

Adventist Health St. Helena & Adventist Health Vallejo 2022 Community Health Plan



The following Implementation Strategy serves as the 2020 – 2022 Community Health Plan for Adventist Health St. Helena & Adventist Health Vallejo and is respectfully submitted to the Office of Statewide Health Planning and Development on May 19th, 2023 reporting on 2022 results.

Executive Summary

Introduction & Purpose

Adventist Health St. Helena and Adventist Health Vallejo is pleased to share its Community Health Implementation Strategy. This follows the development of its 2019 Community Health Needs Assessment (CHNA) in accordance with requirements in the Affordable Care Act and IRS 990 Schedule H requirements and approved by the Adventist Health Board of Directors on October 17, 2019.

After a thorough review of the health status in our community through the community health needs assessment (CHNA), we identified areas that we could address using our resources, expertise and community partners. Through these actions and relationships, we aim to empower our community and fulfill our mission of “Living God’s love by inspiring health, wholeness and hope.”

The results of the CHNA guided this creation of this document and aided us in how we could best provide for our community and the vulnerable among us. This Implementation Strategy summarizes the plans for Adventist Health St. Helena and Adventist Health Vallejo to develop and collaborate on community benefit programs that address prioritized health needs identified in its 2019 CHNA. Adventist Health St. Helena and Adventist Health Vallejo has adopted the following priority areas for our community health investments.

Prioritized Health Needs

- [Health Priority #1: Mental and Behavioral Health](#)
- [Health Priority #2: Access to Healthcare](#)
- [Health Priority #3: Chronic Diseases](#)
- [Health Priority #4: Housing](#)

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 partner to achieve change. More importantly, we hope you imagine a healthier region and work with us to find solutions across a broad range of sectors to create communities that define the well-being of people.

The purpose of the CHNA was to offer a comprehensive understanding of the health needs in Adventist Health St. Helena and Adventist Health Vallejo service area and guide the hospital’s planning efforts to address those needs.

The significant health needs were identified through an analysis of secondary data and community input. These health needs were prioritized according to a set of criteria that included:

- Addresses disparities of subgroups
- Availability of evidence or practice-based approaches
- Community assets and internal resources for addressing needs
- Feasibility of intervention
- Identified community need
- Importance to community
- Magnitude
- Mission alignment and resources of hospitals
- Opportunity for partnership
- Opportunity to intervene at population level
- Severity
- Solution could impact multiple problems

For further information about the process to identify and prioritize significant health needs, please refer to the Adventist Health St. Helena and Adventist Health Vallejo CHNA report at the following link:

<https://www.adventisthealth.org/about-us/community-benefit/>

Adventist Health St. Helena & Vallejo and Adventist Health

Adventist Health St. Helena and Adventist Health Vallejo are affiliates of Adventist Health, a faith-based, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii.

Vision

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

Mission Statement

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

Adventist Health Includes:

- 23 hospitals with more than 3,393 beds
- 370 clinics (hospital-based, rural health and physician clinics)

- 14 home care agencies and eight hospice agencies
- 3 retirement centers & 1 continuing care retirement community
- A workforce of 37,000 including medical staff physicians, allied health professionals and support services

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 all faiths to enhance the health of the communities we serve.

Our commitment to quality health care stems from our heritage, which dates to 1866 when the first Seventh-day Adventist healthcare 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.

Summary of Implementation Strategies

Implementation Strategy Design Process

Stakeholders from the 19 hospital facilities in the Adventist Health System were invited to participate in a Mission Integration Summit on September 26 and 27, 2019. During this two day-long event, participants were introduced to the 2019 Adventist Health Implementation Strategy Template. After the summit, each hospital was invited to participate in a series of technical assistance calls and consultation sessions with representatives from Adventist Health Community Integration and Conduent Health Communities Institute to further develop and refine their implementation strategy.

Adventist Health St. Helena & Adventist Health Vallejo Implementation Strategy

The implementation strategy outlined below summarizes the strategies and activities by Adventist Health St. Helena & Vallejo to directly address the prioritized health needs. They include:

- **Health Need 1: Mental and Behavioral Health**
 - Mentis
 - Healthy Minds Healthy Aging
 - Teens Connect
 - Youth Mental Health First-aid Training
 - This is My Brave
 - Aldea Children & Family Services
- **Health Need 2: Access to Healthcare**
 - Mobile Health Program
 - Operation Access
 - Stop Falls -
 - Collabria Care – Honoring Choices and Palliative Care
- **Health Need 3: Chronic Diseases**
 - AHEAD Genetic Cancer
 - Awaken Education and Support Program for Cancer
 - Diabetes Education and Management Program
 - Dare to C.A.R.E Venous Disease Screening
 - Calistoga Senior Lunch & Learn
 - Turkey Trot
 - ZERO Prostate Cancer
 - Leukemia and Lymphoma Walk

- Park Rx
- Spring Health Challenge for RLS Middle School
- Nuestra Salud – Spanish Zumba Classes
- Walk & Roll to School

- **Health Need 4: Housing and Homelessness**
 - Catholic Charities Nightingale House
 - Napa Valley House Share Program

The Action Plan presented below outlines in detail the individual strategies and activities Adventist Health St. Helena & Vallejo will implement to address the health needs identified through the CHNA process. The following components are outlined in detail in the tables below: 1) actions the hospital intends to take to address the health needs identified in the CHNA, 2) the anticipated impact of these actions as reflected in the Process and Outcomes measures for each activity, 3) the resources the hospital plans to commit to each strategy, and 4) any planned collaboration to support the work outlined.

No hospital can address all the health needs identified in its community. Adventist Health St. Helena & Vallejo are committed to serving the community by adhering to its mission, and using its skills, expertise and resources to provide a range of community benefit programs. This Implementation Strategy does not include specific plan to address the following significant health needs identified in the 2019 CHNA.

Significant Health Needs – NOT Planning to Address

- Access to healthy foods – Need being addressed by many others in the community
- Sexually transmitted diseases – Need being addressed by others in the community

COVID 19 Considerations

The COVID-19 global pandemic has caused extraordinary challenges for Adventist Health hospitals and health care systems across the world including keeping front line workers safe, shortages of protective equipment, limited ICU bed space and developing testing protocols. They have also focused on helping patients and families deal with the isolation needed to stop the spread of the virus, and more recently vaccine roll out efforts.

Adventist Health, like other health care systems, had to pivot its focus to meet the most urgent healthcare needs of its community during the pandemic, as well as reassess the ability to continue with some community health strategies due public health guidelines for social distancing. Adjustments have been made to continue community health improvement efforts as possible, while ensuring the health and safety of those participating. The Strategy Action Plan Grids on the following pages reflect updated activities for each strategy.

During the pandemic, Adventist Health as a system took the following actions in response to the needs created or exacerbated by COVID-19:

- Began offering more virtual health care visits to keep community members safe and healthy.
- Developed an online symptom tracker to help community members determine if they may have COVID-19 or some other flu type illness and what steps to take.
- Was part of a communitywide effort by the local health system to vaccinate eligible community members to help stop the spread of the virus.

Locally, Adventist Health St. Helena & Adventist Health Vallejo took these additional actions:

In support of our county's public health department, our mobile health program launched a testing initiative to reach agricultural workers and vineyard/winery support staff on a biweekly basis meeting them where they were – in the vineyards and wineries. This allowed us to develop relationships, build trust and provide education on safety precautions to keep themselves and their families safe.

The Adventist Health + Blue Zones Solution

Our desire to improve community well-being grew out of not only our mission at Adventist Health -to live God's love by inspiring health, wholeness and hope – but also by the sheer need as seen across our system hospitals. Overwhelmingly, we see issues related to health risk behaviors, mental health and chronic illnesses throughout the communities we serve. That is why we have focused our work around addressing behavior and the systems preventing our communities from achieving optimal health.

In 2020, Adventist Health acquired Blue Zones as a step toward reaching our solution. By partnering with Blue Zones, we will be able to gain ground in shifting the balance from healthcare – treating people once they are ill – to transformative health and wholeness – changing the way communities live, work and play.

Across the globe lie blue zones areas – places where people are living vibrant, active lives well into their hundreds at an astonishing rate—and with higher rates of well-being. Attaining optimal well-being means that our physical, emotional, and social health is thriving. Blue Zones Project works with communities to make sustainable changes to their environment, policies, and social networks to support healthy behaviors. Instead of a focus on individual behavior change, it is an upstream solution focused on making healthy options easy in all the places people spend most of their time. Blue Zones Project is committed to measurably improving the well-being of community residents and through their proven programs, tools and resources, utilizes rigorous metrics to inform strategies and track progress throughout the life of the project. This includes well-being data, community-wide metrics, sector-level progress and outcome metrics, transforming community well-being by making changes to environment, policy, worksites and social networks that create healthy and equitable opportunities for all.

In 2021, St. Helena Adventist Health proudly launched Blue Zone Project Upper Napa Valley (BZPUNV). The BZPUNV team wakes up each morning focused on partnering and collaborating with community leaders and organizations active in the sectors of built environment, education, economic and workforce development, mental and physical well-being, policy and public health. Together the BZPUNV team and sector leaders develop a community Blueprint that strategically aligns and leverages the actions and resources of the sectors where we live, learn, work and play to help advance the efforts around the community's biggest Social Determinant of Health challenges while connecting them to Health-Related Social Needs organizations.

Equity is a strategic priority woven throughout the Blueprint and programs. Policies and initiatives are developed in a way that honors the local culture that is focused on reaching out to all populations. Each year BZPUNV sector leads come together to evaluate and update the Blueprint to ensure community alignment.

Implementation Strategy Plan

Priority Health Need: Mental and Behavioral Health				
Goal Statement: Reduce stigma of mental health for youth and seniors through education and engagement in the communities served by AH St. Helena & Vallejo				
Mission Alignment: Well-Being of People				
Strategy 1.1: Stigma reduction through increased education and awareness.				
Strategy 1.2: Advance existing peer and professional counseling to struggling youth focused				
Strategy 1.3: Increase awareness and resources for seniors to live safely in home.				
Program/Activity	Metrics			
<i>Activity 1.1- Teens Connect</i>	Process Measure:	Year 1 2020	Year 2 2021	Year 3 2022
	Number of youth participating in Teens Café	Previous report available upon request	Previous report available upon request	See Narrative Below
	Number of youth referred to professional counseling services			
	Pre-Survey	Short Term Outcomes		
Increased awareness of mental health	Previous report available upon request	Previous report available upon request		
Increased participation by 10% through Boys & Girls Club accessibility				
Post- Survey	Medium Term Outcomes			
Percentage of youth who demonstrate:	Previous report available upon request	Previous report available upon request		
<ul style="list-style-type: none"> • Increase in coping skills and stress management rating • Decrease in stress level rating • Reduction in depression/anxiety rating 				
<i>Activity 1.2- Aldea Children & Family Services at Boys & Girls Clubs</i>	Process Measure	Year 1 2020	Year 2 2021	Year 3 2022
	Number of youth engaged at Boys & Girls Clubs of St. Helena & Calistoga	27(AHSH) 111(Calistoga)	Previous report available upon request	See Narrative Below
	Number of education classes			
	Number of counseling sessions	6	Previous report available upon request	
	9 (1-day/week)			
Short & Medium Term Outcomes		74%		
Percentage of youth receiving peer counseling who report reduced feeling of depression, anxiety and/or substance abuse.				
<i>Activity 1.3- Healthy Minds Healthy Aging</i>		Year 1 2020	Year 2 2021	Year 3 2022

	Process Measure			
	Number of screening for cognitive, behavioral and psychosocial health issues	49	Previous report available upon request	See Narrative Below
	Number of 65+ receiving in-home health services	N/A		
	Short Term Outcomes			
	Number of referrals of services	5		
	Increase number of cognitive screening & behavioral screening			
	Medium Term Outcomes			
	Reduced ED visits for mental health crisis for 65+	N/A		
Source of Data: Teens Connect, Aldea Children & Family Services, Healthy Minds Healthy Aging				
Target Population(s): Broader community, vulnerable population – seniors, youth, low-income				
Adventist Health Resources: (financial, staff, supplies, in-kind etc.) Financial, in-kind				
Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health) Teens Connect*, Aldea Children & Family Services*, Healthy Minds Healthy Aging*				
CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations) A – Community Health Improvement, E – Cash and In-Kind				

Strategy Results 2022:

Due to the impact of COVID-19, our Teens Connect has been placed on hold since 2021. Our Healthy Minds Healthy Aging program has started a weekly senior women’s support group at the Rianda House - Amistad Y Apyoyo (support and friendship) with an average attendance of 7 people per week. There are currently three therapy clients as well. Aldea Children & Family Services and Boys & Girls Club collaboration did not continue due to lack of personnel.

Additionally we engaged in the following activities during the year.

- Napa High School resource fair- outreach event for Napa High School students specific to mental health awareness and resources- provided education and resources for the National Suicide Prevention Hotline- Over 400 students/ unique lives touched.
- Quarterly participation in Solano County Psychiatric emergency resources group that provides education and linkages to uninsured/ underinsured behavioral health patient population.
- Participation in SolanoConnex- a free community online and free mental health resource guide in which users local to our market are directed for mental health care across the entire continuum- open to all Solano County residents-
- Mental Health Awareness Fair- Solano County- providing free clothing and mental health strategy sessions with one of our mater’s level clinicians- open to all residents of Solano County with a targeted audience of uninsured and under insured population- up to 200 unique lives touched.

Priority Health Need: Access to Healthcare and Health					
Goal Statement: Increase access to quality, culturally competent healthcare and health to underinsured, uninsured and vulnerable in the community served by AH St. Helena and Vallejo.					
Mission Alignment: Well-Being of People					
Strategy 1: Identify and screen vulnerable community members providing education and resources for referrals to ongoing health management.					
Strategy 1.2: Maintain and/or increase referrals for necessary diagnostic and surgical procedures for under or uninsured population.					
Program/Activity	Metrics				
		Year 1 2020	Year 2 2021	Year 3 2022	
Activity 1.1- Mobile Health Program	Process Measure:				
	Number of patients served	Previous report available upon request	Previous report available upon request	See Narrative Below	
	Number of encounters at events				
	Number of people referred to additional resources				
	Number of educational topics				
	Short Term Outcomes				
	Number of mobile screenings for farm workers and 65+	Previous report available upon request	Previous report available upon request		
Percentage of persons with high blood pressure					
Percentage of persons with high cholesterol					
Percentage of persons with high blood sugar					
Medium Term Outcomes					
Percentage of ambulatory sensitive readmissions	Previous report available upon request				
Activity 1.2- Operation Access	Process Measure				
	Number of Specialist Evaluations	2	Active Program. In 2021, there were no Operation Access Patients.	24	
	Number of Diagnostics Procedures	2		19	
	Number of surgical Procedures Performed	1		24	
	Short Term Outcomes				
	Percentage of patients reporting improved health	95%	95%	100%	
	Percentage of patients reporting improved ability to work	95%		100%	
Medium Term Outcomes					
Percentage of patients reporting improved quality of life	95%		100%		

Activity 1.3- Farm to Family Food Boxes		Year 1 2020	Year 2 2021	Year 3 2022
	Process Measure			
	Number of boxes distributed	20,254+	Program ended in May 2021	Program ended in May 2021
	Pounds of food distributed	810,160lbs. +		
Source of Data:				
Adventist Health St. Helena, Operation Access, Area on Aging Agency				
Target Population(s):				
Vulnerable community members – seniors, low-income and farmworker population				
Adventist Health Resources: (financial, staff, supplies, in-kind etc.)				
Financial, staff, supplies, in-kind				
Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health)				
Adventist Health St. Helena, St. Helena Hospital Foundation, Operation Access*, Napa County				
CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations)				
A – Community Health Improvement, E – Cash and In-Kind				

Strategy Results 2022:

Mobile Health

Our Mobile Health program was actively engaged within our community throughout 2022. As we seek to improve the health and well-being of our communities, bringing healthcare to the consumer and meeting people where they are is crucial. Our focus included providing flu and COVID-19 vaccination clinics, along with health assessments throughout Napa County. We have coordinated events that has provided free produce distribution for those who may not have the resources to healthy options. During 2022 our Mobile Health program served over 16,000 residents. We look forward to increasing our impact to those who need it most.

Operation Access

In 2022, physician volunteers provided:

- 24 surgical procedures
- diagnostic services for 19 individuals
- 24 specialist evaluations

Our hope is to continue to outreach and collaborate to get much needed services to those who need them.

Blue Zones

- **Support the Food Policy Committee's development of a healthy foods resolution and advocacy plan. (Calistoga, St. Helena, Yountville).**

- In April, community insights were gathered at the Food Policy Committee meeting facilitated by Blue Zones Project (BZP) Food Policy Expert, Maggi Adamek – committee feedback was incorporated into draft resolution.
- Hosted policy advocacy trainings: facilitated a two part policy advocacy training series. Part one: May 17th (basics of advocacy planning and phases), Part two: June 1st (development of advocacy plan). All three policy committees were invited to both trainings. During part two, committees were broken out into their own Zoom rooms by policy topic to create an advocacy plan using murals as an interactive tool. The trainings were recorded and shared with all committee members, along with the murals, and a training survey. Feedback on the trainings was collected through the online survey.
- **SB 907 LEAF (Local Equitable Access to Food) (Calistoga, St. Helena).** Submitted letter of support to California State Senate (Dr. Pan) for SB 907 Local Equitable Access to Food on 3/9/22. Submitted another letter of support for SB 907 to the Senate Agriculture Committee on 4/20/22, to the Assembly Human Services Committee on 6/8/22, and Assembly Committee on Agriculture on 6/21/22. Opted in on letter to Governor Newsom to sign the bill on 8/19/22. Bill passed on 9/28/22.
- **Plan and facilitate a panel of local mobile market and produce Rx experts for the mobile market workgroup (Calistoga, St. Helena, Yountville).** BZP planned and facilitated a panel session of local and regional experts in the mobile market and produce Rx space. The session provided the BZP Mobile Market Workgroup ideas of successful models and filled knowledge gaps.
- **Establish food insecurity screening and referral through relevant healthcare providers and community-based programs (Regional).** Blue Zones Project co-designed a food access resource with our Food Policy Committee that is printed and used by AHS to distribute to patients experiencing food insecurity. The resource contains all Upper Napa Valley food distribution sites and is reprinted every few months with updated distribution information.

Tobacco

- **Evaluate and advocate for the implementation of a smoke-free policy/ordinance for private multi-unit housing. (Calistoga)** After Blue Zones Project met with the City of Calistoga’s planning staff and housing element consultant, the following commitment to pass a smoke-free ordinance for multi-unit housing was included in their Housing Element, which is pending approval: “Incorporate housing policies and Calistoga-specific policies from the Blue Zones Project Upper Napa Valley Blueprint, including but not limited to adopting a smoke-free ordinance for multifamily housing properties that covers all exclusive-use areas, interior unit spaces, as well as common areas not already covered by state law.”
- **Advocate for the passage of a tobacco flavor ban (Calistoga, St. Helena, Yountville).** Signed on with other California BZP communities to Yes on Prop 31 Campaign (Flavored Tobacco Products Ban Referendum). Prop 31 passed on 11/8/22. <https://voteyeson31.com/take-action/join-campaign> - signed on to this campaign. See page four for BZP listed on prop support.
- **Created and passed a new St. Helena Unified School District Tobacco Protocol, focusing on non-punitive options to addressing tobacco use, along with a Youth Tobacco Resource List**

highlighting cessation resources and opportunities for youth involvement in the tobacco prevention space. (St. Helena)

- BZP facilitated the creation of a tobacco protocol for the St. Helena Unified School District with a focus on non-punitive alternatives to suspension. This protocol was developed in partnership with the school district and spearheaded by the BZP Tobacco Policy Committee. The committee also created an accompanying resource list for use by students, parents, and district employees.
 - The goal of the protocol was to create a document outlining steps the district takes when a student is found with a tobacco product, along with the support that's available to that student. The need for this was identified by the tobacco policy committee, and specifically the School Resource Officers (SRO). The protocol was developed over several months with the tobacco policy committee, who include SROs, UpValley Family Centers, NCOE, County's Tobacco Control Program staff, and more. The group also identified an e-cigarette tip sheet for the district to use that is included in the protocol.
 - The developed resource list also met an identified need. This list will be used by students, parents, and district employees. The bilingual resource outlines available local and online cessation and advocacy resources available to the community. The resource list is being piloted with UpValley Family Centers' diversion caseload.
 - BZP presented the protocol and resource list to the SHUSD Board of Trustees on 11.17.22. The documents were approved and will be posted on the district's website. The tobacco policy committee will continue to promote the resources to district staff.
- **Created and passed a new Calistoga Joint Unified School District Tobacco Protocol, focusing on non-punitive options to addressing tobacco use, along with a Youth Tobacco Resource List highlighting cessation resources and opportunities for youth involvement in the tobacco prevention space. (Calistoga)**
 - BZP facilitated the creation of a tobacco protocol for the Calistoga Joint Unified School District with a focus on non-punitive alternatives to suspension. This protocol was developed in partnership with the school district and spearheaded by the BZP Tobacco Policy Committee. The committee also created an accompanying resource list for use by students, parents, and district employees.
 - The goal of the protocol was to create a document outlining steps the district takes when a student is found with a tobacco product, along with the support that's available to that student. The need for this was identified by the tobacco policy committee, and specifically the School Resource Officers. The protocol was developed over several months with the tobacco policy committee, who include SROs, UpValley Family Centers, NCOE, County's Tobacco Control Program staff, and more. The group also identified an e-cigarette tip sheet for the district to use that is included in the protocol.
 - The developed resource list also met an identified need. This list will be used by students, parents, and district employees. The bilingual resource outlines available local and online cessation and advocacy resources available to the community. The resource list is being piloted with UpValley Family Centers' diversion caseload.
 - BZP presented the protocol and resource list to the CJUSD School Board on 11.7.22. BZP also presented an update to a district AR policy to reference the new tobacco protocol as an appendix. The updated AR policy was approved at the 12.12.22 board meeting,

along with the tobacco protocol and resource list. The tobacco policy committee will continue to promote the resources to district staff.

- **Community Education Campaign - "Becoming a Presenter" Training and Campaign Preparation (Calistoga, St. Helena, Yountville)** Hosted "Becoming a Presenter" training for Tobacco Policy Committee in preparation for community education presentations and speaking with elected officials on policy issues Created needed presentation tools for our committee's Community Education Campaign to build awareness and support for policy changes
- **Sonoma County Q&A Strategy Session (Calistoga, St. Helena, Yountville)** Blue Zones Project connected with Sonoma County's Tobacco Control team (Carley Moore) to discuss their TRL and flavor ban work. BZP facilitated several meetings with Carley (and the tobacco committee co-chairs) to plan the meeting agenda to make it a valuable session for all. BZP created the agenda, Mural for meeting engagement, connected with other coalitions to spread the meeting invitation, and facilitated the actual committee meeting. BZP led the group through the knowledge checks, strategy session, and more.
- **Expand opportunities for youth to engage in community education and prevention campaigns through a SHUSD Student Tobacco Poster Contest (St. Helena)** BZP's Tobacco Policy Committee facilitated and supported a student tobacco-free poster design contest for SHUSD students. BZP promoted the winning student posters in the community to educate community members on the dangers of tobacco use.

Community Engagement

- The Blue Zones Project Upper Napa Valley Team has over 50 community-wide cooking demo, purpose workshops and engagement events to provide locals of Calistoga, St. Helena, and Yountville the power and knowledge to make healthier choices and support mental health.
- We have Blue Zones Project Approved all four St. Helena Public Schools. Where through a rubric of options, the schools made environmental/policy changes to support and educate students/staff on the importance of make choices to live healthier.
- All Calistoga Public Schools are working through the same process and on track to be approved.

Priority Health Need: Chronic Diseases – Heart Disease, Obesity/Diabetes, Cancer				
Goal Statement: Increase community’s knowledge and ability to self-manage their disease.				
Mission Alignment: Well-Being of People				
Strategy 1: Local education and screening capacity addressing heart disease, obesity/diabetes and cancer through mobile screening program, local events and disease specific screening opportunities.				
Strategy 1.2: Educate community on prevention of chronic diseases.				
Program/Activity	Metrics			
		Year 1 2020	Year 2 2021	Year 3 2022
Activity 1.1- Dare to C.A.R.E	Process & Short Term Outcomes			
	Number of participants screening	36	Currently on Hold	Currently on Hold
	Medium Term Outcomes			
	Percentage of increase in number of participants screened			
Activity 1.2- 4-Week Diabetes Education Course	Process & Short Term Outcomes			
	Number of participants	Program on hold due to COVID-19	9	3
	Number of Classes			
	Medium Term Outcome			
	Percentage of A1C decrease for participants enrolled in the program		N/A	N/A
Activity 1.3- AHEAD Hereditary Cancer Screening	Process Measure			
	Number of participants screened	1,263	1,455	1,102
	Number of participants affected	166	171	190
	Number of participants unaffected	1,097	1,284	912
	Short Term Outcomes			
	Number of high risk (eligible for genetics)	412	411	391
	Number of patients tested	369	354	427
	- Results Pending	197	105	61
	- High Risk Negative	72	51	67
	- Pathogenic Mutations	40	30	52
Medium Term Outcomes				
Number of prophylactic surgeries recommended	N/A	26	41	
Number of cancer diagnosis	N/A	N/A	N/A	
Activity 1.4- Blue Zones		Year 1 2020	Year 2 2021	Year 3 2022

	<p align="center">Process Measure</p> <p>Complete Readiness Assessment</p>	Readiness assessment completed	See Narrative Below	Blueprint has been created and implemented
	<p align="center">Short Term Outcomes</p> <p>Complete foundation phase and identify programs for transformation phase</p>	N/A		
	<p align="center">Medium Term Outcomes</p> <p>Create Blueprint for transformation phase</p>	N/A		
<p>Source of Data: Adventist Health Heart & Vascular Institute, Adventist Health St. Helena, Adventist Health Martin O’Neil Cancer Center</p>				
<p>Target Population(s): Broader community – Seniors and at-risk individuals</p>				
<p>Adventist Health Resources: (financial, staff, supplies, in-kind etc.) Staff, financial, supplies</p>				
<p>Collaboration Partners: (place a “*” by the lead organization if other than Adventist Health) Adventist Health</p>				
<p>CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations)</p>				

Strategy Results 2022:

Dare to CARE

Due to the COVID-19 pandemic, Dare to CARE was put on hold back in early 2020 and currently remains on hold.

4-week Diabetes Program

With COVID-19 still actively present in 2022, there were limited number of community outreach and education classes conducted. Total number of persons served in 2022: 3.

Blue Zones

Food

- **Support design of food skills inventory research project to determine assets and gaps in food skills. (Regional)**
 - Created tools for food skills inventory research project: connected with Adventist Health about the food skills project. Through various meetings, the first few steps of the research project, including tool development ("food skills inventory toolkit" and "food skills - programs list") were created. Toolkit was reviewed and updated and a survey was created. The tools developed include an interview guide, an online survey questionnaire, sample email templates, and a contact list.
 - Trained a Pacific Union College (PUC) student on food skills inventory tools: coordinated meetings between PUC professor and BZP Food Policy Committee Member. Student and professorial roles for the project were outlined, and the tools were finalized as a group. BZP employee created a food skills contact list, identifying contacts best suited for a

survey vs. an interview. She conducted high-level onboarding with PUC student, and BZP Food Policy Expert conducted in-depth onboarding with student, familiarizing her with the tools and research process. Survey developed for data collection.

- **Conducted food skills inventory to determine assets and gaps and developed targeted food skills development plan (Regional).** Conducted a food skills inventory in the Upper Napa Valley to identify assets and gaps to inform a community food skills development plan. BZP Policy Intern used the inventory tools created to conduct the inventory through surveys and interviews. She analyzed the data with the support, and drafted a food skills inventory report. Draft documents and data were further refined by BZ Food policy research team into a final community food skills development plan. The report will be shared with our Food Policy Committee to determine next steps in addressing identified food skills gaps.
- **Bring together regional partners through a Farm to School Working Group to build capacity and develop a Farm to School pilot (includes harvest of the month and food/gardening skills components) and consistent backbone support for school gardens and garden curriculum. (Calistoga, St. Helena)**
 - To gain a better understanding of both UpValley school districts' current garden infrastructure, history of school gardens usage, goals and barriers, we interviewed the districts' food service directors and toured the gardens. With this information, we created school garden environmental scans. These gave us a starting point to work from and allowed for the formation of a farm to school working group.
 - Blue Zones Project created and facilitated a farm to school working group comprised of three Napa County school districts, including one outside of our service area for regional partnership. These school districts have not worked together in this capacity before. Local non-profit, Innovative Health Solutions (IHS), was also brought to the table. The group met many times over the course of several months to build trust and strengthen relationships, all while coming up with ideas to regionally implement farm to school initiatives. These ideas became solidified and the basis for our CDFA Farm to School Partnership Grant application.
 - Blue School Zones acted as the liaison between the working group and the two UpValley school district superintendents, securing buy-in for the CDFA program. Blue Zones Project also built relationships outside of the working group that became crucial partnerships for the grant (such as the local farmers' market). We drafted 10 unique letters of support for the grant, and coordinated submission. We also wrote most of the grant narrative, working closely with IHS as the grant's lead agency. In total, we brought 11 unique organizations to the table supporting the grant application, with more partnerships being built every day.

Community Engagement

- In partnership with the AHSB Cardiac Rehab Center, Blue Zones Project is working on supporting healthy cooking demonstration for patients in need of plant-based, heart-healthy recipes.

Priority Health Need: Housing and Homelessness				
Goal Statement: Community Collaboration to provide goods to individuals experiencing housing insecurity.				
Mission Alignment: Well-Being of People or Equity				
Strategy 1: Community Building Initiatives (CBI)				
Program/Activity	Metrics			
<i>Activity 1- Inspire Hope/World Vision*</i>		Year 1 2020	Year 2 2021	Year 3 2022
	Process Measure Number of individuals served in program	>300		Program did not continue in 2022
	Short & Medium Term Outcomes Percentage in number of individuals served			
Source of Data: Adventist Health				
Target Population(s): Homeless/ vulnerable population				
Adventist Health Resources: (financial, staff, supplies, in-kind etc.) In-kind				
Collaboration Partners: (place a "*" by the lead organization if other than Adventist Health) TBD				
CBISA Category: (A - Community Health Improvement; E - Cash and In-Kind; F - Community Building; G - Community Benefit Operations) F – Community Building				

Strategy Results 2022:

Blue Zones

Built Environment

- Expand Age-Friendly Collaborative (Calistoga, St. Helena, Yountville)** Built regional capacity and grew partnerships in the Age-Friendly space in preparation for age-friendly resolutions, workplans, and designation. Built relationships and capacity with the Napa/Solano Area Agency on Aging, Rianda House, Collabria Care, Napa County HHSA, Healthy Aging Population Initiative, and community Parks and Recreation Departments. Worked to expand the existing Bay Area Age Friendly County Leadership Group to include the Napa/Solano Area Agency on Aging. BZP connected the needed partners to expand the group's scope to include Napa and Solano Counties, and set a clear path to prioritizing age-friendly work. Email chains documenting these connections are in the BPC folder.

Community Benefit & Economic Value for Prior Year

Our community benefit work is rooted deep within our mission, with a recent recommitment 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.

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Office of Statewide Health Planning and Development in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Charity Care, Medicaid and other means-tested programs is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.