measure (if available): _____

DUHN Target group: Low income adults, older adults, children and families

Activity 1: Content category of activity/program: Community Health Services **Sub-content category of activity/program:** **A2 Community-based Clinical Services**

Activity 2: Content category of activity/program: Community Health Services **Sub-content category of activity/program:** **A2 Community-based clinical Services**

Activity 3: Content category of activity/program: Community Health Services **Sub-content category of activity/program:** **A2 Community-based Clinical Services**

How does this initiative fit with the identified DUHN needs and assets?

Ranked among the highest community needs, significant community collaborative planning is occurring to develop community-based mental health services to improve availability of psychiatric consultation, and culturally and linguistically intervention services for low-income community members. It is estimated to Napa County's current population, up to 26,800 persons in the county could suffer from some level of mental disorder. Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. A key disparity often hinges on a person's financial status; formidable financial barriers block needed mental health care regardless of whether one has health insurance with inadequate mental health benefits or lack any insurance.

How many unduplicated persons do you target to serve in this initiative in FY 09? 65 patients in Care network; 750 psychiatric visits to 180 patients ; 20 community planning partners

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
<p>To improve access to a coordinated continuum of behavioral health services and programs for low income adults, families, and seniors</p>	<ol style="list-style-type: none"> 1. Increase home-based and site-based mental health assessments, interventions and consultation for Care Network patients 2. Increase access to psychiatric consultations at community clinic 3. Increase access to community-based culturally competent behavioral health services 	<p><i>Strategy 1 - Measure:</i></p> <ul style="list-style-type: none"> • Number of assessments • # of services • % of patients reporting increased ability to manage disease <p><i>Strategy 2 - Measure</i></p> <ul style="list-style-type: none"> • Number of psychiatric consultations <p><i>Strategy 3 - Measure:</i></p> <ul style="list-style-type: none"> • <i>Number of collaborative planning sessions/partners</i> • <i>Development of defined activities and strategies</i>

INITIATIVE LEVEL
Template for Key DUHN Community Benefit Initiatives

Initiative: PERINATAL HEALTH

Activity/Program Name(s): 1. Perinatal Education
2. Postpartum Depression Screening and Counseling
3. _____

Outcome Measure (if available): _____

DUHN Target group: Low Income women

Activity 1: Content category of activity/program: Community Health Services **Sub-content category of activity/program:** A2 Community-based Clinical Services

Activity 2: Content category of activity/program: Community Health Services **Sub-content category of activity/program:** A2 Community-based clinical Services

Activity 3: Content category of activity/program: Community Health Services **Sub-content category of activity/program:** A1 Community-Health Education

How does this initiative fit with the identified DUHN needs and assets?

The education program links to prenatal care for the poor provided through the medical center. An assessment of perinatal educational offerings in the community found that there is a disparity between the education that is available in Spanish compared to what is available in English. National statistics show that symptoms of depression and anxiety occur in 10-15% of expectant and new mothers and may be as high as 38% for women with other risk factors such as lower socio-economic status. Based on this we believe those suffering from symptoms of depression are under-reported. This program is one of a kind in the Valley.

How many unduplicated persons do you target to serve in this initiative in FY 09? 3,800 women

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
<p>Improve access to perinatal education and support for low income women, particularly those who have limited English skills</p>	<ol style="list-style-type: none"> 1. Increase access to consistent and high quality prenatal education provided to low-income Spanish and English speaking women in accessible local community settings 2. Increase access to screening for perinatal mood disorders for all pregnant women in the city of Napa referral for appropriate intervention services and follow-up to ensure access to and continuity of care. 	<p><i>Strategy 1 - Measure:</i></p> <ul style="list-style-type: none"> • % of participants demonstrating improved knowledge of perinatal health through pre-post test • # underserved community locations; # participants • #/% of session in Spanish • <p><i>Strategy 2 - Measure:</i></p> <ul style="list-style-type: none"> • Number of providers screening and referring clients for postpartum depression assessment • %/number of identified women with a postpartum depression service plan • % of women identified with depression who demonstrate improvement •

INITIATIVE LEVEL
Template for Key DUHN Community Benefit Initiatives

Initiative: CHILDHOOD ASTHMA PREVENTION

Activity/Program Name(s): 1. Asthma prevention community education
2. Napa Valley Asthma Coalition

Outcome Measure (if available): Reduction in childhood asthma attacks

DUHN Target group: Low -income children – Broader Community

Activity 1: Content category of activity/program: Community Health Services

Sub-content category of activity/program: A1 community Health Education

Activity 2: Content category of activity/program: Community Health Services

Sub-content category of activity/program: A1 community Health Education

How does this initiative fit with the identified DUHN needs and assets?

15.4% in Napa County have ever been diagnosed with asthma. Nearly one half (45.5%) of all Napa County children and adolescents with asthma experienced an asthma attack in 2003 compared to about one third (36.3%) in California (Table 30). This suggests that a larger proportion of the county's children and adolescents than the state average may be at risk for serious illness and other complications associated with asthma, such as activity limitations and missed days of school. This can be addressed through collaboration with community/public agency partners through the Asthma coalition and linking community education efforts

How many unduplicated persons do you target to serve in this initiative in FY 09? 144 education participants and 15 coalition member agencies.

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
<p>Working community partnership through the Asthma Coalition, improve childhood asthma indicators through community awareness and policies that improve indoor air quality</p>	<ol style="list-style-type: none"> 1. Increase public education through presentations about indoor air quality and relationship to asthma 2. Conduct assessment of classroom indoor air quality 3. Increase participation of policymakers in addressing childhood asthma 	<p><i>Strategy 1 - Measure:</i></p> <ul style="list-style-type: none"> • # of presentations • # of participants • Increase in Knowledge of participants • # of presentations • # of participants • Increase in Knowledge of participants • Reduction in asthma attacks related to indoor air quality/triggers <p><i>Strategy 2 - Measure:</i></p> <ul style="list-style-type: none"> • # of Coalition participants • Increase in indoor air quality policies in schools and other community settings • Reduction in asthma attacks

INITIATIVE LEVEL
Template for Key DUHN Community Benefit Initiatives

Initiative: BI-NATIONAL COMMUNITY HEALTH AND WELLNESS

- Activity/Program Name(s):**
1. Bi-National Health screenings and events
 2. Bi-National Community Health Education Outreach

DUHN Target group: Low income Underserved Latinos

Activity 1: Content category of activity/program: Community Health Services

Sub-content category of activity/program: A2 Community-based Clinic Services

Activity 2: Content category of activity/program: Community Health Services

Sub-content category of activity/program: A1 Community Health Education

How does this initiative fit with the identified DUHN needs and assets?

Access to information, preventive screening knowledge of how to access the systems of care and empowerment are key to preventing health inequities among underserved populations. Latinos, particularly new immigrants, need targeted approaches to reduce disparities.

How many unduplicated persons do you target to serve in this initiative in FY 09? 800 persons

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
<p>To improve health literacy/knowledge among underserved Latinos to prevent health problems and increase access to care in partnership with community organizations</p>	<ol style="list-style-type: none"> 1. Increase culturally and linguistically appropriate outreach preventive screening 2. Increase access to culturally and linguistically appropriate health education and literacy and improve community empowerment to reduce health inequities 	<p><i>Strategy 1 - Measure:</i></p> <ul style="list-style-type: none"> • # of screenings; # of participants • # of outreach contacts; # of referrals <p>Strategy 2 Measure</p> <ul style="list-style-type: none"> • # of presentations in local community settings • # of events/groups • % of participants who report increased knowledge of health and how to advocate for themselves and their families

INITIATIVE LEVEL
Template for Key DUHN Community Benefit Initiatives

Initiative: ACCESS TO HEALTHCARE

Activity/Program Name(s): 1. Children’s Health Insurance Assistance

Outcome Measure (if available): Percent of children continuously enrolled in health care insurance

DUHN Target group: Uninsured low income children and families

Activity 1: Content category of activity/program: Community Health services

Sub-content category of activity/program: A3 Health care support services

How does this initiative fit with the identified DUHN needs and assets?

Results from the California Health Information Survey (CHIS) suggest 6.8% (with a range of 2.3% to 11.3%) of children ages 0-18 in Napa County, are uninsured all or part of the year (Table 16), i.e., a range of 736 to 3,616 uninsured children. Children without insurance use the ER and other urgent care services. This program links to the community enrollment program and hospital services assuring children seen at the Medical Center are enrolled in insurance. Since ht program began in 2005 2,200 children have been enrolled throughout the county.

How many unduplicated persons do you target to serve in this initiative in FY 09? 265 children

GOAL	STRATEGY(IES)	STRATEGY(IES) MEASURE
To insure every child in Napa	1. <i>Increase access to health insurance for children through enrollment assistance, case management for retention and utilization tracking Support for CHI insurance assistance</i>	<i>Strategy 1 - Measure:</i> <ul style="list-style-type: none"> • % of children enrolled and retained • # of children treated who do not have insurance • % of QVMC tracked children utilizing healthcare

Attachment F

All Other Community Benefit Initiatives and/or Activities /Programs DUHN and Broader Community

1. **Initiative: Women's Health (A Care for the Poor Initiative)**

Activity/ Program Name: Woman's Health/Well Women Exams

Activity/Program Description: Early cancer detection and diagnosis for breast and cervical cancer among underserved, underinsured women. Partnership with Napa County FQHC Community Health Clinic Ole

Target Group: Low-income, un/under insured women seen through our local FQHC Community Health Clinic Ole

2. **Initiative: Community Health**

Activity/Program Name: Healthy Aging Planning Initiative (HAPI)

Activity/Program Description: Community collaborative enhancing community health education, outreach and safety for older adults in Napa County.

Target Group: Older Adults, Broader Community

3. **Initiative: Healthy Communities**

Activity/Program Name: The Outreach Network (TON)

Activity/Program Description: A community collaborative of front line outreach workers enhancing continuity of care and services within the community.

Target Group: Low-income, underserved population

4. **Initiative: Healthy Communities**

Activity/Program Name: Vintage High School Community Garden

Activity/Program Description: A collaborative with Vintage High School promoting nutrition and community volunteerism (Kathy you may have better description in mind?). Produce harvested is donated to local food bank.

Target Group: High school students and low-income