St. Helena Hospital Napa Valley & Center for Behavioral Health

2017 Community Health Plan

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Adventist Health Overview

St. Helena Hospital is an affiliate of Adventist Health, a faith-based, nonprofit, integrated health system headquartered in Roseville, California. We provide compassionate care in more than 75 communities throughout California, Hawaii, Oregon and Washington.

OUR MISSION:
Living God's love by inspiring health, wholeness and hope.

OUR VISION:
Adventist Health will be a recognized leader in mission focus, quality care and fiscal strength.

Adventist Health entities include:

- 20 hospitals with more than 2,700 beds
- More than 260 clinics (hospital-based, rural health and physician clinics)
- 15 home care agencies and seven hospice agencies
- Four joint-venture retirement centers
- Workforce of 32,900 includes more than 23,600 employees; 5,000 medical staff physicians; and 4,350 volunteers

We owe much of our heritage and organizational success to the Seventh-day Adventist Church, which has long been a promoter of prevention and whole person care. Inspired by our belief in the loving and healing power of Jesus Christ, we aim to bring physical, mental and spiritual health and healing to our neighbors of all faiths. Every individual, regardless of his/her personal beliefs, is welcome in our facilities. We are also eager to partner with members of other faiths to enhance the health of the communities we serve.

Our commitment to quality health care stems from our heritage, which dates back to 1866 when the first Seventh-day Adventist health care facility opened in Battle Creek, Michigan. There, dedicated pioneers promoted the "radical" concepts of proper nutrition, exercise and sanitation. Early on, the facility was devoted to prevention as well as healing. They called it a sanitarium, a place where patients—and their families—could learn to be well.

More than a century later, the health care system sponsored by the Seventh-day Adventist Church circles the globe with more than 170 hospitals and more than 500 clinics, nursing homes and dispensaries worldwide. And the same vision to treat the whole person—mind, body and spirit—continues to provide the foundation for our progressive approach to health care.

Dear Friends and Colleagues,

As Chief Executive Officer of St. Helena Hospital, I would like to share our Community Health Plan with you. As you read this plan, please join me in imagining new ways to work together with the community to help our residents achieve optimal health.

As we look back to 2016 and look forward to another three years of addressing the needs that we've found through the Community Health Needs Assessment, central to our effort is knowing that creating a healthy community is more than just about medical care. Studies have shown that health education, the conditions in which people live, learn, work and age affect their health. Social determinants such as housing, literacy, early child experiences, income and social support among others can influence our residents' lifelong health and well-being for generations to come.

Through our partnerships with other organizations for the 2016 Community Health Needs Assessment we have gained new insight into the health of our community, areas we collectively have identified as priorities, and where we can work together with other partners to achieve better health outcomes in our region. Our goal is to build on collective wisdom and use resources throughout the community to improve health and quality of life for everyone in Napa County.

We are encouraged by the collaborative partners in our community. Through these partnerships, we will find innovative solutions that can make a difference in the lives of the families in our community.

Steven Herber, MD
President & CEO

Hospital Identifying Information

St. Helena Hospital Napa Valley

Number of Hospital Beds: 151

10 Woodland Avenue

St. Helena, CA, 94574

St. Helena Hospital Center for Behavioral Health

61 beds

525 Oregon St,

Vallejo, CA 94590

Existing healthcare facilities that can respond to the health needs of the community:

- Lifestyle Medicine Institute – Lifestyle Medicine – St. Helena
- Adventist Heart Institute – Hidden Valley Lake, St. Helena, Vallejo
- Coon Joint Replacement Institute – St. Helena
- St. Helena Medical Specialties Family Practice – St. Helena
- St. Helena Medical Specialties Family Practice and Psychology – Calistoga
- St. Helena Medical Specialties General Surgery – St. Helena
- St. Helena Medical Specialties Nephrology/Internal Medicine/Neurology – St. Helena
- St. Helena Women's Center – OB/GYN - St. Helena & Napa
- St. Helena Medical Specialties Orthopedics – St. Helena
- St. Helena Medical Specialties Plastic Surgery – St. Helena
- St. Helena Medical Specialties – Pulmonology and Gastroenterology – St. Helena
- St. Helena Medical Specialties – Urology – St. Helena

Community Health Development Team

Steven Herber, MD

President & CEO

Buck McDonald

Chief Financial Officer

Suwanna Vatananan

Communications Manager

CHNA/CHP contact:
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Communications Manager
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10 Woodland Rd., St. Helena, CA 94574
To request a copy, provide comments or view electronic copies of current and previous community health needs assessments: https://www.adventisthealth.org/Documents/Community%20Benefits/CHNA%202016-2018/Final_2016_CHNA_SHNV.CBH.pdf

Invitation to a Healthier Community

Fulfilling the Adventist Health Mission

Where and how we live is vital to our health. We recognize that health status is a product of multiple factors. To comprehensively address the needs of our community, we must take into account health behaviors and risks, the physical environment, the health system, and social determinants of health. Each component influences the next and through strategic and collective action improved health can be achieved.

The Community Health Plan marks the second phase in a collaborative effort to systematically investigate and identify our community's most pressing needs. After a thorough review of health status in our community through the Community Health Needs Assessment (CHNA), we identified areas that we could address through the use of our resources, expertise, and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission, "To live God's love by inspiring health, wholeness and hope."

Identified Community Needs

The results of the Community Health Needs Assessment guided the creation of this document and aided us in how we could best provide for our community and the most vulnerable among us. As a result, St. Helena Hospital has adopted the following priority areas for our community health investments for 2017-2019:

- Mental Health
- Obesity and Diabetes
- Access to Primary Health Care
- Cancers
- Access to affordable housing/care

Additionally, we engage in a process of continuous quality improvement, whereby we ask the following questions for each priority area:

- Are our interventions making a difference in improving health outcomes?
- Are we providing the appropriate resources in the appropriate locations?
- What changes or collaborations within our system need to be made?
- How are we using technology to track our health improvements and provide relevant feedback at the local level?
- Do we have the resources as a region to elevate the population's health status?

Building a healthy community requires multiple stakeholders working together with a common purpose. We invite you to explore how we intend to address health challenges in our community and who we intend to

partner with to achieve change. More importantly though, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities we all want for ourselves and our families.

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Community Profile

How our community is defined

Each hospital in the Napa County Community Health Needs Assessment (CHNA) Advisory Group defines the community served by a hospital as those individuals residing within its hospital service area. Those hospitals consist of St. Helena Hospital Napa Valley, The Kaiser Foundation Hospital – Vallejo, and Queen of the Valley Medical Center. The hospital service areas include all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. For the county-wide CHNA, the service area for each hospital is Napa County. The Kaiser Foundation Hospital – Vallejo service area includes parts of Solano County.

Demographics of the community

The following data provides an overall picture of the Napa County population. Demographic and socioeconomic data present a general profile of residents, while overall health indicators present an overall assessment of the health of county residents. Key drivers of health (e.g., healthcare insurance, education, and poverty) point to important upstream conditions that affect the health of Napa County today and into the future. Finally, indicators related to climate and physical environment indicators complement these socioeconomic factors to provide a comprehensive understanding of the determinants of health in Napa County. All indicators include California comparison data as a benchmark to determine disparities between Napa County and the state. Healthy People 2020 benchmarks are also included when available.

Napa County is a generally healthy and affluent county, especially compared to California as a whole. However, Napa is also an aging county and has substantial disparities in socioeconomic status. These issues present challenges for the health of Napa County residents.

Napa County and California Demographic and Socioeconomic Data[1]		
Indicator	**Napa County**	**California**
Demographic and Socioeconomic Information		
Total Population	139,253	38,066,920
Median Age	40.3 years	35.6 years
Under 18 Years Old	22.4%	24.2%
65 Years Old and Older	16.0%	12.1%
White	77.2%	62.1%
Hispanic/Latino	33.0%	38.2%
Some Other Race	8.9%	12.9%
Asian	7.4%	13.5%
Multiple Races	3.6%	4.5%
Black	2.1%	5.9%
Native American/ Alaskan Native	0.5%	0.8%
Pacific Islander/ Native Hawaiian	0.3%	0.4%
Median Household Income	$70,925	$61,489

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Unemployment[2]	5.6%	6.8%
Linguistically Isolated Households	6.8%	9.6%
Households with Housing Costs > 30% of Total Income	42.6%	45.0%

Napa County and California Health Profile Data[3]			
Indicator	**Napa County**	**California**	**HP 2020[4]**
Overall Health			
Diabetes Prevalence (Age Adjusted)[5]	6.8%	8.1%	--
Adult Asthma Prevalence[6]	13.8%	14.2%	--
Adult Heart Disease Prevalence[7]	9.9%	6.3%	--
Poor Mental Health[8]	11.3%	15.9%	--
Adults with Self-Reported Poor or Fair Health (Age Adjusted)[9]	16.7%	18.4%	--
Adult Obesity Prevalence (BMI > 30)[10]	24.%	22.3%	≤ 30.5%
Child Obesity Prevalence (Grades 5, 7, 9) (BMI>30)[11]	14.8%	19.0%	≤ 16.1%
Adults with a Disability	10.8%	10.1%	--
Infant Mortality Rate (per 1,000 births)[12]	5.4	5.0	≤ 6.0
Cancer Mortality Rate (Age Adjusted) (per 100,000 pop.)[13]	167.8	157.1	≤ 160.6
Key Drivers of Health			
Living in Poverty (<200% FPL)[14]	28.1%	36.4%	--
Children in Poverty (<100% FPL)[15]	14.0%	22.7%	--
Age 25+ with No High School Diploma	16.9%	18.8%	--
High School Graduation Rate[16]	85.3%	80.4%	≥ 82.4%
Reading Below Proficiency (Grade 4 ELA Test)[17]	40.0%	36.0%	--
Percent of Population Uninsured[18]	13.9%	16.7%	--
Climate and Physical Environment			
Days Exceeding Particulate Matter 2.5 (Pop. Adjusted)[19]	6.3%	4.2%	--

[1] Unless noted otherwise, all data presented in this table is from the US Census Bureau, 2010-14 American Community Survey 5-Year Estimate.
[2] US Department of Labor, Bureau of Labor Statistics, June 2015.
[3] Unless noted otherwise, all data presented in this table is from the US Census Bureau, 2009-13 American Community Survey 5-Year Estimate.
[4] Whenever available, Healthy People 2020 Benchmarks are provided. Healthy People 2020. Washington, DC: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.
[5] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[6] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional analysis by CARES, 2011-12.
[7] California Health Interview Survey, 2011-12.
[8] University of California Center for Health Policy Research, California Health Interview Survey, 2013-14.
[9] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse, 2006-12.
[10] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[11] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[12] Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research, 2006-10.
[13] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[14] US Census Bureau, 2010-14 American Community Survey 5-Year Estimate.
[15] Ibid.
[16] California Department of Education, 2013.
[17] California Department of Education, 2012-13.
[18] US Census Bureau, 2010-14 American Community Survey 5-Year Estimate.
[19] Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network. 2008.

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Days Exceeding Ozone Standards (Pop. Adjusted)[20]	0.2%	2.5%	--
Weeks in Drought[21]	93.0%	92.8%	--
Total Road Network Density (Road Miles per Acre)[22]	1.4	4.3	--
Pounds of Pesticides Applied[23]	1,259,700	193,597,806	--
Population within Half Mile of Public Transit[24]	0.0%	15.5%	--

Priority Areas Identified

1. **Education:** Educational attainment is strongly correlated with health: people with low levels of education are prone to experience poor health outcomes and stress, whereas people with more education are likely to live longer, practice healthy behaviors, experience better health outcomes, and raise healthier children.

   In Napa County, extreme disparities exist among subpopulations in key educational outcomes. Hispanic/Latino students and English Language Learners (ELL) are at high risk for dropping out of high school. Only 22.0% of tenth grade English Language Learners passed the California High School Exit Exam in English Language Arts; only 39.0% passed in Mathematics.[25] For all students in the county, harassment and bullying in schools were also raised as issues of high concern.

2. **Economic and Housing Insecurity:** Economic resources such as jobs paying a livable wage, stable and affordable housing, as well as access to healthy food, medical care, and safe environments can impact access to opportunities to be healthy.

   The high cost of living in Napa exacerbates issues related to economic security and stable housing. Among all households, 42.9% spend 30% or more of household income on housing costs. Malnutrition and food insecurity are also key issues for Napa County residents, as many are forced to spend most of their income on housing, and do not qualify for public benefits.

3. **Mental Health:** Mental health includes emotional, behavioral, and social well-being. Poor mental health, including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder, has profound consequences on health behavior choices and physical health.

   Mental health was raised as a high concern. Most notably, Napa residents have a high risk of suicide. An estimated 10.3% of Napa County residents report having seriously considered suicide; among Latinos in the county, this estimate is 27.9%. Older adults, transition age youth, LGBTQ youth, and Latinos were noted as populations of high concern for mental health issues. Social stigma and the geographic distribution of resources were considered as barriers to receiving appropriate mental health services.

4. **Obesity and Diabetes:** Overweight and obesity are strongly related to stroke, heart disease, some cancer, and type 2 diabetes. These chronic diseases represent some of the leading causes of death nationwide.

[20] Ibid.
[21] US Drought Monitor, 2012-14.
[22] Environmental Protection Agency, EPA Smart Location Database, 2011.
[23] California Department of Pesticide Regulation (CDPR), 2013.
[24] Environmental Protection Agency, EPA Smart Location Database, 2011.
[25] California Department of Education, 2013-14.

There is a high prevalence of adults and youth who are obese throughout Napa County. In the case of adults 24% have a BMI > 30 and 6.8% of adults are diagnosed with diabetes. In the case of youth, 14.8% have a BMI > 30. Other data suggests that 64.7% of adults have low fruit and vegetable consumption and 51.6 % of youth ages 2-13 have low fruit and vegetable consumption as compared to 47.4% in California. Primary and secondary data indicate that throughout Napa County access to affordable healthy food is limited, and lack of physical activity may be driven in part by a lack of affordable exercise options and lack of time.

5. **Access to Primary and Oral Health Care:** Access to comprehensive, affordable, quality primary and oral health care is critical to the prevention, early intervention, and treatment of health conditions. The cost of care, including insurance premiums and medications, is a serious barrier to access. Additionally, recruiting health care providers has been difficult given the high cost of living in Napa. Older adults have specific needs that also present additional barriers to accessing care, such as mobility and transportation challenges. Immigration status and stigma are also noted barriers that prevent access to care and undocumented immigrants are not eligible for health insurance under the Affordable Care Act.

   In Napa County, access to primary and oral health care was identified as concerns. Among adults, 43.7% are without dental insurance, 7.6% of adults have poor dental health and only 77% of the entire population has access to dentists. Additionally, even with ACA, a large population in Napa County still does not have health insurance because health insurance premiums are high. Data suggests that 7.7% of the population is without access to a regular doctor.

6. **Substance Use:** Use or abuse of tobacco, alcohol, prescription drugs, and illegal drugs, can have profound health consequences.

   In Napa County, substance abuse was identified as a concern, particularly with respect to alcohol consumption. Among adults, 21.3% of residents report heavy alcohol consumption. Youth were noted as a high risk population, and data indicates that in the prior 30 days 11.8% of 11th grade students reported using cigarettes, 22.8% reported binge drinking, and 24.9% reported using marijuana.

7. **Cancers:** Cancer is a broad term which encompasses over 100 specific diseases, all of which begin with abnormal cell growth. Cancer is typically defined by the primary site of abnormal growth, and the progression of the disease is affected by the cancer type, as well as the phase of detection, and available treatment options.

   Compared to California state averages, Napa County has higher incidence of breast, prostate, colon and rectum, and lung cancer, as well as a higher all-cancer mortality rate. Racial/ethnic disparities exist in cancer morbidity and mortality.

Information Gaps

The Napa County CHNA data platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. While changes to the platform are ongoing, the data presented in this report reflect estimates from the Kaiser Permanente CHNA data platform on September 9, 2015. Supplementary secondary data was obtained from reliable data platforms

including U.S. Census Bureau American FactFinder, AskCHIS, and others. However, as with any secondary data estimates, there are some limitations. With attention to these limitations, the process of identifying health needs was based on triangulating primary data and multiple indicators of secondary data estimates. The following considerations may result in unavoidable bias in the analysis:

- Some relevant drivers of health needs could not be explored in secondary data because information was not available.
- Many data were available only at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data related to age, ethnicity, race, and gender are not available for all data indicators, limiting the ability to examine disparities of health within the community.
- In all cases where secondary data estimates by race/ethnicity are reported, the categories presented reflect those collected by the original data source, which results in inconsistencies in racial labels within this report.
- For some county level indicators, data are available but reported estimates are statistically unstable; in this case estimates are reported but instability is noted.
- Secondary data collection was subject to differences in rounding from different data sources; i.e., Kaiser Platform indicators generated from county-level data now round to the nearest tenth decimal place. Figures for all indicators generated from ZIP codes, census tracts, and points/addresses round to the nearest hundredth decimal places, and other data sources may report only to the nearest tenth or whole number.
- Data are not always collected on a yearly basis, meaning that some data estimates are several years old and may not reflect the current health status of the population. In particular, data reported from prior to 2013 should be treated cautiously in planning and decision-making.
- California state averages (where applicable) and United States national averages are provided for context. No analysis of statistical significance was done to compare county data to a benchmark; thus, these benchmarks are intended to provide contextual guidance and do not intend to imply a statistically significant difference between county and benchmark data.

Primary data collection and the prioritization process are also subject to information gaps and limitations. The following limitations should be considered in assessing validity of the primary data.

- Themes identified during interviews and focus groups reflect the experience of individuals selected to provide input; the Napa County CHNA Advisory Group sought to receive input from a robust and diverse group of stakeholders to minimize this bias.
- The final prioritized list of health needs is also subject to the affiliation and experience of the individuals who attended the Prioritization Day event, and reflect how those individuals voted on that particular day. The final scores are close in number and, therefore, suggest that all identified health needs are important to stakeholders in Napa County. Nonetheless, they have been prioritized according to the final average scores, and are assigned a corresponding rank order.

Community Health Needs Assessment Overview

Link to final CHNA report

Napa County has a rich network of community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment. Examples of community resources available to respond to each community identified health need, as identified in qualitative data and by the Napa County CHNA Advisory Group, are indicated in each health need profile in Appendix A. For a more comprehensive list of community assets and resources, please call 2-1-1 OR 800-273-6222, or reference http://www.211bayarea.org/.

The Napa County CHNA can be found online at: https://www.adventisthealth.org/pages/about-us/community-health-needs-assessments.aspx.

Methodology for CHNA

The CHNA process used a mixed-methods approach to collect and compile data to provide a robust assessment of health in Napa County. A broad lens in qualitative and quantitative data allowed for the consideration of many potential health needs as well as in-depth analysis. Data sources included:

- Analysis of over 150 health indicators from publicly available data sources such as the California Health Interview Survey, American Community Survey, and the California Healthy Kids Survey. Secondary data were organized by a framework developed from Kaiser Permanente's list of potential health needs, and expanded to include a broad list of needs relevant to Napa County.
- Interviews were conducted with 18 key informants from the local public health department, as well as leaders, representatives, and members of medically underserved, low-income, minority populations, and those with a chronic disease. Other individuals from various sectors with expertise in local health needs were also consulted.
- Four focus groups were conducted in English and Spanish, reaching 47 residents, representing populations identified as having worse health outcomes or at risk for worse health outcomes.

Additional secondary data was compiled and reviewed from existing sources including California Health Interview Survey, American Community Survey, and California Healthy Kids Survey, among other sources. Where more recent data was readily available and current estimates were critical to assessing changing landscapes such as health insurance status, Kaiser Permanente CHNA Data Platform information was updated as new data was publicly released, to reflect more recent data. In addition to statewide and national survey data, previous community health assessments and other relevant external reports were reviewed to identify additional existing data on additional indicators at the county level.

Secondary data was organized by a framework of potential health needs, and a comprehensive list of health need areas were explored during this assessment process. This framework was developed from Kaiser Permanente's list of potential health needs, which was based on the most commonly identified health needs from the 2013 CHNA cycle, and expanded to include a broad list of needs relevant to Napa County. The consulting team and Napa County CHNA Advisory Group finalized this framework in advance of analysis.

Data were used to score each health need. Potential health needs were included in the prioritization process if:

a) Multiple indicators reviewed in secondary data demonstrated that the county estimate was greater than 1% "worse" than the benchmark comparison estimate (in most cases, the benchmark used was the California state average).

b) The health issue was identified as a key theme in at least half of interviews OR in at least one focus group.

The Napa County CHNA Advisory Group convened an event on December 18, 2015, with a group of diverse community stakeholders to review the identified health needs, discuss the key findings from CHNA, and prioritize top health issues that need to be addressed in the County. The group utilized the Criteria Weighting Method, which enabled consideration of each health area using four criteria: severity, disparities, impact, and prevention.

Collaborative Partners

Live Health Napa County (LHNC): Napa County community members understand that improving the health of individuals, families, and communities requires a comprehensive understanding of health, one must consider all of the conditions in which people are born, grow, live, work, and age. By addressing all of these conditions, sometimes called the "social determinants of health," as well as the health care system, people and communities can be healthier and enjoy an enhanced quality of life. The LHNC collaborative was created from the notion that improving overall health requires a shared responsibility among diverse stakeholders. LHNC is a collaboration whose intention is to promote and protect the health and well-being of every member of the community. LHNC is a public-private partnership bringing together, among others, representatives not just from health and healthcare organizations, but also from business, public safety, education, government and the general public to develop a shared understanding and vision of a healthier Napa County.

St. Joseph Health, Queen of the Valley Medical Center (SJH-QVMC): St. Joseph Health Queen of the Valley Medical Center (SJH-QVMC) is a vital resource and integral part of the Napa Valley community. A full-service acute care 208-bed medical center, SJH-QVMC employs approximately 1,100 employees. The medical center is located within the City and County of Napa, and is the major diagnostic and therapeutic medical center for Napa County and the surrounding region. Services include the county's only Level III Trauma Center, the Peggy Herman Neuroscience Center, and a Maternity Center and Well Baby Nursery. SJH-QVMC is committed to community wellness and is one of the first acute care providers to successfully develop and implement a medical fitness center, Synergy Medical Fitness Center, on the Medical Center campus. Other medical specialties include robotic surgery for cardiac, gynecology and urology; cancer care; heart care; orthopedics; inpatient and outpatient rehabilitation services; and imaging.

As a member of St. Joseph Health, a Catholic health system founded by the Sisters of St. Joseph of Orange, SJH-QVMC devotes resources to outreach activities and services that help rebuild lives and care for the underserved and disadvantaged. SJH-QVMC recognizes and embraces the social obligation to create, collaborate on and implement programs that address identified needs and provide benefits to the communities they serve. Partnerships it has developed with schools, businesses, local community groups and national organizations allow the hospital to focus tremendous skills and commitment on solutions that have an

enduring impact on the community. Based on identified community needs, SJH-QVMC provides and/or supports an extensive matrix of nationally recognized, award winning, well-organized and coordinated community benefit service programs and activities addressing issues such as obesity, mental health, chronic disease management, dental health, education and empowerment, access to food, housing, and preventive health care.

Kaiser Permanente: Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. Kaiser Permanente was created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since the beginning, Kaiser Permanente has been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today it serves more than 10 million members in nine states and the District of Columbia. Its mission is to provide high-quality, affordable health care services and to improve the health of its members and the communities it serves.

Care for members and patients is focused on its Total Health and guided by its personal physicians, specialists, and team of caregivers. Kaiser Permanente's expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

Napa County's approach to CHNAs is collaborative, cross-sector (including representatives from health and healthcare organizations, business, public safety, education, government and the general public), and grounded in the understanding that improving the health of individuals, families, and communities requires a comprehensive understanding of health. This approach takes into account the conditions in which people are born, grow, live, work, and age, (or the social determinants of health) in an effort to assess and strengthen community health.

Napa County's CHNA Advisory Group drew upon Kaiser Permanente's free, web-based CHNA data platform that provides access to a core set of approximately 150 publicly available indicators to understand health through a framework that includes social and economic factors; health behaviors; physical environment; clinical care; and health outcomes. In addition to reviewing the secondary data available through the CHNA data platform and other publicly available sources of data on additional indicators, the Napa County CHNA Advisory Group and the consultant team collected primary data through key informant interviews and focus groups. Primary data collection consisted of reaching out to local public health experts, community leaders,

and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

The Napa County CHNA Advisory Group then developed a set of criteria to prioritize the identified health needs in their community. A community meeting was held to apply the criteria and prioritize the health needs. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

Community Voices

Community input was provided by a broad range of community members and leaders through key informant interviews and focus groups. The consultant team interviewed individuals who were identified as having valuable knowledge, information, and expertise relevant to the health needs of the community. Interviewees included representatives from the local public health department as well as leaders, representatives, or members of medically underserved, low-income, chronically diseased, and minority populations. Other individuals from various sectors with expertise of local health needs were also consulted. A total of 18 key informant interviews were conducted during this needs assessment. For a complete list of individuals who provided input, see Appendix C.

Additionally, four focus groups were conducted throughout Napa County. These groups were intentionally sampled to reach specific subpopulations of the county that were identified as having worse health outcomes or at risk for having worse health outcomes in Napa County. These subpopulations included youth county-wide, as well as residents in American Canyon and Calistoga. Focus groups were monolingual, conducted in either English or Spanish.

Community partners provided invaluable assistance in recruiting and enrolling focus group participants. Many individuals who participated in focus groups identified as leaders, representatives, or members of medically underserved, low-income, chronically diseased, and minority populations.

Interview and focus group protocols, designed to explore the top health needs in the community, as well as a broad range of social, economic, environmental, behavioral, and clinical care factors that may act as contributing drivers of health needs, were developed by the consulting team and reviewed by the Napa County CHNA Advisory Group.

All qualitative data was coded and analyzed using ATLAS.ti software. The consultant team coded transcripts for information related to each potential health need, as well as to identify comments related to specific drivers of health needs, subpopulations or geographic regions disproportionately affected, existing assets or resources, and community recommendations for change. At the onset of analysis, the consultant team coded one interview transcript and one focus group transcript to ensure inter-coder reliability and minimize bias.

The consultant team analyzed the transcripts to identify common themes across interviewees and focus group participants, as well as specific themes that emerged within a particular focus group or in a key leader interview. Health needs identification in qualitative data was based on the number of interviewees or groups who referenced each health need as a concern, regardless of the number of mentions of that particular health need within each transcript.

Identified Priority Needs from 2016 CHNA

Identified Needs

Mental Health

Goal

Increase access to mental health services

Increase awareness and interventions for youth

Objective 1: Increase access to mental health services for older adults, especially at day centers and adult shelters

- Partner with OLE Health and other local not-for-profit healthcare organizations to provide mental health services for Napa County, specifically Calistoga and St. Helena
- Utilize the Center for Behavioral Health in Vallejo to expand services and awareness within Solano and Napa County

Objective 2: Increase mental health intervention staff in schools

- Provide seminars and lectures on mental health in a way that is appropriate for youth
- Collaborate with community partners to provide educational opportunities
- Recruit physicians and psychiatrists to offer services
- Participate and support community health fairs
- Support programs that are designed to raise awareness in teens (i.e. support groups)

Objective 3: Increase outpatient services

- Expand access to psychiatric services offered in local outpatient clinics in St. Helena
- Expand access to psychiatric services offered via telemedicine at other out-of-network clinic locations
- Expand access to outpatient behavioral health services at other locations

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Increase access to mental health services	# of patients served for mental health services	100% of persons who need services are able to access needed services	# of patients treated	Patients/Clients

Increase awareness and treatment of mental health in schools	Increase awareness of mental health issues and service options	100% awareness	#of patients treated	Patients/Clients
Increase outpatient services	# of patients treated for outpatient services	100% of persons who need services are able to access needed services	# of patients treated	Patients/Clients

Identified Needs

Obesity and Diabetes

Goal

Increase accessibility to healthy, affordable foods

Increase opportunities for physical activity

Increase education about healthy eating and active living

Objectives

Objective 1: Create a community garden

- Offer spaces in the community garden for local schools to learn about growing healthy foods
- Create opportunity for students to sell or donate garden items at an affordable price to those in need (i.e. create a community farmer's market)
- Offer food demonstrations and lessons on how to grow your own vegetables
- Allow opportunity for community to garden
- Grow fruit and vegetables to serve in hospital cafeteria for patients and employees
- Create vegetable boxes to sell to community members in need

Objective 2: Strengthen partnerships between cities, school district, nonprofits and other local business to increase wellness activities in the community

- Create childhood obesity prevention programs that allow students to get active in the community at a low-cost or free
- Encourage local schools to work together in programs to create awareness about physical activity
- Partner with others to change nutrition policies
- Enhance the safety of roads and sidewalk to promote active transportation
- Lead community partners, including the St. Helena Foundation, to pursue blue zones in the Upper Valley
- Support activity based events and organizations that encourage active living (i.e. Promotoras, Let's Move Day)

Objective 3: Utilize physicians, integrative medicine specialists, and nutritionists to educate parents and children

- Provide culturally relevant nutrition information and cooking classes
- Include prenatal and early life nutrition as a topic in prenatal programs
- Provide multilingual education about healthy food choices
- Enhance diabetes education program to accommodate for more of the community, including Spanish speaking patients

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Increase accessibility to healthy foods	% of persons consuming <5 servings of fruit and vegetables	100% of persons able to access healthy foods	Access to healthy foods and vegetables	Patients/Clients
Increase opportunities for physical activity	# of opportunities available for physical activity	% of person participating in opportunities	Attendance	Patients/Clients
Increase education about healthy eating and active living	Knowledge of healthy foods and exercise patterns	% of increased knowledge as a result of education and resources	Knowledge level	Patients/Clients

Identified Needs

Access to Primary Health Care & Dental Care

Goal

Expand accessibility

Increase awareness of resources

Objectives

Objective 1: Support separate healthcare networks to fill service gaps

- Partner with OLE Health and other local not-for-profit healthcare organizations to provide additional services primary care and dental care
- Enhance the use of telemedicine to accommodate patients unable to come for hospital visits

Objective 2: Recruit physicians into network

- Increase the number of providers in primary service area
- Decrease wait times for appointments

Objective 3: Offer free health clinics

- Partner with local business to offer free health screenings throughout the community
- Follow up with patients

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Expand accessibility	% of persons with a primary care doctor	100% of persons with an assigned doctor	Doctor assignment	Patients/clients
Increase awareness of resources	Awareness of issues and service options	% increase in awareness as a result of education and resources	Awareness level	Patients/clients

Identified Needs

Cancers

Goal

Increase access to cancer detection services and related support services

Increase awareness and interventions to prevent cancer

Short-term Objective

Objective 1: Increase cancer detection and treatment services offered at multidisciplinary clinics

- Partner with OLE Health and other local not-for-profit healthcare organizations to provide access to cancer prevention, detection and support services
- Provide access to genetic cancer screening program for all primary care clinics within and outside of Adventist Health network of clinics
- Provide access to lung health screening programs as a means for early detection of lung cancer
- Provide access to advanced 3D mammography screening technology, a cutting-edge technology proven to increase detection of all breast cancers by 29%
- Provide access to a higher standard of breast cancer care as evidenced by those centers who achieve breast center of excellence

Objective 2: Increase awareness and interventions that prevent cancer

- Provide access to seminars and lectures on cancer prevention including the Awaken Series, an education series focused on prevention of cancer using techniques that align with our heritage of healing of the mind, body and spirit
- Provide education to the community at local events, including community health fairs, community partner events
- Provide support for other community partners who focus on disease education, including the Zero Prostate Run, Light the Night for Leukemia and Sisters Crush Walk/Run

Objective 3: Provide access to support and education patients undergoing treatment for cancer and their caregivers

- Provide access to education and support services, including the Cancer Support Circle, Art Classes for patients and caregivers, the Look Good Feel Better classes for patients who are undergoing cancer treatment

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Increase access to diagnosis of breast cancer	# of breast cancer cases detected	% increase in 3D mammography screenings	3D mammography screenings that test positive	Patients/Clients
Increase access to diagnosis of lung cancer screening	# of lunch cancer screening cases detected	% increase in lung cancer screenings	# of low dose CT screenings	Patients/Clients
Increase in number of cases identified through genetic testing	# of cancer cases detected	% increase in cancers identified through genetic testing	Genetic testing that tests positive	Patients/Clients
Increase awareness of interventions that prevent cancer	# of attendees	% decrease in diagnosis of cancer	# of cases diagnosed per year	Community Health Needs Assessment
Provide cancer support services for patients diagnoses with cancer and their caregivers	# of attendees	100% attendance	Patients/Clients	Patients/Clients

Identified Needs

Access to shelter and respite care for the homeless

Goal

Increase access to respite care for the homeless who meet admissions criteria

Objective 1: Increase access to respite care for homeless residents in the Napa Valley

- Through the Gasser Foundation, St. Helena Hospital will provide $100,000 in financial support in the first year for shelter beds at Medical Respite Care Facility, a location identified for patients without homes who require care after they are discharged from the hospital

Evaluation Metrics

Objective	Baseline Measurement	Performance Target	Indicator	Data Source
Increase access to care for the homeless	# of patients served by the Medical Respite Care Facility	100% of persons who need services are able to access needed services	# of patients treated	Patients/Clients

Identified Needs from CHNA, Not Addressed

Taking existing hospital and community resources into consideration, St. Helena Hospital Napa Valley will not directly address the remaining health needs identified in the CHNA including: education, economic and housing insecurity, substance use, and cancers. The hospital cannot address all the health needs present in the community, therefore, it will focus efforts on the health needs that can most effectively be addressed given the organization's areas of focus and expertise. St. Helena Hospital Napa Valley will look for partnership opportunities that address needs not selected where it can appropriately contribute to address those needs, or where those needs align with current strategy and priorities.

OUR MISSION:
Living God's love by inspiring health, wholeness and hope

Making a difference: Evaluation of 2014-2016 CHP

Making a difference in our community based on needs identified

Adventist Health wants to ensure that our efforts are making the necessary changes in the communities we serve. In 2013 we conducted a CHNA and the identified needs were:

Education

- In partnership with author, Shalini Singh Anand, we provided over 200 students at Calistoga Elementary school with "Lee the Bee" books (totaling $2,314) and personal readings with the author which encouraged students to stay in school and gave the students exposure to the benefits of getting a great education.
- Through the St. Helena Unified School District, we have provided over 100 hours at school Field Days at St. Helena Primary School, St. Helena Elementary School, Foothills Elementary, PUC Elementary School, Vichy Elementary School, and Pueblo Vista Elementary.
- Through Girls on the Run Napa & Solano, a $5,000 donation was able to impact 775 girls at 44 different schools, a 40% increase from the previous year. This program is a year-long process that guides girls in grades 3rd to 8th . Volunteer life coaches lead the girls through experiential activities and discussions. The program ends with a 5K event that had a participation of over 1,000.

Economic and Housing Security

- Through the Promotoras Program (in partnership with the UpValley Family Center), 11 active Promotoras (all bi-lingual woman) were sponsored to become advocates in the community, providing them with access to information and resources, meeting monthly to coordinate their work. Within this program, the Promotoras have led five free Zumba classes per week in Calistoga and three in St. Helena – reaching 140 people, led four sessions of nutrition classes in Calistoga, led mental health town hall meetings in Spanish in Calistoga and St. Helena – reaching 100 people, and coordinated visits from the Mexican Consulate – reaching over 200 people.

Mental Health

- A new geriatric medical psychiatric unit at SHNV was opened to increases access throughout Northern California to acute inpatient medical care for patients with complicating behavioral comorbidities. The unit is fully staffed and can accept up to 6 patients at a time. In the months since opening, we have reached census for three months.
- We have partnered with the UpValley Family Center to increase awareness about mental health by participating in several wellness events and meetings. Each wellness meeting has about 50 community stakeholders in participation.

Obesity and Diabetes

- The Diabetes Self-Management Class for 60 (total for the year) diagnosed individuals is a free monthly educational class for the community. A continued $5,000 has been given to support the costs of the program.
- A partnership with Calistoga Elementary School and Safe Routes to School provided a program to encourage families on safe and alternative transportation to school. A total of 20 hours was committed throughout the school year; reaching over 350 students and parents each week.
- The Bariatric Support Group meets monthly with a participation of 10-15 individuals. Half of those individuals were signed up for a consultation with the bariatric specialist, Dr. Richard Parent.
- In partnership with the St. Helena and Napa Unified School Districts, participation in the Field Days of St. Helena Elementary School, St. Helena Primary School, St. Helena High School, Pueblo Vista Elementary School and Vichy Elementary has reached over 2000 students to encourage physical activity and provide resources and activities to prevent obesity.
- A total of $160,000 was given to organizations such as Alzheimer's Association, American Cancer Society, American Heart Association, Zero Prostate, Heroes for Health, and Pacific Union College to raise awareness and fund research. A total 24 hours of staff time was dedicated to participating in fundraising events.
- In partnership with the Rianda House, five free health screenings were provided for adults of the Napa County testing for blood glucose, blood pressure, and body composition. An average of 20 older adults participated in each screening with 2-3 suggestions of a follow up with a primary care physician.

Access to Primary and Oral Health Care

- A new intensivist team of three doctors were added to the Intensive Care Unit allowing us to have 24-hour coverage for the patients with the highest acuity. With that, one of the doctors within that group created what is a referred to as an "angel cart" in which there are donated goods that are available for patients and their families at any time.
- We actively participated in local health fairs and employee benefit fairs to educate the community on the primary health care services. Combined, these events reached approximately 2,000 individuals across Napa County.
- Doctors from the Coon Joint Replacement Institute and the St. Helena Arrhythmia Center traveled and educated literally thousands of patients on best practices for treatment of joint replacement and A-FIB and other cardiac issues

Substance Abuse

- Peer support groups and a recovery program are provided through the St. Helena Recovery Center. A recovery center alumni group is also provided for people who had previously participated in addiction

therapy and need support for ongoing sobriety. The attendance for the initial recovery program is between 30 and 40, while the alumni group has around half of that attendance.

Cancers

In addition to the Awaken Series educational events, we also provided cancer education events and support groups on topics related to prevention and treatment of cancer. This included the Awaken Series, the Caregiver Support Circle, Palliative Care Monthly Education series, and art therapy classes for patients and their families. We also provided ongoing educational events surrounding risk factors for cancer, heart disease, and cerebrovascular disease, used CDC-endorsed My Plate curricula, Champions of Change cookbooks and brochures at health fairs, health seminars, classes, support groups, and health screenings. In total 5,000 people in our target communities received education around prevention and treatment of cancer.

Strategic Partner List

St. Helena Hospital Napa Valley supports local partners to augment our own efforts, and to promote a healthier community. Partnership is not used as a legal term, but a description of the relationships of connectivity that are necessary to collectively improve the health of our region. One of our objectives is to partner with other nonprofit and faith-based organizations that share our values and priorities to improve the health status and quality of life of the community we serve. This is an intentional effort to avoid duplication and leverage the successful work already in existence in the community. Many important systemic efforts are underway in our region, and we have been in partnership with multiple not-for-profits to provide quality care to the underserved in our region.

Community Partners	
• Angwin Fire Department	• Bay Area Nutrition and Physical Activity Collaborative
• Books by Shalini, LLC	• Boys and Girls Club of St. Helena and Calistoga
• Calistoga Fire Department	• Calistoga Police Department
• Calistoga Recreational Department	• Catalyst Coalition
• Children and Weight Coalition	• Clinica Verde
• Healthy Bodies Coalition	• Kaiser Permanente
• Live Healthy Napa County	• Nutrition Education and Obesity Prevention
• Napa County Office of Education	• Napa County School District
• Operation Access	• Pacific Union College
• Rianda House	• Safe Routes to School
• St. Helena Fire Department	• St. Helena Police Department
• St. Helena Unified School District	• Up Valley Partnership for Youth
• Up Valley Family Center	• St. Helena Hospital Foundation
• Queen of the Valley Hospital	• Gasser Foundation

Community Benefit Inventory

St. Helena Hospital knows working together is key to achieving the necessary health improvements to create the communities that allow each member to have safe and healthy places to live, learn, work, play, and pray. Below you will find an inventory of additional interventions taken from our Community Benefit Inventory for Social Accountability (CBISA) software and documented activities.

Year 2016-Inventory

Priority Need	Interventions	Description	Partners	# of community members served
Education	Coon Joint Replacement Seminars	Education on joint replacement and services offered	Coon Joint Replacement Institute	2891
	Heart Institute Seminars	Education on A-Fib and ways of treating it	Adventist Heart Institute, St. Helena Arrhythmia Center	1281
	Lunch and Learn for Older Adults	Providing education for seniors of various topics such as nutrition, finance, safety	Calistoga Community Center, UpValley Family Center, Area Agency on Aging	75
	Employee Wellness Fairs	Resource table	Auberge du Soleil, Calistoga Ranch, Pacific Union College,	900
	Rethink Your Drink	Resource table	Children and Weight Coalition of Napa Valley	1000

Obesity and Diabetes	Diabetes Self-Management Education Classes	Teaching how to manage diabetes before, during, and after diagnosis. Also provided nutrition education		131
	Free Health Screenings	Provided screenings for blood glucose, HDL, TDL, blood pressure, and BMI	Rianda House	119
	Napa Valley Marathon	Physical activity, provided drink and snack station		1000
	School Field Days	Encouraging physical activity and healthy eating	Napa Unified School District, St. Helena Unified School District, Calistoga Unified School District	3000

	Bariatric Information Sessions and Support Groups	To raise awareness of treatment options for obesity	St. Helena Bariatric and Metabolic Surgery Center	430
Cancers	Zero Prostate Cancer Run/Walk	To raise awareness for prostate cancer	Zero Prostate	500
	Sisters Crush Run/Walk	To raise awareness for breast cancer	Sisters Crush	500
	LLS Light the Night	To raise awareness for leukemia and lymphoma	Martin-O'Neil Cancer Center, Leukemia and Lymphoma Society	500
	Awaken Series	To provide education around prevention of cancer	Martin-O'Neil Cancer Center	1000
Mental Health	Calistoga Elementary School Back to School Night	Community Event, Nutrition Education was provided alongside a resource table		300
Other Community Benefit Activities	St. Helena Musical Picnics	Community gathering event, Resource table	St. Helena Chamber of Commerce	600

Connecting Strategy and Community Health

As hospitals move toward population health management, community health interventions are a key element in achieving the overall goals of reducing the overall cost of health care, improving the health of the population, and improving access to affordable health services for the community both in outpatient and community settings. The key factor in improving quality and efficiency of the care hospitals provide is to include the larger community they serve as a part of their overall strategy.

Health systems must now step outside of the traditional roles of hospitals to begin to address the social, economic, and environmental conditions that contribute to poor health in the communities we serve. Bold leadership is required from our administrators, healthcare providers, and governing boards to meet the pressing health challenges we face as a nation. These challenges include a paradigm shift in how hospitals and health systems are positioning themselves and their strategies for success in a new payment environment. This will impact everyone in a community and will require shared responsibility among all stakeholders.

Population health is not just the overall health of a population but also includes the distribution of health. Overall health could be quite high if the majority of the population is relatively healthy—even though a minority of the population is much less healthy. Ideally such differences would be eliminated or at least substantially reduced.

Community health can serve as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

1) The distribution of specific health statuses and outcomes within a population;
2) Factors that cause the present outcomes distribution; and
3) Interventions that may modify the factors to improve health outcomes.

Improving population health requires effective initiatives to:

1) Increase the prevalence of evidence-based preventive health services and preventive health behaviors,
2) Improve care quality and patient safety and
3) Advance care coordination across the health care continuum.

Our mission as a health system is to share God's love by providing physical, mental and spiritual healing and we believe the best way to re-imagine our future business model with a major emphasis of community health is by working together with our community.

Financial Assistance Policies

Adventist Health (AH) facilities exist to serve patients. They are built on a team of dedicated health care professionals – physicians, nurses and other health care professionals, management, trustees, and volunteers. Collectively, these individuals protect the health of their communities. Their ability to serve well requires a relationship with their communities built on trust and compassion. Through mutual trust and goodwill, Adventist Health and patients will be able to meet their responsibilities. These principles and guidelines are intended to strengthen that relationship and to reassure patients, regardless of their ability to pay, of AH's commitment to caring.

The purpose of this policy is to enact and ensure a fair, non-discriminatory, consistent, and uniform method for the review and completion of charitable emergency and other Medically Necessary care for individuals of our community who may be in need of Financial Assistance.

More information can be found by accessing our link, https://www.adventisthealth.org/napa-valley/pages/patients-and-visitors/financial-assistance-.aspx.

Community Benefit & Economic Value for Prior Year

St. Helena Hospital is committed to our mission of living God's love by inspiring health, wholeness and hope. Our community benefit work is rooted deep within our mission, with a recent re-commitment of deep community engagement within each of our ministries.

We have also incorporated our community benefit work to be an extension of our care continuum. Our strategic investments in our community are focused on a more planned, proactive approach to community health. The basic issue of good stewardship is making optimal use of limited charitable funds. Defaulting to charity care in our emergency rooms for the most vulnerable is not consistent with our mission. An upstream and more proactive and strategic allocation of resources enables us to help low-income populations avoid preventable pain and suffering; in turn allowing the reallocation of funds to serve an increasing number of people experiencing health disparities.

Valuation of Community Benefit

Year 2016

ST. HELENA HOSPITAL DBA ST. HELENA HOSPITAL NAPA VALLEY DBA CENTER FOR BEHAVIORAL HEALTH	TOTAL COMMUNITY BENEFIT COSTS		DIRECT CB REIMBURSEMENT	UNSPONSORED COMMUNITY BENEFIT COSTS	
	TOTAL CB EXPENSE	% OF TOTAL COSTS	OFFSETTING REVENUE	NET CB EXPENSE	% OF TOTAL COSTS
Traditional charity care	2,295,305	0.94%	-	2,295,305	0.94%
Medicaid	-	-	-	-	-
Medicare	135,463,093	55.65%	103,923,877	31,539,216	12.96%
Other means-tested government programs	8,387	0.00%	279	8,108	0.00%
Community health improvement services	103,021	0.04%	-	103,021	0.04%
Health professions education	-	-	-	-	-
Non-billed and subsidized health services	4,568,667	1.88%	-	4,568,667	1.88%
Research	-	-	-	-	-
Cash and in-kind contributions for community benefit	57,942	0.02%	-	57,942	0.02%
Community building activities	256,204	0.11%	-	256,204	0.11%
TOTAL COMMUNITY BENEFIT	142,752,619	58.64%	103,924,156	38,828,463	15.95%

OUR MISSION:
Living God's love by inspiring health, wholeness and hope

Appendices

Glossary of terms

Medical Care Services (Charity Care and Un-reimbursed Medi-Cal and Other Means Tested Government Programs)

Free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are thereby deemed unable to pay for all or portion of the services. Charity Care does not include: a) bad debt or uncollectible charges that the hospital recorded as revenue but wrote-off due to failure to pay by patients, or the cost of providing care to such patients; b) the difference between the cost of care provided under Medicaid or other means-tested government programs, and the revenue derived there from; or c) contractual adjustments with any third-party payers. Clinical services are provided, despite a financial loss to the organization; measured after removing losses, and by cost associated with, Charity Care, Medicaid, and other means-tested government programs.

Community Health Improvement

Interventions carried out or supported and are subsidized by the health care organizations, for the express purpose of improving community health. Such services do not generate inpatient or outpatient bills, although there may be a nominal patient fee or sliding scale fee for these services.

Community Health Improvement – These activities are carried out to improve community health, extend beyond patient care activities and are usually subsidized by the health care organization. Helps fund vital health improvement activities such as free and low cost health screenings, community health education, support groups, and other community health initiatives targeting identified community needs.

Subsidized Health Services – Clinical and social services that meet an identified community need and are provided despite a financial loss. These services are provided because they meet an identified community need and if were not available in the area they would fall to the responsibility of government or another not-for-profit organization.

Financial and In-Kind Contributions – Contributions that include donations and the cost of hours donated by staff to the community while on the organization's payroll, the indirect cost of space donated to tax-exempt companies (such as for meetings), and the financial value (generally measured at cost) of donated food, equipment, and supplies. Financial and in-kind contributions are given to community organizations committed to improving community health who are not affiliated with the health system.

Community Building Activities – Community-building activities include interventions the social determinants of health such as poverty, homelessness, and environmental problems.

Health Professions Education and Research

Educational programs that result in a degree, certificate, or training that is necessary to be licensed to practice as a health professional, as required by state law; or continuing education that is necessary to retain state license or certification by a board in the individual's health profession specialty. It does not include education

or training programs available exclusively to the organization's employees and medical staff, or scholarships provided to those individuals. Costs for medical residents and interns may be included.

Any study or investigation in which the goal is to generate generalized knowledge made available to the public, such as underlying biological mechanisms of health and disease; natural processes or principles affecting health or illness; evaluation of safety and efficacy of interventions for disease such as clinical trials and studies of therapeutic protocols; laboratory-based studies; epidemiology, health outcomes and effectiveness; behavioral or sociological studies related to health, delivery of care, or prevention; studies related to changes in the health care delivery system; and communication of findings and observations (including publication in a medical journal)

OUR MISSION:
To share God's love by providing physical, mental and spiritual healing

Community Health Needs Assessment and Community Health Plan Coordination Policy

Entity:

☒ **System-wide Corporate Policy**	**Corporate Policy**	**No. AD-04-006-S**
☒ **Standard Policy**	**Department:**	**Administrative Services**
☐ **Model Policy**	**Category/Section:**	**Planning**
	Manual:	**Policy/Procedure Manual**

POLICY SUMMARY/INTENT:

This policy is to clarify the general requirements, processes and procedures to be followed by each Adventist Health hospital. Adventist Health promotes effective, sustainable community benefit programming in support of our mission and tax-exempt status.

DEFINITIONS

1. Community Health Needs Assessment (CHNA)**:** A CHNA is a dynamic and ongoing process that is undertaken to identify the health strengths and needs of the respective community of each Adventist Health hospital. The CHNA will include a two document process, the first being a detailed document highlighting the health related data within each hospital community and the second document (Community Health Plan or CHP) containing the identified health priorities and action plans aimed at improving the identified needs and health status of that community.

   A CHNA relies on the collection and analysis of health data relevant to each hospital's community, the identification of priorities and resultant objectives and the development of measurable action steps that will enable the objectives to be measured and tracked over time.

2. Community Health Plan: The CHP is the second component of the CHNA and represents the response to the data collection process and identified priority areas. For each health need, the CHP must either: a) describe how the hospital plans to meet the identified health need, or b) identify the health need as one the hospital does not intend to specifically address and provide an explanation as to why the hospital does not intend to address that health need.

3. Community Benefit: A community benefit is a program, activity or other intervention that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of these objectives:

   - Improve access to health care services
   - Enhance the health of the community
   - Advance medical or health care knowledge
   - Relieve or reduce the burden of government or other community efforts

   Community benefits include charity care and the unreimbursed costs of Medicaid and other means-tested government programs for the indigent, as well as health professions' education, research, community health improvement, subsidized health services and cash and in-kind contributions for community benefit.

AFFECTED DEPARTMENTS/SERVICES:
Adventist Health hospitals

POLICY: COMPLIANCE – KEY ELEMENTS
PURPOSE:
The provision of community benefit is central to Adventist Health's mission of service and compassion. Restoring and promoting the health and quality of life of those in the communities served, is a function of our mission "To share God's love by providing physical, mental and spiritual healing." The purpose of this policy is: a) to establish a system to capture and report the costs of services provided to the underprivileged and broader community; b) to clarify community benefit management roles; c) to standardize planning and reporting procedures; and d) to assure the effective coordination of community benefit planning and reporting in Adventist Health hospitals. As a charitable organization, Adventist Health will, at all times, meet the requirements to qualify for federal income tax exemption under Internal Revenue Code (IRC) §501(c)(3). The purpose of this document is to:

1. Set forth Adventist Health's policy on compliance with IRC §501(r) and the Patient Protection and Affordable Care Act with respect to CHNAs;
2. Set forth Adventist Health's policy on compliance with California (SB 697), Oregon (HB 3290), Washington (HB 2431) and Hawaii State legislation on community benefit;
3. Ensure the standardization and institutionalization of Adventist Health's community benefit practices with all Adventist Health hospitals; and
4. Describe the core principles that Adventist Health uses to ensure a strategic approach to community benefit program planning, implementation and evaluation.

A. General Requirements

1. Each licensed Adventist Health hospital will conduct a CHNA and adopt an implementation strategy to meet the community health needs identified through such assessment.

2. The Adventist Health *Community Health Planning & Reporting Guidelines* will be the standard for CHNAs and CHPs in all Adventist Health hospitals.

3. Accordingly, the CHNA and associated implementation strategy (also called the Community Health Plan) will initially be performed and completed in the calendar year ending December 31, 2013, with implementation to begin in 2014.

4. Thereafter, a CHNA and implementation strategy will be conducted and adopted within every succeeding three-year time period. Each successive three-year period will be known as the Assessment Period.

5. Adventist Health will comply with federal and state mandates in the reporting of community benefit costs and will provide a yearly report on system wide community benefit performance to board of directors. Adventist Health will issue and disseminate to diverse community stakeholders an annual web-based system wide report on its community benefit initiatives and performance.

6. The financial summary of the community benefit report will be approved by the hospital's chief financial officer.

7. The Adventist Health budget & reimbursement department will monitor community benefit data gathering and reporting for Adventist Health hospitals.

B. Documentation of Public Community Health Needs Assessment (CHNA)

1. Adventist Health will implement the use of the Lyon Software CBISA™ product as a tool to uniformly track community benefit costs to be used for consistent state and federal reporting.

2. A written public record of the CHNA process and its outcomes will be created and made available to key stakeholders in the community and to the general public. The written public report must include:

    a. A description of the hospital's community and how it was determined.

    b. The process and methods used to conduct the assessment.

    c. How the hospital took into account input from persons who represent the broad interests of the community served.

    d. All of the community health needs identified through the CHNA and their priorities, as well as a description of the process and criteria used in the prioritization.

    e. Existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

3. The CHNA and CHP will be submitted to the Adventist Health corporate office for approval by the board of directors. Each hospital will also review their CHNA and CHP with the local governing board. The Adventist Health government relations department will monitor hospital progress on the CHNA and CHP development and reporting. Helpful information (such as schedule deadlines) will be communicated to the hospitals' community benefit managers, with copies of such materials sent to hospital CFOs to ensure effective communication. In addition, specific communications will occur with individual hospitals as required.

4. The CHNA and CHP will be made available to the public and must be posted on each hospital's website so that it is readily accessible to the public. The CHNA must remain posted on the hospital's website until two subsequent CHNA documents have been posted. Adventist Health hospitals may also provide copies of the CHNA to community groups who may be interested in the findings (e.g., county or state health departments, community organizations, etc.).

5. For California hospitals, the CHPs will be compiled and submitted to OSHPD by the Adventist Health government relations department. Hospitals in other states will submit their plans as required by their state.

6. Financial assistance policies for each hospital must be available on each hospital's website and readily available to the public.

Corporate Initiated Policies: (For corporate office use)
References: **Replaces Policy: AD-04-002-S**
Author: **Administration**
Approved: **SMT 12-9-2013, AH Board 12-16-2013**
Review Date:
Revision Date:
Attachments:
Distribution: **AHEC, CFOs, PCEs, Hospital VPs, Corporate AVPs and Direct**

2017 Community Health Plan

This community health plan was adopted on May 8, 2017, by the Adventist Health System/West Board of Directors. The final report was made widely available on May 15, 2017.

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Request a copy, provide comments or view electronic copies of current and previous community health needs assessments: https://www.adventisthealth.org/Documents/Community%20Benefits/CHNA%202016-2018/Final_2016_CHNA_SHNV.CBH.pdf