## COMMUNITY HEALTH NEEDS ASSESSMENT

## 2020

# Queen of the Valley Medical Center



To provide feedback about this CHNA or obtain a printed copy free of charge, please email Teresa Smith, CHI Program Manager at Teresa.Smith@stjoe.org

St. Joseph Health
Queen of the Valley

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# MESSAGE TO THE COMMUNITY AND ACKNOWLEDGEMENTS

It is with great joy and pride that we present Queen of the Valley Medical Center's 2020 Community Health Needs Assessment to our community – both our collaborative partners as well as the communities we serve.

For the past several months we have worked diligently to gather the appropriate and most complete data on the health-related needs of our service area. This will enable us to make informed and thoughtful decisions about how best to serve and provide resources to areas with highest needs and to the most vulnerable populations.

The Community Health Needs Assessment process was disrupted by the SARS-COV-2 virus and COVID-19, which has impacted all of our communities. While our communities have focused on crisis response, it has required concentration of resources and reduced community engagement, which impacted survey fielding and community listening sessions.

Despite the challenges presented by a global pandemic, we held steadfast to our guiding principles of including the voice of the community in this report. We spoke with several key stakeholders about what they felt were the biggest needs in our community and held virtual listening sessions with caregivers who directly serve vulnerable populations.

We've also analyzed and examined data that demonstrates how social determinants and health disparities affect communities and neighborhoods. The data overwhelmingly validates the gaps and inspire us to continue our work towards addressing the social determinants of health and their influence on the health and wellbeing of our communities without distinction.

We could not have done this work alone and would like to thank our partners who brought diverse skills and expertise to this process.

I invite you to study the findings and most importantly to join us in our efforts to restore health and improve quality of life to our *Dear Neighbors* and the communities in which they live.

With deep gratitude,

Larry Coomes
Chief Executive Officer,
Queen of the Valley Medical Center

Sr. Nadine McGuinness
Chair, Queen of the Valley Medical Center,
Community Benefit Committee

# RESPONDING TO THE COVID-19 PANDEMIC

The 2020 Community Health Improvement Planning process was disrupted by the SARS-COV-2 virus and COVID-19, which has impacted all of our communities. While our communities have focused on crisis response, it has required concentration of resources and reduced community engagement, which impacted survey fielding and community listening sessions. Additionally, the impacts of COVID-19 are likely to effect community health and well-being beyond what is currently captured in secondary and publicly available data. We seek to engage the community as directly as possible in prioritizing needs and through the community health improvement process.

We recognize that in these unprecedented times, COVID-19 is likely to exacerbate existing community needs and may bring others to the forefront. Our commitment first and foremost is to respond to the needs of our communities, particularly individuals who are disproportionately impacted by the economic and social effects of COVID-19. While this is a dynamic situation, we recognize the greatest needs of our communities will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our communities in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

# EXECUTIVE SUMMARY

## Understanding and Responding to Community Needs, Together

Improving the health of our communities is foundational to our Mission and deeply rooted in our heritage and purpose. Our Mission calls us to be steadfast in serving all, with a special focus on our most economically poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets, and opportunities. This CHNA was approved by the Queen of the Valley Medical Center's Community Benefit Committee on February 18, 2021.

## Our Starting Point: Gathering Community Health Data and Community Input

Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. This process built upon the 2017 CHNA, which prioritized mental health, substance abuse, and social determinants of health (housing concerns, economic issues, and access to care). Across the County of Napa, information collected includes public health data regarding health behaviors; morbidity and mortality; and hospital-level data. Listening sessions were held with caregivers who serve individuals that have chronic conditions, are from diverse communities, have low-incomes, and/or are medically underserved. Stakeholder interviews were conducted with representatives from organizations that serve these populations. Some key findings include the following:

- Both stakeholders and caregivers agreed homelessness and lack of safe, affordable housing is the number one community need, stressing that the housing crisis in Napa highlights racial and economic inequities in the community.
- The Hispanic population is disproportionately represented in the high need service area compared to Napa County overall. Stakeholders and caregivers spoke to the Latino/a community being disproportionately affected by housing instability, food insecurity and economic insecurity due to systemic inequities and racism.
- The median income in the high need service area is about $11,000 lower than Napa County and $24,000 lower than the broader service area. These areas with lower median incomes are more likely to experience severe housing cost burden (households spending 50% or more of income on housing costs), with 25% of renter households in the high need service area being severely housing cost burdened compared to 21% in the broader service area.
- Stakeholders and caregivers emphasized a lack of specialists in Napa, leading to challenges with transportation for individuals who must travel outside of the community to access needed services.

- Stakeholders and caregivers identified a lack of mental health and substance use treatment services in the county, specifically those that are tailored and responsive to the Latino/a and LGBTQ+ communities.

## Identifying Top Health Priorities, Together

Through a collaborative process engaging Queen of the Valley Medical Center's Community Benefit Committee, the following community health needs were prioritized:

### PRIORITY 1: HEALTH EQUITY – RACIAL & LGBTQ

The disproportionate impact of COVID-19 on Black, Brown, Indigenous, and People of Color (BBIPOC), as well as the national call for racial justice have highlighted the need for additional community conversations around racism and inequities. Health inequities and systemic racism are preventing BBIPOC communities, particularly the Latino/a community, from accessing opportunities and living their healthiest lives. Discrimination also prevents the LGBTQ+ community from receiving responsive health care and visibility in the community. A greater commitment to equity in all programs and collaboratives is warranted.

### PRIORITY 2: HOUSING & HOMELESSNESS

A major and growing community need is around more safe and affordable housing stock, particularly for people with low incomes. A lack of affordable housing leads to over-crowding and poor living conditions. Housing is foundational to all other needs; once people are housed securely, they can address other needs related to their health and wellbeing. Two groups are of particular concern: the Latino/a community and older adults. The housing crisis in Napa highlights racial and economic inequities in the community, disproportionately affecting the Latino/a community, especially mixed status families. There is additional concern for older adults who have few affordable options in the community, particularly those living on a fixed income.

### PRIORITY 3: MENTAL HEALTH & SUBSTANCE USE SERVICES

There is a general lack of mental health and substance use treatment services in the community. School-age children and older adults need more mental health support in the current environment, increasing the demand for services. The Latino/a community is also underserved, especially mixed status families, with the following barriers preventing Latino/a individuals from receiving services: stigma, a lack of culturally relevant education and outreach, and a lack of bilingual and bicultural providers. LGBTQ-friendly mental health providers are also difficult to find in the area. There is limited access to mental health services for individuals who do not meet the high-acuity criteria for severe mental illness at Napa County Health and Human Services, as well as limited substance use disorder treatment options. The COVID-19 pandemic is creating a mental health crisis; people are feeling hopeless, afraid, stressed, anxious, and depressed. The stress from the COVID-19 pandemic is compounding trauma related to local fires.

### PRIORITY 4: ACCESS TO HEALTH SERVICES

There is concern around lack of access to health insurance for mixed status families as well as people losing their insurance due to job loss during the pandemic. A lack of specialists in Napa disproportionately affects individuals on Medi-Cal or without insurance. When individuals are referred to a specialist outside of the area, transportation then becomes a barrier to accessing care. Language barriers prevent Spanish-speaking individuals from receiving responsive care, and virtual interpreters are not nearly as effective as in-person options. Access to care challenges became especially apparent during the COVID-19 pandemic. While telemedicine has improved access to care for some populations, for others this transition has created additional barriers to care, including lack of smart phones or computers, lack of comfort with technology or stable internet access, language barriers, and lack of private space for appointments. Many individuals do not want to talk to their provider on the phone and are not receiving the care they need.

## Community Health Improvement Plan

Queen of the Valley Medical Center will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs in collaboration with community partners considering resources, community capacity, and core competencies.

# INTRODUCTION

## Mission, Vision, and Values

| | |
|---|---|
| *Our Mission* | As expressions of God's healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable. |
| *Our Vision* | Health for a Better World. |
| *Our Values* | Compassion — Dignity — Justice — Excellence — Integrity |

## Who We Are

Queen of the Valley Medical Center is an acute-care hospital founded in 1958 and located in Napa, California. The hospital has 208 licensed beds, more than 1,687 caregivers (employees) and professional relationships with many local physicians. Major programs and services offered to the community include acute rehabilitation, bariatric surgery, cancer, cardiac, emergency, maternity and infant care, neurosciences and orthopedics. Synergy Health Club, a St. Joseph Health owned facility offering fitness and studio classes, is located on the hospital's campus and St. Joseph Health Prompt Care, an urgent care clinic, is located about a 10-minute drive from the hospital.

## Our Commitment to Community

Queen of the Valley Medical Center dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During the most recent fiscal year, our hospital provided $33,487,837 in community benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in Napa County.

Queen of the Valley Medical Center further demonstrates organizational commitment to the community health needs assessment (CHNA) through the allocation of staff time, financial resources,

[1] A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community. To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

participation and collaboration to address community identified needs. The Northern California Regional Director of Community Health Investment and the local Community Health Investment Program Manager at Queen of the Valley Medical Center are responsible for ensuring compliance with Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital leadership, physicians, and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

## Health Equity

At Providence St. Joseph Health, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is "Health for a Better World," and to achieve that we believe we must address not only the clinical care factors that determine a person's length and quality

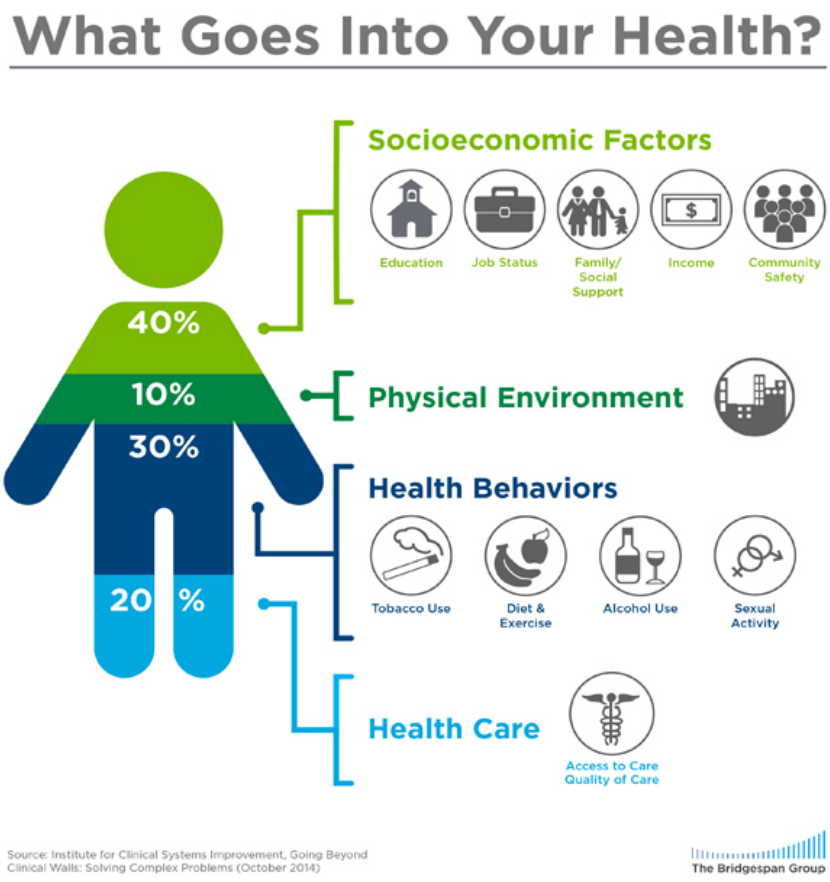



***Figure 1. Factors contributing to overall health and well-being***

of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1[2]).

The Community Health Needs Assessment (CHNA) is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets (see Figure 2 for definition of terms[3]). Across our organizational footprint, we consistently heard from our community partners that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

**Health Equity**

A principle meaning that "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups." (Braverman, et al., 2017)

**Health Disparities**

Preventable differences in the burden of disease or health outcomes as a result of systemic inequities.

***Figure 2. Definitions of key terms***

To ensure that equity is foundational to our CHNA, we have developed an equity framework that outlines the best practices that each of our hospitals will implement when completing a CHNA. These practices include, but are not limited to the following:

[2] Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

[3] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

### Approach

Explicitly name our commitment to equity

Take an asset-based approach, highlighting community strengths

Use people first and non-stigmatizing language

### Community Engagement

Actively seek input from the communities we serve using multiple methods

Implement equitable practices for community participation

Report findings back to communities

### Quantitative Data

Report data at the block group level to address masking of needs at county level

Disaggregate data when responsible and appropriate

Acknowledge inherent bias in data and screening tools

# OUR COMMUNITY

## Description of Community Served

Queen of the Valley Medical Center provides Napa County communities with access to advanced care and advanced caring. The hospital's community extends from Calistoga and the Lake County border in the north, American Canyon and the Solano County border in the south, the Yolo County border in the east and the Sonoma County border in the west. This includes a population of approximately 147,000 people.

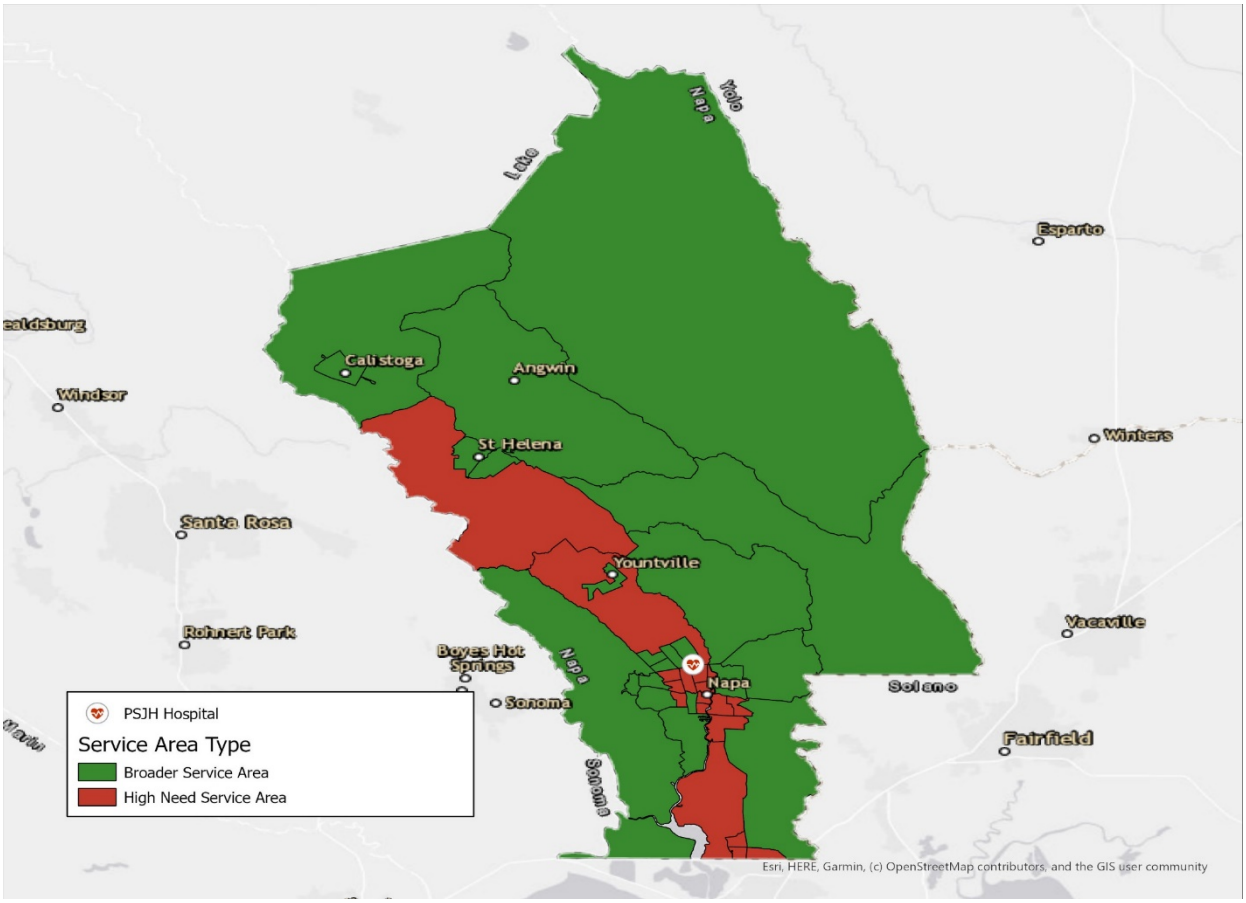
## Hospital Service Area

QVMC serves all of Napa County. Based on the availability of data, geographic access to these facilities, and other hospitals in neighboring counties, Napa County serves as the boundary for the hospital service areas.

***Table 1. Cities and ZIP Codes Included in Total Service Area***

| Cities/ Communities | ZIP Codes |
|---|---|
| Napa | 94558, 94559 |
| American Canyon | 94503 |
| Yountville | 94599 |
| St. Helena | 94574 |
| Calistoga | 94515 |
| Angwin | 94508, 94576 |

***Figure 3. Queen of the Valley Medical Center Total Service Area***




## Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about the Queen of the Valley Medical Center Service Area and how the high need area compares to the broader service area. The service area of Queen of the Valley Medical Center includes approximately 140,000 people and encompasses the entire county of Napa. The high need service area consists of a disproportionate amount of younger (age 0-54) residents and people of color or other races. There is about a $24,000 difference in median income between the broader service area and the high need service area.

## POPULATION AND AGE DEMOGRAPHICS

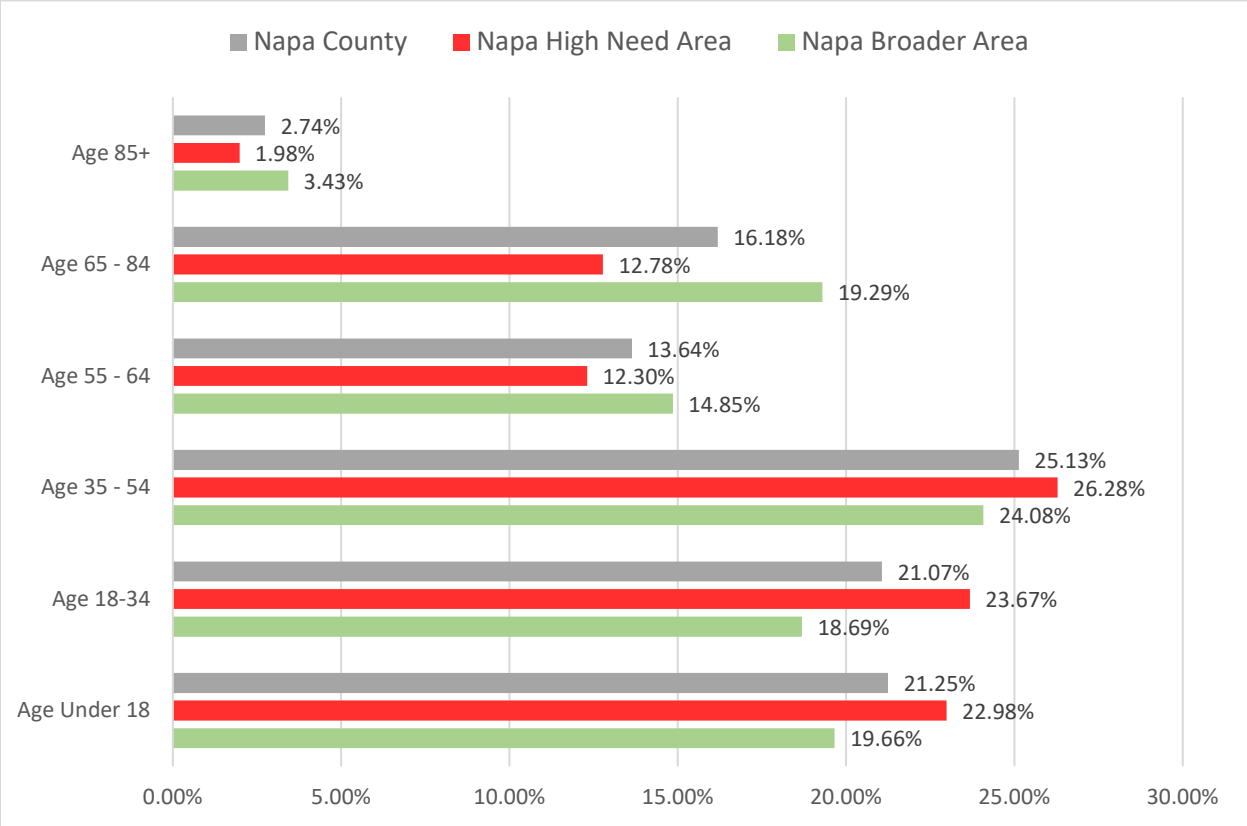
***Table 2. Population Demographics for Napa County Service Areas***

| Indicator | Napa County | Napa Broader Area | Napa High Need Area |
|---|---|---|---|
| 2019 Total Population | 140,394 | 73,393 | 67,001 |
| Female Population | 49.93% | 50.35% | 49.47% |
| Male Population | 50.07% | 49.65% | 50.53% |

Of the over 140,000 permanent residents of Napa County, roughly 48% live in the "high need" area, defined by lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to census tracts across the County. For reference, 200% FPL is equivalent to an annual household income of $51,500 or less for a family of 4. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.

The male-to-female distribution is roughly equal across Napa County geographies.

***Figure 4. Age Group by Geography in Napa County***

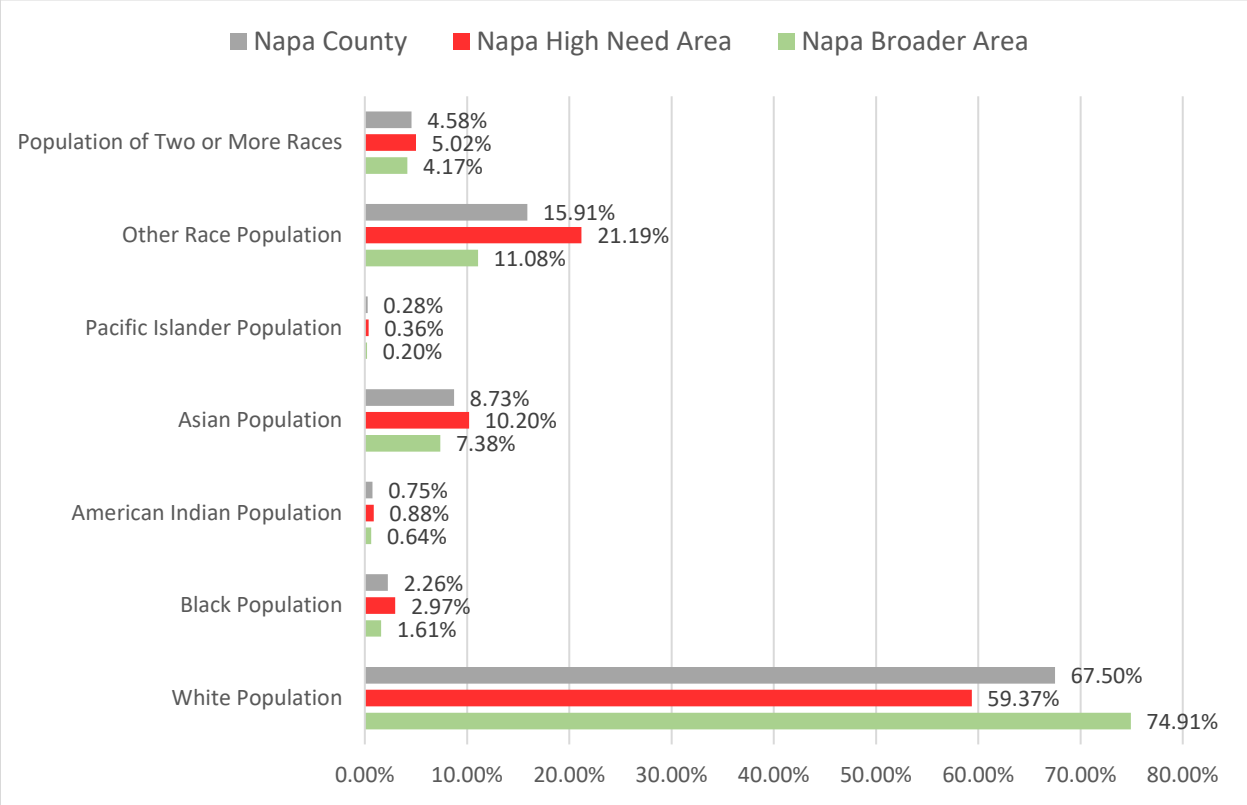


Younger age groups are disproportionately represented in the high need communities of Napa County, most likely representing households with young children. Alternatively, age groups 55 and over are less likely to fall into the high need communities or live within those designated census tracts.

In Napa County, approximately 7% of the population are veterans, which is higher than that of the state of California, 5%.

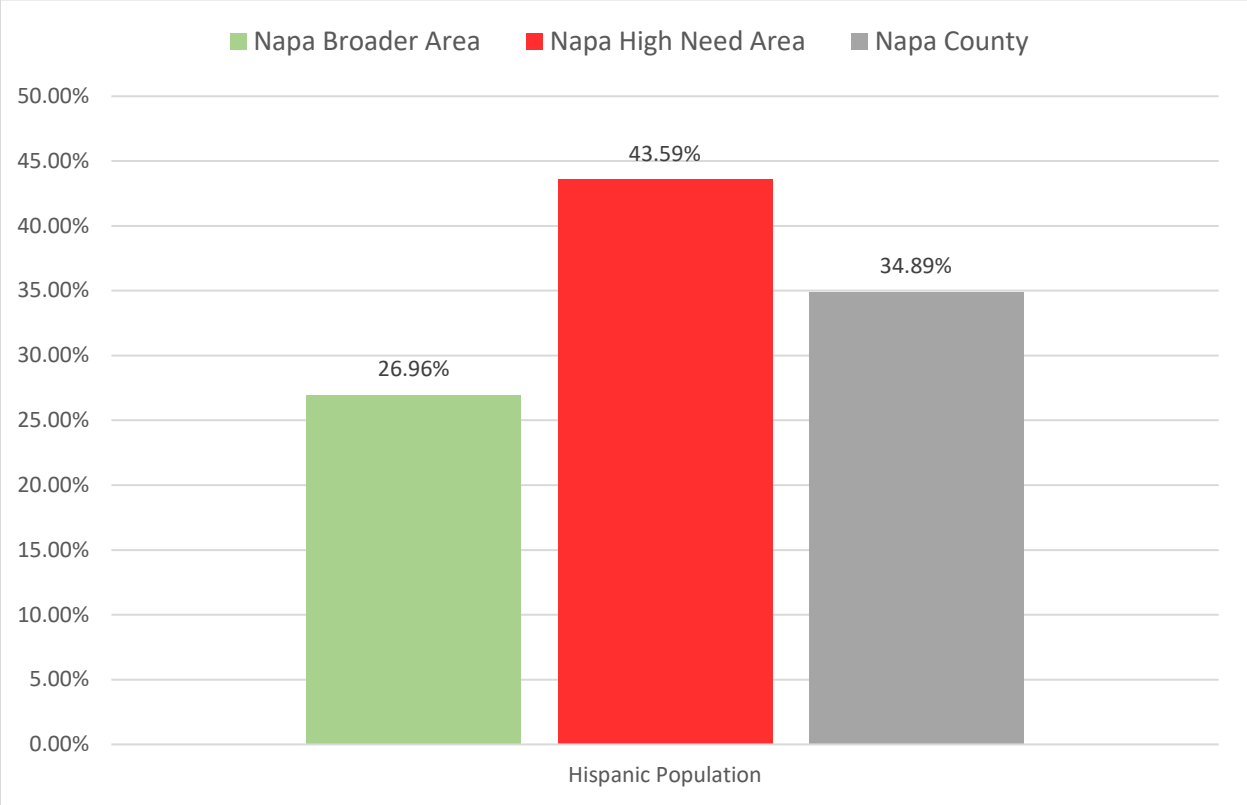
## POPULATION BY RACE AND ETHNICITY

***Figure 5. Race by Geography in Napa County***




Individuals who identify as Hispanic (below), Asian, or "other race," are more likely to live in high needs census tracts than their peers of other races.

***Figure 6. Hispanic Population by Geography in Napa County***



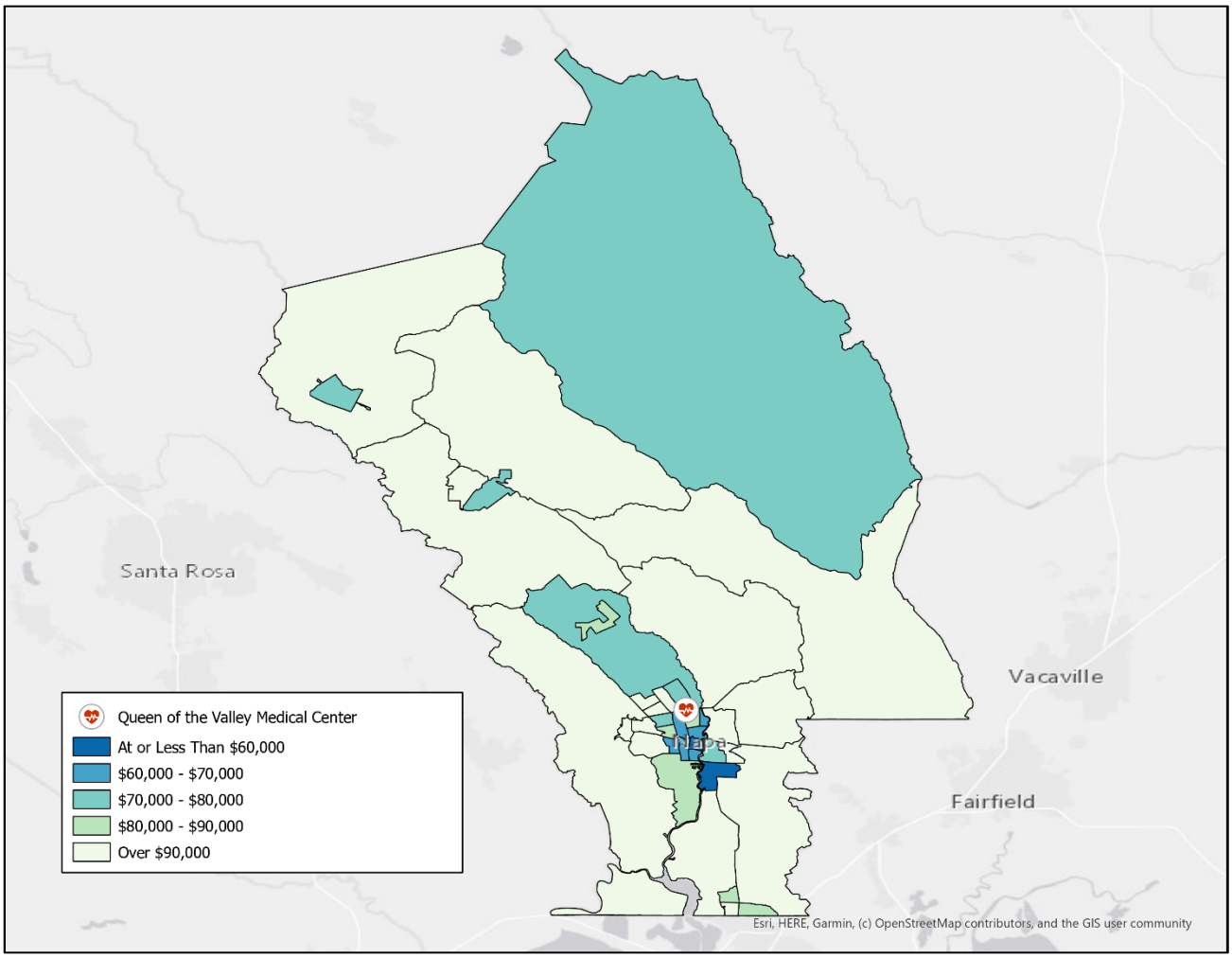

## MEDIAN INCOME

***Table 3. Income Indicators for Napa County Service Areas***

| Indicator | Broader Service Area | High Need Service Area | Napa County |
|---|---|---|---|
| **Median Income**<br>Data Source: American Community Survey<br>Year: 2019 | $101,330 | $77,129 | $88,457 |

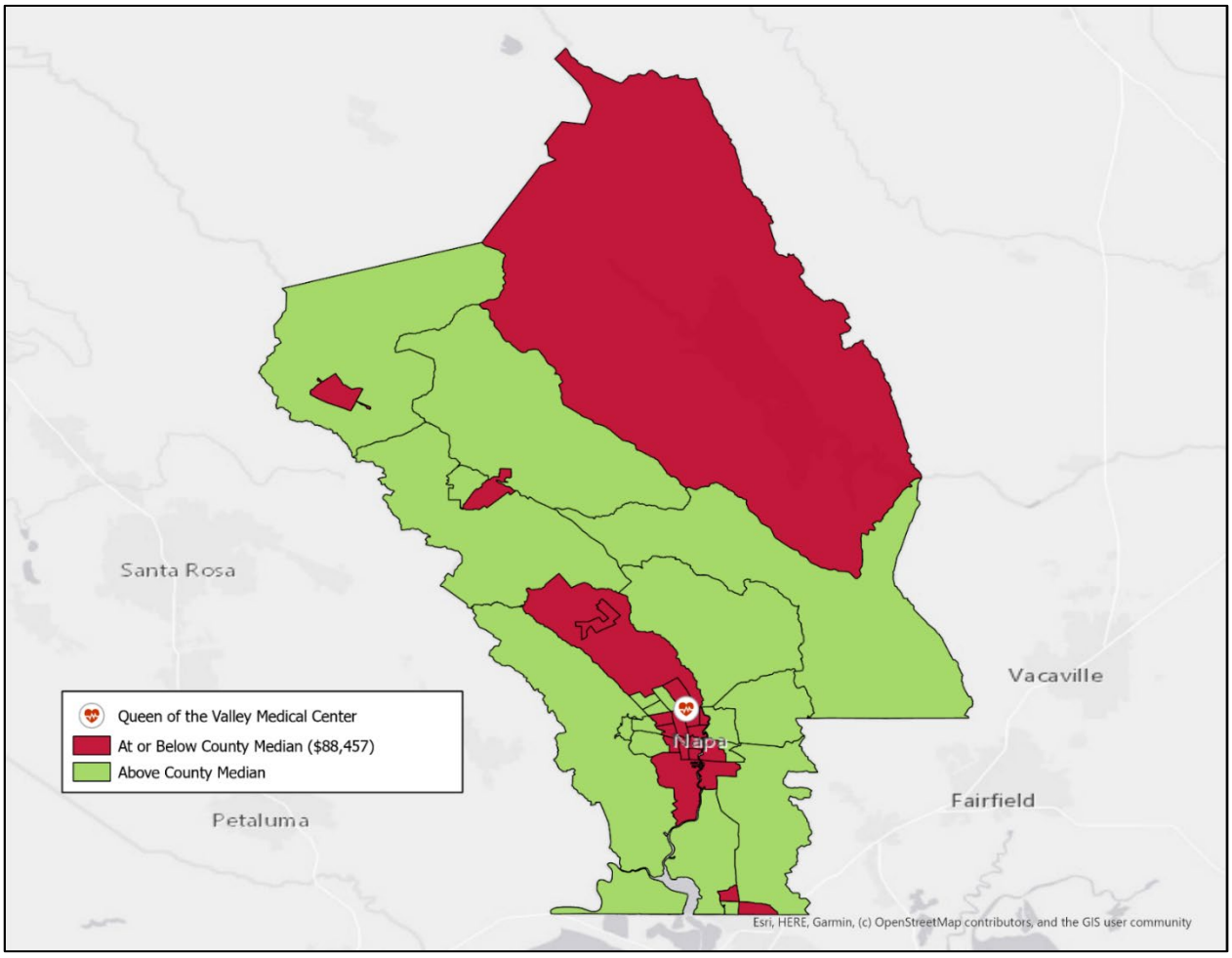
- The median income in the high need service area is about $11,000 lower than Napa County.
- There is about a $24,000 difference in median income between the broader service area and the high need service area.

***Figure 7. 2019 Median Household Income by Census Tract in Napa County***



In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red.

***Figure 8. Comparison of Median Household Income by Census Tract to County Average***



## SEVERE HOUSING COST BURDEN

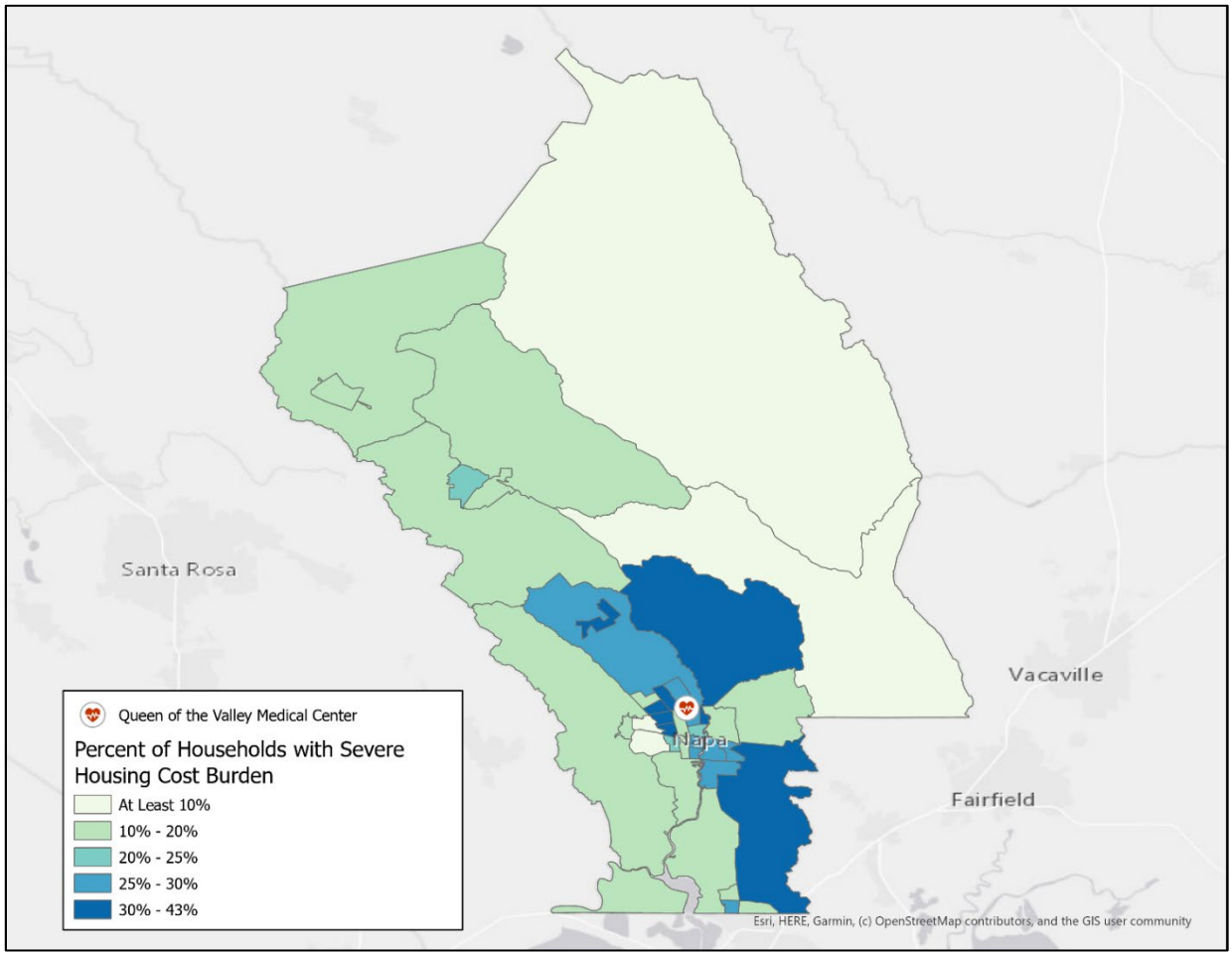
***Table 4. Severe Housing Cost Burden for Napa County Service Areas***

| Indicator | Broader Service Area | High Need Service Area | Napa County |
|---|---|---|---|
| **Percent of Renter Households with Severe Housing Cost Burden**<br>Data Source: American Community Survey<br>Year: Estimates based on 2013 – 2017 data | 20.8% | 25.2% | 23.0% |

Severe housing cost burden is defined as households that are spending 50% or more of their income on housing costs. On average about 23% of households in Napa County are severely housing cost burdened.

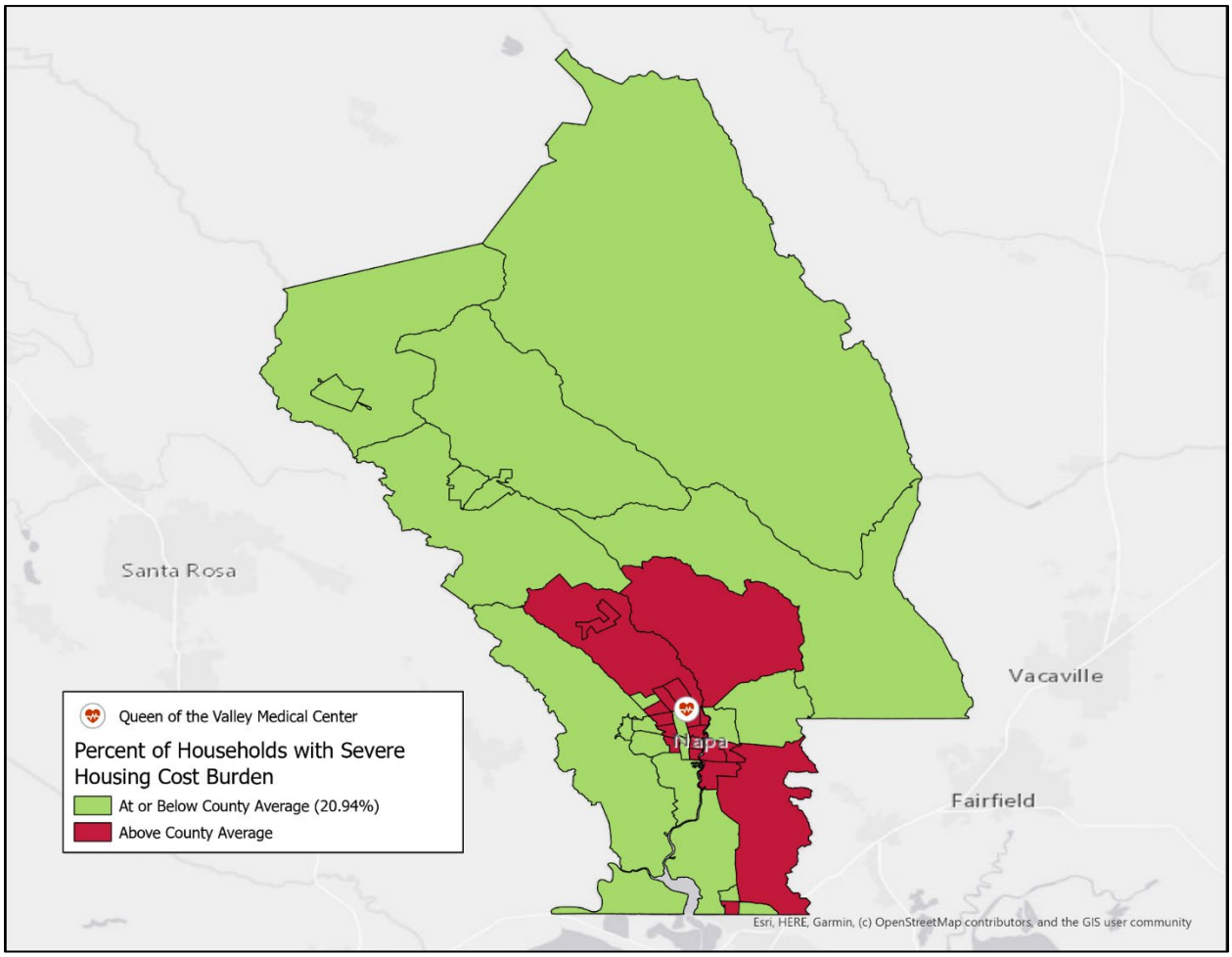
In the high need service area, 25.2% of renter households are severely housing cost burdened. Within the total service area there are census tracts in which 30% to 43% of households are experiencing severe housing cost burden.

***Figure 9. Percent of Households with Severe Housing Cost Burden by Census Tract in Napa County***



In the map below, census tracts that perform better than the county average (20.94%) are colored in green while census tracts that perform worse are in red.

***Figure 10. Comparison of Housing Cost Burden by Census Tract to County Average***




## HEALTH PROFESSIONAL SHORTAGE AREA

A census tract in Napa County is considered a geographic Health Professional Shortage Area (HPSA). A Federally Qualified Health Center, OLE Health, is also within the service area and is a designated HPSA for primary care, dental care, and mental health. While Queen of the Valley is not located in an HPSA, large portions of the service area to the north of the hospital are considered a primary care HPSA. Napa County also has a designated Medically Underserved Population, people with low incomes.

**See Appendix 5 for additional data and details on HPSA and Medically Underserved Areas and Medically Underserved Populations.**

# OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The Community Health Needs Assessment (CHNA) process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospital, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the ZIP Code, census tracts, or census block group level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address disparities within and across communities. Census designated geographies also ensure similar total population size, improving comparability.

We reviewed data from the American Community Survey and local public health authorities. In addition, we include hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected.

## Data Limitations and Information Gaps

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

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is little community-level data on the incidence of mental health or substance abuse.
- Data that are gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.
- Information gathered during stakeholder interviews and caregiver listening sessions is dependent on who was invited and who participated. Efforts were made to include people who could represent the broad interests of the community and/or were representative of communities of greatest need.

## Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2017 CHNA and 2018-2020 CHIP reports, which were made widely available to the public via posting on the internet in December 2017 (CHNA) and May 2018 (CHIP), as well as through various channels with our community-based organization partners.

No comments or questions were received.

# HEALTH INDICATORS

The following indicators compare Napa County to the state of California and the other PSJH service areas in Northern California. Red indicates a measure "worse than" that of the state, green indicates a measure "better than" the state, and yellow indicates a measure equal to that of the state.

## Socioeconomic Indicators

***Table 5. Socioeconomic Indicators Comparing Northern CA Counties to the State***

| Indicator | California | Humboldt County | Napa County | Sonoma County |
|---|---|---|---|---|
| Median Household Income | $75,300 | $49,500 | $85,600 | $81,000 |
| Children eligible for free or reduced lunch (enrolled in public schools) | 60% | 61% | 51% | 48% |
| Children in poverty | 17% | 23% | 9% | 12% |

Napa County's median household income is much greater than California's overall. Far fewer children are living in poverty (9% compared with 17% statewide).

## Physical Environment

***Table 6. Physical Environment Indicators Comparing Northern CA Counties to the State***

| Indicator | California | Humboldt County | Napa County | Sonoma County |
|---|---|---|---|---|
| More than 1 occupant per room | 8% | 4% | 8% | 5% |
| Severe housing problems | 27% | 25% | 22% | 23% |
| Pollution Burden | 25 | 13 | 18 | 15 |
| Air pollution: particulate matter | 10 | 9 | 11 | 10 |
| Violent crimes (rate per 100,000 inhabitants) | 421 | 432 | 398 | 368 |

Napa County performs better than the state as a whole across physical environment domains, except particulate matter.

## Health Outcomes

***Table 7. Health Outcome Indicators Comparing Northern CA Counties to the State***

| Indicator | California | Humboldt County | Napa County | Sonoma County |
|---|---|---|---|---|
| Self-reports of fair or poor health (age-adjusted) | 17% | 16% | 14% | 14% |
| Self-reports of fair or poor health (ages 65+) | 29% | 27% | 24% | 24% |
| Asthma in children (ages 1-17) | 15% | 10% | 24% | 16% |
| Asthma in adults (ages 18+) | 15% | 18% | 18% | 18% |
| Diabetes in adults (ages 18+) | 10% | 7% | 9% | 8% |
| Heart disease (ages 18+) | 6% | 7% | 7% | 6% |
| Serious psychological distress (ages 18+) | 8% | 10% | 6% | 10% |

In general, Napa County performs better than the state as whole across most health outcomes. However, the county does see higher percentages of people with asthma, particularly in children, and a slightly higher prevalence of heart disease in adults.

## Health Behaviors

***Table 8. Health Behavior Indicators Comparing Northern CA Counties to the State***

| Indicator | California | Humboldt County | Napa County | Sonoma County |
|---|---|---|---|---|
| Overweight (ages 2-11) | 15% | N/A | 6% | 16% |
| Overweight or obese (ages 12-17) | 38% | 17% | 47% | 17% |
| Obese (ages 18+) | 28% | 31% | 29% | 24% |
| Sugary drink consumption (ages 18+) | 11% | 13% | 9% | 9% |
| Regular physical activity (ages 5-17) | 17% | 48% | 6% | 27% |

| | | | | |
|---|---|---|---|---|
| Youth alcohol/drug use in the past month (7th grade) | 7% | 10% | 7% | 9% |
| Youth alcohol/drug use in the past month (9th grade) | 20% | 27% | 15% | 22% |
| Youth alcohol/drug use in the past month (11th grade) | 29% | 45% | 30% | 40% |
| Current smoker (ages 18+) | 11% | 14% | 10% | 10% |

## Clinical Care

***Table 9. Clinical Care Indicators Comparing Northern CA Counties to the State***

| Indicator | California | Humboldt County | Napa County | Sonoma County |
|---|---|---|---|---|
| Uninsured (ages 0-17) | 3% | 4% | 4% | 3% |
| Uninsured (ages 18-64) | 10% | 11% | 10% | 9% |
| First trimester prenatal care | 84% | 80% | 89% | 88% |
| # of people per primary care physician | 1,260 | 1,440 | 1,040 | 980 |
| # of people per non-physician primary care provider | 1,590 | 928 | 1,765 | 1,428 |
| # of people per dentist | 1,180 | 1,270 | 1,120 | 1,090 |
| # of people per mental health provider | 280 | 220 | 180 | 220 |

Napa County performs relatively well on clinical care indicators. The percentage of people ages 0 to 17 that are uninsured is slightly higher than the state (4% in Napa County compared to 3% in California), and the percentage of people ages 18 to 64 that are uninsured is the same (10%). The ratios of primary care physicians, dentists, and mental health providers to people are better in Napa County compared to California. The ratio of non-physician primary care providers to people is slightly worse in Napa County than the state.

**See Appendix 5: Quantitative Data for data sources**

## Hospital Utilization Data

In addition to this public health surveillance data, our hospitals can provide timely information regarding access to care and disease burden across Napa County. We were particularly interested in studying potentially avoidable Emergency Department visits and Prevention Quality Indicators. Avoidable Emergency Department (AED) is reported as a percentage of all Emergency Department visits over a given time period and are identified based on an algorithm developed by PSJH's Population Health Care Management team based on NYU and Medi-Cal's definitions.

The Prevention Quality Indicators (PQIs) are similar, although they are based on in-patient admissions. Both PQIs and AED serve as proxies for inadequate access to, or engagement in, primary care. As possible, we look at the data for total utilization, frequency of diagnoses, demographics, and payer to identify disparities.

***Table 10. Avoidable Emergency Department Visits for PSJH Northern California Ministries***

| Facility | Non-AED Visits | AED Visits | Total ED Visits | AED % |
|---|---|---|---|---|
| Petaluma Valley Hospital | 11,765 | 5,100 | 16,865 | 30.2% |
| Queen of The Valley Medical Center | 16,902 | 8,188 | 25,090 | 32.6% |
| Redwood Memorial Hospital | 7,458 | 4,307 | 11,765 | 36.6% |
| Santa Rosa Memorial Hospital | 23,898 | 12,610 | 36,508 | 34.5% |
| St. Joseph Hospital Eureka | 16,880 | 11,307 | 28,187 | 40.1% |
| **Grand Total** | **76,903** | **41,512** | **118,415** | **35.1%** |

Across PSJH's northern California service areas, QVMC had a below average percentage of potentially avoidable ED utilization in 2019. At QVMC, individuals identifying as Pacific Islander/ Native Hawaiian, white, and "other" race had the highest percentages of avoidable ED visits.

Individuals under the age of 18 had the highest percentage of avoidable ED visits, with ZIP Code 94558 producing the greatest number of potentially avoidable ED visits. This one ZIP Code was responsible for approximately 54% (4,435) of all potentially avoidable visits in 2019. There were 359 additional visits from patients identified as experiencing homelessness (ZIP Code "ZZZZZ"), with 51% of visits by this population being categorized as avoidable.

***Table 11. Avoidable Emergency Department Visits by Ministry and Patient Zip Code***

| Encounters by Patient Zip Code | Non-AED Visits | AED Visit | Total ED Visits | AED % |
|---|---|---|---|---|
| Queen of The Valley Medical Center | 16,902 | 8,188 | 25,090 | 32.6% |
| 94558 | 8,941 | 4,435 | 13,376 | 33.2% |
| 94559 | 3,224 | 1,655 | 4,879 | 33.9% |
| 94503 | 706 | 385 | 1,091 | 35.3% |
| ZZZZZ | 348 | 359 | 707 | 50.8% |

**See Appendix 5: Quantitative Data**

# COMMUNITY INPUT

## Summary of Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, representatives from Queen of the Valley Medical Center conducted 19 stakeholder interviews and 8 listening sessions, including 27 Community Outreach Caregivers. All interviews and listening sessions occurred in June 2020, during which time participants discussed the issues and opportunities of the people, neighborhoods, and cities of the service area. Below is a high-level summary of the findings of these sessions; full details on the protocols, findings, and attendees are available in Appendix 2.

| | |
|---|---|
| **Homelessness/ lack of safe, affordable housing** | Both stakeholders and caregivers agreed homelessness and lack of safe, affordable housing is the number one community need. Both groups stressed a **lack of affordable housing stock**, particularly for people with low-incomes in the community, noting this leads to over-crowding and poor living conditions. A common theme was that **housing is foundational** to all other needs; once people are housed securely, they can address other needs related to their health and wellbeing.<br><br>Two groups were of particular concern: the **Latino/a community** and **older adults**. Stakeholders stressed the housing crisis in Napa highlights racial and economic inequities in the community, disproportionately affecting the Latino/a community, especially mixed status families. Caregivers were particularly concerned about older adults who have few affordable options in the community, particularly those living on a fixed income. |
| **Behavioral health challenges (includes both mental health and substance use disorder) and access to care** | Most stakeholders and caregivers agreed there is a lack of mental health and substance use treatment services in the community. They shared school-age children and older adults need increased mental health support. Both stakeholders and caregivers were concerned about the **Latino/a community**, especially mixed status families, although this group was especially prevalent in the caregiver interviews. They noted the following barriers prevent the Latino/a community from receiving services: stigma, a lack of culturally relevant education and outreach, and a lack of bilingual and bicultural providers. Stakeholders also shared that finding **LGBTQ-friendly** mental health providers is difficult in the area.<br><br>Caregivers emphasized limited access to mental health services for individuals who do not meet the **high-acuity criteria for severe mental illness** at Napa County Health and Human Services. Both groups noted limited **substance use disorder treatment** options, recommending better integration of these services into the community. Stakeholders emphasized the COVID-19 pandemic is creating a **mental health crisis**, sharing people are feeling hopeless, afraid, stressed, anxious, and depressed. |

| | |
|---|---|
| **Access to health care services** | While both stakeholders and caregivers prioritized access to care, caregivers prioritized it more frequently and with stronger importance. Both groups were concerned about lack of access to **health insurance** for **mixed status familes,** as well as people losing their insurance due to job loss during the pandemic. Both emphasized **a lack of specialists** in Napa, disproportionately affecting individuals on Medi-Cal or without insurance, and challenges with **transportation** as a barrier to care. Both groups shared that **language barriers** prevent Spanish-speaking individuals from receiving responsive care, stating that virtual interpreters are not nearly as effective as in-person options.<br><br>Access to care challenges are especially prevalent during the COVID-19 pandemic, with **telemedicine** appointments creating additional barriers for people. Lack of smart phones or computers, lack of comfort with technology, language barriers, and lack of private space for appointments were noted by both groups. Caregivers emphasized that people do not want to talk to their provider on the phone and are not receiving the care they need. |

The following findings represent **medium-priority health-related needs** based on feedback from stakeholders and caregivers:

| | |
|---|---|
| **Food insecurity** | Stakeholders and caregivers were concerned about community members' access to good quality, nutritious food, particularly because the pandemic exacerbated the need. They shared food insecurity is closely linked with **income**; families with low incomes or job loss are forced to make tradeoffs in how they spend their money, sometimes needing to prioritize housing above food. While increased food distribution has worked to meet the community need, they noted that families are still anxious about **long wait times** for food and **not receiving enough food** for their family size.<br><br>Stakeholders were particularly concerned about the **Latino/a community** and fear of public charge preventing mixed status households from accessing CalFresh and WIC. Caregivers were particularly concerned about **older adults** who are homebound. |
| **Unemployment and lack of a living wage** | Stakeholders and caregivers were concerned with rising unemployment as a result of COVID-19, as well as individuals in the **service industry** and **agriculture** who are not paid sufficient income to live in Napa. Stakeholders were concerned about the **Latino/a community** that may be in lower paying jobs and experiencing barriers to improving their financial security. Caregivers were primarily concerned with **mixed status families** who do not qualify for unemployment benefits and **older adults** who are living on a fixed income that is too low to cover their basic needs. |

Two other needs were prioritized by stakeholders:

| | |
|---|---|
| **Domestic violence and child abuse/neglect** | Stakeholders were both concerned with increasing domestic violence (DV) and child abuse/neglect during the pandemic, as well as the long-term effects of violence and abuse on individuals' well-being and health. DV and child abuse/neglect was most often discussed in connection with **mental health**. Stakeholders shared a need for more **support services** and **safe housing options** for survivors of DV. The COVID-19 pandemic has increased concerns for these issues because people may be **isolated** in unsafe homes and, with schools closed there is reduced **insight into children's safety** and wellbeing. |
| **Racism and discrimination** | Stakeholders acknowledged that the disproportionate impact of COVID-19 on Black, Brown, Indigenous, and People of Color (BBIPOC), as well as the national call for racial justice have highlighted the need for additional community conversations around racism and inequities. Woven throughout every interview were discussions of health inequities and systemic racism preventing BBIPOC communities, particularly the **Latino/a community**, from accessing opportunities and living their healthiest lives. They also shared discrimination prevents the **LGBTQ+ communit**y from receiving responsive health care and visibility in the community. Stakeholders shared the community needs more **commitment to equity** in all programs and collaboratives. |

**See Appendix 2: Community Input: Qualitative Data**

## Challenges in Obtaining Community Input

Obtaining robust community input during the COVID-19 pandemic was especially challenging and prevented Queen of the Valley Medical Center from completing any in-person conversations. While stakeholder interviews were easily adapted to a virtual setting through a video conferencing platform, it was not feasible to host listening sessions comprised of community members in this same way. While video conferencing does facilitate information sharing, there are challenges creating the level of dialogue that would take place in person. Additionally, due to many community organizations engaging in COVID-19 response, some organizations had limited capacity and were not able to participate in interviews.

# SIGNIFICANT HEALTH NEEDS

## Prioritization Process and Criteria

The Community Benefit Committee served as the oversight committee to identify and prioritize the top health-related needs in Napa County for the subsequent CHIP. Committee members reviewed and analyzed the aggregated quantitative and qualitative data in the CHNA, as well as the needs prioritized by the community stakeholders and caregivers. The Providence St. Joseph Health Data Integration Team presented an in-depth review of publicly available data, internal utilization data, and findings from the stakeholder interviews and caregiver listening sessions. The Community Benefit Committee identified the following list of significant health needs based on the data presentation. Each member then completed an online prioritization survey identifying the top three health-related needs from the following list of significant health needs:

- Access to health care
- Health equity: racial and LGBTQ
- Housing instability and homelessness
- Mental health and substance use
- Economic insecurity
- Food insecurity
- Domestic violence and child abuse/neglect

The following criteria were used in the prioritization process:

- Worsening trend over time
- Disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities
- PSJH service area/high need service area rates worse than state average and/or national benchmarks
- Opportunity to impact: organizational commitment, partnership, severity, and/or scale of need
- Alignment with existing System priorities

The Community Benefit Committee members discussed their ranking choices and refined the language and scope of the health-related needs. The results of the online criteria-based ranking and the subsequent discussion determined the CHIP priorities, which were reviewed and adopted by the committee.

## 2020 Priority Needs

The list below summarizes the rank ordered significant health needs identified through the Community Health Needs Assessment process:

### PRIORITY 1: HEALTH EQUITY – RACIAL & LGBTQ

The disproportionate impact of COVID-19 on Black, Brown, Indigenous, and People of Color (BBIPOC), as well as the national call for racial justice have highlighted the need for additional community conversations around racism and inequities. Health inequities and systemic racism are preventing BBIPOC communities, particularly the Latino/a community, from accessing opportunities and living their healthiest lives. Discrimination also prevents the LGBTQ+ community from receiving responsive health care and visibility in the community. A greater commitment to equity in all programs and collaboratives is warranted.

### PRIORITY 2: HOUSING & HOMELESSNESS

A major and growing community need is around more safe and affordable housing stock, particularly for people with low incomes. A lack of affordable housing leads to over-crowding and poor living conditions. Housing is foundational to all other needs; once people are housed securely, they can address other needs related to their health and wellbeing. Two groups are of particular concern: the Latino/a community and older adults. The housing crisis in Napa highlights racial and economic inequities in the community, disproportionately affecting the Latino/a community, especially mixed status families. There is additional concern for older adults who have few affordable options in the community, particularly those living on a fixed income.

### PRIORITY 3: MENTAL HEALTH & SUBSTANCE USE SERVICES

There is a general lack of mental health and substance use treatment services in the community. School-age children and older adults need more mental health support in the current environment, increasing the demand for services. The Latino/a community is also underserved, especially mixed status families, with the following barriers preventing Latino/a individuals from receiving services: stigma, a lack of culturally relevant education and outreach, and a lack of bilingual and bicultural providers. LGBTQ-friendly mental health providers are also difficult to find in the area. There is limited access to mental health services for individuals who do not meet the high-acuity criteria for severe mental illness at Napa County Health and Human Services, as well as limited substance use disorder treatment options. The COVID-19 pandemic is creating a mental health crisis; people are feeling hopeless, afraid, stressed, anxious, and depressed. The stress from the COVID-19 pandemic is compounding trauma related to local fires.

### PRIORITY 4: ACCESS TO HEALTH SERVICES

There is concern around lack of access to health insurance for mixed status families as well as people losing their insurance due to job loss during the pandemic. A lack of specialists in Napa disproportionately affects individuals on Medi-Cal or without insurance. When individuals are referred to a specialist outside of the area, transportation then becomes a barrier to accessing care. Language barriers prevent Spanish-speaking individuals from receiving responsive care, and virtual interpreters

are not nearly as effective as in-person options. Access to care challenges became especially apparent during the COVID-19 pandemic. While telemedicine has improved access to care for some populations, for others this transition has created additional barriers to care, including lack of smart phones or computers, lack of comfort with technology or stable internet access, language barriers, and lack of private space for appointments. Many individuals do not want to talk to their provider on the phone and are not receiving the care they need.

## Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Department of Public Health, Adventist Health St. Helena Hospital, Federally Qualified Health Center – Ole Health, and Kaiser Medical Clinic. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. For a list of potentially available resources available to address significant health needs see Appendix 3.

**Appendix 3: Resources potentially available to address the significant health needs identified through the CHNA**

# EVALUATION OF 2018-2020 CHIP IMPACT

This report evaluates the impact of the 2018-2020 Community Health Improvement Plan (CHIP). Queen of the Valley Medical Center responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

The 2017 CHNA resulted in the following priorities:

- Mental health
- Substance abuse
- Social determinants of health: housing concerns, economic issues, and access to care

***Table 12. Outcomes from 2018-2020 CHIP***

| Priority Need | Program or Service Name | Results/Outcomes | Type of Support |
|---|---|---|---|
| Social Determinants of Health - Access to Care | Queen's Mobile Dental Clinic | This program provided dental care for children 6 months to 26 years of age from low-income families who are Denti-Cal eligible or are uninsured/underinsured. The mobile dental clinic is one of only 3 providers of oral health services available to children from low-income families with Denti-Cal, no insurance or other low reimbursement insurance. The Queen's Mobile Dental Clinic completed 16,582 clinic visits during the 2018-2020 CHIP time period. | The Mobile Dental Clinic is a St. Joseph Health Queen of the Valley Community Health Investment Program. |
| Social Determinants of Health - Access to Economic Stability | CARE Network | The CARE Network Program provides socio-economic and medical care coordination to low income vulnerable individuals with complex needs. Serving individuals through a continuum of services and supports linked to community-based services, financial assistance and medical resources. A Behavioral Health RN was added to the CARE Network team in 2019. The CARE Network team made 65,853 contacts with community members during the 2018-2020 CHIP time period. | The CARE Network is a St. Joseph Health Queen of the Valley Community Health Investment Program. |
| Social Determinants of Health – | Napa Valley Parent University | Parent University is a learning environment for parents to gain critical parenting and leadership skills to support their child's | Parent University is a collaboration with Napa Valley |

| | | | |
|---|---|---|---|
| Education Equity | | academic success. Classes are bilingual. Parent University made 26,225 contacts with Napa County community members during the 2018-2020 CHIP time period. | Unified School District and a local nonprofit, On the Move. QVMC supports the program with 1 FTE and additional financial support. |
| Mental Health | Mentis<br>CARE Network<br>Healthy Minds Healthy Aging | Increased access to mental health services for low-income and vulnerable individuals. Embedded 1.5 FTE's of behavioral health therapists within Community Health Investment to provide services for complex care clients with positive screens for depression (including 1 bilingual therapist). Therapy and brief case management for older adults was made available to vulnerable community members with positive screens for depression through the Healthy Minds Healthy Aging Collaborative. HMHA provides behavioral health services for complex care clients with positive screens for depression. Mentis programs assisted CHI with making contact with 5,794 sessions and or phone interactions during the 2018-2020 CHIP time period. | Financial Support to embed services within Queen of the Valley Community Health Investment's CARE Network Department and to expand services for the elderly in Napa County. |
| Mental Health | Perinatal Emotional Wellness | Increased access and provided brief counseling and or referrals by a licensed therapist to pregnant and postpartum women screened for depression. A caring, nonjudgmental sounding-board for any thoughts or feelings that concern a client in pregnancy and postpartum.<br>The Perinatal Emotional Wellness program made 1,307 contacts during the 2018-2020 CHIP time period. | The Perinatal Emotional Wellness Program is a St. Joseph Health Queen of the Valley Community Health Investment Program. |
| Substance Use | Napa County Drug and Alcohol<br>McAlister<br>Center Point | Increased access to withdrawal management and residential substance use disorder treatment for individuals referred from QVMC inpatient, ED and CARE Network including highly vulnerable individuals experiencing problems with alcohol and other drugs in a safe supportive environment. | Financial Support for both bed nights and collaboration with community partners to co-locate a Substance Use Navigator within St. Joseph |

| | | | |
|---|---|---|---|
| | | | Health Queen of the Valley's Community Health Investment Program. |
| Housing | Napa Nightingale Medical Respite | Collaboration with Catholic Charities of the Diocese of Santa Rosa's Napa Nightingale Program. Napa Nightingale is the only medical respite shelter program in Napa County. Services are specifically targeted to individuals experiencing homelessness. This program allows individuals recently discharged from local hospitals the opportunity to rest in a safe environment until they are well enough to exit to other housing opportunities. The 11-bed respite shelter provides three meals a day, laundry and shower facilities, case management by QVMC's CARE Network team, and service coordination. | Financial Support and collaboration with QVMC's CARE Network interdisciplinary case management team. |
| Housing | CARE Network / SOAR | CARE Network SSI/SSDI Outreach, Access and Recovery (SOAR) specialists expanded and enhanced the implementation of the SOAR model in Napa County to include participants of Napa's Whole Person Care (WPC) program. The SOAR team identifies and assists adults who are experiencing or are at risk of homelessness and have a mental illness, medical impairment, and/or co-occurring substance use disorders in Napa County by filing complete applications for SSI and SSDI that will be approved in less than 100 days. The CARE Network SOAR team has been integral to housing efforts aimed at the homeless population providing system linkages and case management. | SOAR is a CARE Network program at St. Joseph Health Queen of the Valley within the Community Health Investment Program. SOAR is supplemented by a Napa County Whole Person Care grant. |
| Housing | Heritage House and Valle Verde Housing Projects | Heritage House is an approved housing project that will consist of 66 units of permanent supportive housing dedicated for homeless and very low income individuals. To ensure success of every resident at | Financial commitment for both housing projects in addition to a commitment |

| | | | |
|---|---|---|---|
| | | Heritage House, wraparound services including mental health, drug and alcohol recovery, and self-sufficiency services will be offered. Valle Verde is an approved affordable housing development consisting of 24 units of multi-family apartments designed for low income families | for CARE Network to take part in ensuring the best possible outcome for supportive services at Heritage House. |

## Addressing Identified Needs

The Community Health Improvement Plan developed for the Napa County service area will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how Queen of the Valley Medical Center plans to address the health needs. If the hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions Queen of the Valley Medical Center intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Queen of the Valley Medical Center and community-based organizations in addressing the health need.

# 2020 CHNA GOVERNANCE APPROVAL

This Community Health Needs Assessment was adopted by the Queen of the Valley Medical Center Community Benefit Committee[4] of the hospital on February 18, 2021.

Kevin Klockenga — Date
Region Chief Executive, Northern California

*Sr. Nadine McGuinness, CSJ* 2/19/2021

Sr. Nadine McGuinness — Date
Chair, Community Benefit Committee, Queen of the Valley Medical Center

6/29/2021

Justin Crowe — Date
Senior Vice President, Community Partnerships
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To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email CHI@providence.org.

[4] **See Appendix 4: Queen of the Valley Medical Center Community Benefit Committee**

Sector: Hospital, Community-based Organization, Education, Affordable Housing

# APPENDICES

## Appendix 1: Definition of Terms

**Access to health care services:** The timely use of personal health services to achieve the best health outcomes (excluding oral health and behavioral health care services, which are included in other categories). Health care services include primary care providers, pediatricians, OB/GYN, and specialists. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

**Access to oral health care services:** The timely use of oral health care services to achieve the best health outcomes related to dental care, tooth loss, oral cancer, and gum disease. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system. Access to safe, nearby transportation

**Accessibility for people with disabilities:** The ease with which a person with a disability can utilize or navigate a product, device, service, or environment.

**Affordable daycare and preschools**: All families, regardless of income, can find high-quality, reasonably priced, convenient childcare options for their children birth to five. This includes free or reduced cost daycare and preschools for families that meet certain income requirements.

**Aging problems**: The challenges faced by adults as they age, specifically those over the age of 65, who may experience memory, hearing, vision, and mobility challenges. Adults over the age of 65 make up a larger percentage of the U.S. population than ever before and require specific supportive services related to health care, housing, mobility, etc.

**Air quality**: The degree to which the air is pollution and smoke-free.

**Avoidable Emergency Department Utilization (AED)**: Based on algorithms by Medi-Cal and NYU, PSJH Healthcare Intelligence developed an "AED" flag. This is a list of conditions by diagnostic code that should not require Emergency Department care and are better treated at a more appropriate level of care. Reported at the hospital level and by payor group.

**Behavioral health challenges and access to care**: Includes challenges related to both mental health and substance use disorders, as well as difficulties getting the support services and care to address related challenges. Covers all areas of emotional and social well-being for all ages, including issues of stress, depression, coping skills, as well as more serious health conditions such as mental illness and Adverse Childhood Experiences. Access encompasses issues around insurance coverage, cost of care, timing and availability of appointments, geographic availability, availability of culturally responsive and linguistically appropriate providers, and navigating the complexities of the health care system.

**Bullying and verbal abuse:** Put downs and personal attacks that cause a person emotional harm. Examples include name calling, shaming, jokes at the expense of someone else, excessive criticism,

yelling and swearing, and threats. Specifically referring to instances taking place outside of the home, in places in the community such as school and the workplace.

**Child abuse and neglect**: "Injury, sexual abuse, sexual exploitation, negligent treatment or maltreatment of a child by any person under circumstances which indicate that the child's health, welfare, and safety is harmed."[5]

**Discrimination**: Treating a person unfairly because of who they are or because they possess certain characteristics or identities. Examples of characteristics or identities that are discriminated against include the following: age, gender, race, sexual orientation, disability, religion, pregnancy and maternity, gender reassignment, and marriage and civil partnership.[6]

**Domestic violence**: Also called intimate partner violence, "a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain control over another intimate partner."[7]

**Economic Insecurity**: Lacking stable income or other resources to support a standard of living now and in the foreseeable future.

**Few arts and cultural events**: A lack of representation of different cultures and groups in the community demonstrated through music, dance, painting, crafts, etc.

**Firearm-related injuries**: Gun-related deaths and injuries.

**Food insecurity:** A lack of consistent access to enough good-quality, healthy food for an active, healthy life.

**Gang activity/ violence**: Encompasses the incidence of crime and violence in the community as well as the fear of it, which prevents people from using open space or enjoying their community.

**Health Equity:** A principle meaning that "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups."[8]

**HIV/AIDS:** Acquired immunodeficiency syndrome (AIDS), a chronic potentially life-threatening condition caused by the human immunodeficiency virus (HIV). Refers to challenges addressing the spread of HIV in the community and challenges providing treatment, support, and health education related to HIV and AIDS.

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[5] https://www.dcyf.wa.gov/safety/what-is-abuse

[6] https://www.eoc.org.uk/what-is-discrimination/

[7] https://www.thehotline.org/is-this-abuse/abuse-defined/

[8] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

**Homelessness/ lack of safe, affordable housing:** Affordability, availability, overcrowding, and quality of housing available in the community. Includes the state of having no shelter or inadequate shelter.

**Job skills training**: Occupational training with an emphasis on developing the necessary skills to support and guide individuals in finding jobs that meet their interests and pay a livable wage.

**Lack of community involvement:** Individuals in a defined geographic area do not actively engage in the identification of their needs, nor do they participate in addressing those needs.

**Obesity**: Primarily defined as the health condition in which individuals are sufficiently overweight as to have detrimental effects on their overall health. This does not include issues of exercise or food choices, which are listed as separate issues.

**Poor quality of schools:** Schools that do not provide a quality education to all students regardless of race, ethnicity, gender, socioeconomic status, or geographic location. A quality education is defined as one that "provides the outcomes needed for individuals, communities, and societies to prosper. It allows schools to align and integrate fully with their communities and access a range of services across sectors designed to support the educational development of their students."[9]

**Racism:** "Prejudice against someone based on race, when those prejudices are reinforced by systems of power."[10]

**Safe and accessible parks/recreation:** Issues around a shortage of parks or green spaces, or existing parks/green spaces being poorly maintained, inaccessible, or unsafe.

**Safe streets for all users**: People walking, biking, driving, and using public transportation can generally trust that they are safe on the road. Includes safety features such as crosswalks, bike lanes, lighting, and speed limits.

**Social Determinants of Health:** Conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

**Unemployment/ lack of living wage jobs:** Not having employment or lacking a job that pays the minimum income necessary for a worker to meet their basic needs.

[9] http://www.ascd.org/ASCD/pdf/siteASCD/policy/ASCD-EI-Quality-Education-Statement.pdf

[10] Oluo, Ijeoma. *So You Want to Talk About Race.*

# Appendix 2: Community Input

## INTRODUCTION

Queen of the Valley Medical Center (QVMC) conducted stakeholder interviews and caregiver listening sessions, recognizing the importance of including the voices of community leaders who help make Napa County healthier. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. The stakeholder interviews and caregiver listening sessions are particularly important this CHNA cycle as the COVID-19 pandemic has prevented us from facilitating listening sessions with community members. We relied on community stakeholders to represent the broad needs of the communities they serve.

QVMC included interviews from 19 stakeholders, people who are invested in the wellbeing of the community and have first-hand knowledge of community needs and strengths. They also included 8 listening sessions including 27 Community Outreach Caregivers. These caregivers are Registered Nurses, Social Workers, Community Health Workers, and Community Health Educators who provide direct services to individuals who have low incomes, chronic conditions, and/or are medical underserved. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

## METHODOLOGY

### *Selection*

A total of 8 listening sessions were completed with 27 Community Outreach Caregivers who represent the needs and challenges of the clients they serve. Participants included 6 nurses, 13 Social Workers, 3 Community Health Workers, 3 Community Health Educators, and 2 other licensed staff.

***Apx 2_Table 1. Community Outreach Caregivers Listening Sessions***

| Community Input Type (e.g. Listening sessions, community forum, etc.) | City, State | Date (Month, Day, Year) | Language |
|---|---|---|---|
| Caregiver Listening Session (Nurses) | Napa, CA | June 16, 2020 | English |
| Caregiver Listening Session (Community Health Workers) | Napa, CA | June 16, 2020 | English |
| Caregiver Listening Session (Social Workers) | Napa, CA | June 18, 2020 | English |
| Caregiver Listening Session (Nurses) | Napa, CA | June 18, 2020 | English |
| Caregiver Listening Session (Social Workers) | Napa, CA | June 19, 2020 | English |
| Caregiver Listening Session (Social Workers) | Napa, CA | June 19, 2020 | English |
| Caregiver Listening Session (Community Health Educators) | Napa, CA | June 22, 2020 | English |
| Caregiver Listening Session (LMFT/LCSWs) | Napa, CA | June 24, 2020 | English |

A total of 19 stakeholder interviews were completed by representatives from QVMC. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who are economically poor and vulnerable. QVMC aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was a Public Health Officer from Napa County Public Health.

***Apx 2_Table 2. Community Stakeholder Interviews***

| Organization | Name | Title | Sector |
|---|---|---|---|
| CA Grower's Association | Rebecca Barlow | Executive Director | Health Insurance / Access |
| City of Napa, Housing Division | Lark Ferrell | Housing Manager | Housing & homeless / Gov't |
| Community Health Initiative | Elba Gonzalez | Executive Director | Health Insurance / Access |
| COPE Family | Michele Grupe | Executive Director | Family Resource Centers |
| First 5 Napa County | Joelle Gallagher | Executive Director | Social services |
| LGBTQ Connection | Ian Posadas | Program Director | Education & Social Justice |
| Mayor of American Canyon | Leon Garcia | Mayor | Elected Official |
| Mentis | Rob Weiss | Executive Director | Mental Health |
| Napa City Council | Liz Alessio | City Councilmember | Elected Official |
| Napa Co Office of Education | Barbara Nemko | Superintendent of Schools | Education |
| Napa County HHSA | Jennifer Yasumoto | Director | Government |
| Ole Health/FQHC | Alicia Hardy | CEO | Healthcare Provider |
| On The Move | Alissa Abdo | Executive Director | Education |
| Partnership Health Plan | Dr. Colleen Townsend | Regional Medical Director | Managed Care |
| Puertas Abiertas | Blanca Huijon | Executive Director | Family Resource Centers |

| | | | |
|---|---|---|---|
| Up Valley Family Centers | Jenny Ocon | Executive Director | Family Resource Centers |
| Napa County Board of Supervisors | Diane Dillon | District Supervisor | Elected Official |
| Napa County Public Health | Dr. Karen Relucio | Public Health Officer | Public Health |
| NEWS | Tracy Lamb | Executive Director | Social services (DV svcs) |

### *Facilitation Guide*

Providence St. Joseph Health developed a facilitation guide that was used across all hospitals completing their 2020 CHNAs (see "Stakeholder Interview and Listening Session Questions" at the end of Appendix 2 for full questions):

- The role of the stakeholder's organization and community served
- Prioritization of unmet health related needs in the community, including social determinants of health
- Populations disproportionately affected by the unmet health-related needs
- Gaps in services that contribute to unmet health-related needs
- Barriers that contribute to unmet health-related needs
- Community assets that address these health-related needs
- Opportunities for collaboration between organizations

### *Training*

The facilitation guide provided instructions on how to conduct a stakeholder interview, including basic language on framing the purpose of the interview. Each facilitator was provided a list of questions to ask the stakeholder.

### *Data Collection*

The facilitator conducted all of the interviews using the Microsoft Teams platforms and recorded the interviews with participants' permission.

### *Analysis*

Qualitative data analysis of stakeholder interviews was conducted by Providence St. Joseph Health using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The stakeholder names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each

code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) role of organization, 2) population served by organization, 3) unmet health-related needs, 4) disproportionately affected population, 5) gaps in services, 6) barriers to services, 7) community assets, and 8) opportunities to work together.

The analyst then coded the information line by line. All information was coded and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were groups together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "mental health" can occur often with the code "stigma." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need and the barriers to addressing those needs. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

## FINDINGS FROM COMMUNITY OUTREACH CAREGIVER LISTENING SESSIONS

Community Outreach Caregivers, hereinafter referred to as caregivers, were asked to identify their top five health-related needs in the community. Three needs were mentioned in every listening sessions and were categorized as high priority. Two additional needs were also frequently prioritized and categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs but will also be summarized in its own section.

### *Community Outreach Caregivers: High Priority Unmet Health-Related Needs*

Caregivers were most concerned about the following health-related needs, which were mentioned in every listening session (in order of priority):

1. Homelessness/ lack of safe, affordable housing
2. Access to health care services
3. Behavioral health challenges (includes both mental health and substance use disorder) and access to behavioral health care

**Homelessness/ lack of safe, affordable housing**

Caregivers were primarily concerned with a lack of safe, affordable housing, noting the importance of people having their own safe space and a roof over their head. They were concerned that the high cost of housing in Napa leads to **overcrowding**, with multiple families sharing a small space, and **poor-quality housing** with mold and other hazards that landlords refuse to address.

They shared there are robust services in Napa County to support people experiencing homelessness, which they credit as drawing more people living unhoused to the area. Once in Napa though, there are

few **resources to move people into permanent housing** or keep them housed. They shared people often wait two to three years for low-income public housing and the system does not help people become self-sufficient. Once housed, there are few **case management services** to offer support. Additionally, there are few resources to **prevent homelessness**, such as rental assistance to prevent eviction. Caregivers spoke to having the most resources to support someone who is already experiencing homelessness.

Caregivers emphasized the connection between **housing and health**, noting that people are better able to manage their chronic conditions and mental health challenges when stably housed. Living unsheltered puts additional stress on people's overall health and well-being.

*"The usual factors. I have found again and again and again that if my clients are housed and housed securely that it is so much easier for them to maintain their health, and for me to bring them resources and education to maintain their health."—Community Outreach Caregiver*

*"I go with housing as number one. Some clients have said, 'I can't take care of my health if I don't have housing.' They prioritize their housing before taking care of themselves. That's something that I've heard in multiple times from my clients."—Community Outreach Caregiver*

Caregivers were primarily concerned about the following populations experiencing housing instability:

- **Older adults**: Most groups of listening session participants discussed concerns for older adults and a lack of appropriate, affordable housing. They noted that for older adults on Social Security Income (SSI) and Social Security Disability Income (SSDI), they have difficulty meeting their basic needs. After paying rent, there is typically only a few hundred dollars left in their fixed income, leading to spending tradeoffs. Additionally, people receiving SSI income do not qualify for low-income housing, limiting the support resources available to them. For older adults needing more physical support or memory care, there are even fewer options, with a lack of affordable assisted living options.

  *"They have worked all of their life and I just feel that they're just living paycheck by paycheck. Not paycheck but through the social security, and they cannot even do anything extra because they don't have any money. They hardly have money to survive with the $200 left after they've paid the rent. I just hope that there could be something for all the seniors where they can pay less than what they pay now so they can have a more quality of life. Not worrying so much about just having the necessary money just to cover their food." – Community Outreach Caregiver*

- **Mixed status families:** Families including members with a variety of documentation statuses may not qualify for public housing programs or benefits.
- **Families with low incomes**: There are few affordable options for families with low incomes. These families often have to spend a considerable amount of their income on rent (leading to

housing cost burden), live with other families (leading to overcrowding), or choose poor-quality housing (leading to health and safety concerns).

Caregivers also noted that there are many populations that may have difficulty affording the high cost of rent in Napa County. They shared that even for **middle income earners**, rent can be unaffordable. Other groups that may be unable to find affordable, safe housing are **Transitional Age Youth** and individuals on the **sex offender registry**. **Adults in their 50s who cannot work** are also limited in options as they cannot qualify for senior housing. Additionally, there are a lack of supportive living facilities for people with disabilities, such as people with a **traumatic brain injury.**

*"In the community the lack of affordable housing for even middle income and service job people and elderly people who can't pay the $3,000 or $4,000 a month for like Springs and Redwood Retirement and that new Watermark it's $4,000 a month for a studio apartment there. Just the middle income and people who don't necessarily want to live in a mobile home. There's just nothing out there for seniors. I hear that from a lot of people that I know. Their parents, they're very worried about them."—Community Outreach Caregiver*

They discussed the need to lower the income limits for low-income housing, noting that it is not realistic and does not take into account the SSI fixed income. They also shared the **Vulnerability Index—Service Prioritization Decision Assistance Tool** (VI-SPDAT) is a flawed tool for determining people's housing risk and seems to be more or less accurate depending on the person administering it.

Caregivers discussed seeing a potential increase in homelessness due to the economic effects of the **COVID-19 pandemic**. They were particularly concerned about mixed status families who may not qualify or want to apply for public benefits, such as unemployment insurance. Additionally, overcrowding could contribute to easier spread of the virus. On a positive note, the pandemic has led to increased efforts to temporarily house people experiencing homelessness and has demonstrated that hotels can serve as transitional housing.

**Access to health care services**

Caregivers were concerned that too many people in Napa County experience barriers to accessing needed primary and specialty care. Their primary concern was the **lack of specialists** in Napa, noting that people have to travel to UC San Francisco or UC David, which are far away and create additional **transportation** barriers. Finding a specialist is especially challenging for people with Medi-Cal or lacking insurance, noting sometimes people wait six months to be seen. Additionally, for people with Medi-Cal, their only real **primary care** option is the one local FQHC, Ole Health. Another gap in health care services is tubal ligations, noting they are not available to the community.

Besides transportation, caregivers shared the following barriers to care:

- **Language**: Most listening session groups named language as a major barrier to care, noting a need for more bilingual, culturally responsive providers. They shared there is a need for more in person interpreters who speak the same dialect as the patient, emphasizing a virtual interpreter is not always adequate.

- **Complexity of the health care system:** Caregivers noted a lack of health literacy can make navigating the complexity of the health care system a challenge for many, but especially **older adults** and **people with limited English proficiency**. They noted a need for more support systems in place to help navigate technology barriers, scheduling, and paperwork.

  *"I wish, in a utopia world, that there was somebody that could help seniors negotiate the medical system, just trying to get the doctor appointments, trying to go online, setting up that little website so you can log on and see when your appointment is, and your medical records and information."—Community Outreach Caregiver*

- **Racism and discrimination**: Caregivers shared patients are sometimes afraid to seek care for fear they will experience discrimination or will not be understood by their provider. Being heard and understood goes beyond just language but includes providers who are culturally responsive and compassionate.

  *"Just the fear of doctors or fear of going to people who are providing care because of the fear of being discriminated against or not getting the care that they need because of racial practices that have been moved on generation to generation. Just understanding where those things come from and by teaching the providers to be more culturally competent will provide more care and more quality to the people that we serve, and that will be a service to the populations."—Community Outreach Caregiver*

- **Fear of public charge:** Mixed status families may be afraid to apply for Medi-Cal due to public charge rules.
- **Appointment hours**: People may not always have the flexibility to take off work to visit a provider or they may not be able to afford losing wages.

Due to **COVID-19**, caregivers noted people have diminished access to care and poorer quality interactions with their providers. Seven of eight listening session groups spoke to people having challenges utilizing **telehealth**, whether because of a lack of a phone, computer, Wi-Fi, or comfort with technology. The technology can be too complicated or unfamiliar for people, and others do not have sufficient privacy in their home for an honest conversation with a provider.

*"Most of the doctors or providers are changing into telemedicine so once again the language barrier, access to services like internet or having a smartphone or even a computer puts our low-income families out of that so we have to be creative and figure ways how the clients can communicate with the providers via phone number, or Zoom, or face to face. I think that access to care has changed." —Community Outreach Caregivers*

They shared that for patients with low **health literacy**, describing their problems to a provider over the phone is an additional barrier. Even more complicated, for patients with low literacy or limited English proficiency, reading information and following instructions for a telehealth visit is an additional barrier. Caregivers shared hearing people report having lower-quality interactions with their provider. They have also seen patients receive a **large window of time** for their appointment, meaning people have to wait

by their phone for hours. Caregivers noted sometimes the calls come hours after the scheduled appointment window, causing frustration and missed appointments.

> *"I'm thinking literacy levels. I know information was shared but a lot of our low literacy clients did not comprehend what was going on. There was a lot of confusion, misunderstanding, who do we reach out to or if they were presenting any symptoms which goes-- I'm sorry. I just reminded myself as well to the previous questions, a lot of our clients don't know how to read or write. With telemedicine that complicates them as they don't know how to text or dial numbers or read information as well. Low literacy." —Community Outreach Caregivers*

Caregivers shared many of the people they support do not want to talk to their doctor over the phone and are **opting to wait** until they can be seen in person. This means they are allowing their health condition to go unmanaged and are being seen once they are really sick.

> *"[Care] is not happening. Clients, they don't want to talk to their doctor on the phone. They're not calling. They're calling me with worsening things, and these are my clients. You know there's a whole-- They're the tip of the iceberg and what's happening with the rest of the iceberg of people. They're walking around with conditions that are not being treated." —Community Outreach Caregivers*

They shared they are seeing patients delay **well-child checks** and **vaccine** appointments, creating concern that there will be fallout for decades to come.

**Behavioral health challenges (includes both mental health and substance use disorder) and access to behavioral health care**

Caregivers described a lack of both mental health and substance use disorder (SUD) treatment services in Napa County leading to **long wait lists** for mental health appointments, especially for new patients.

The primary gap in mental health services described by caregivers was **limited access at the county for individuals who do not meet the criteria for serious mental illness (SMI)**. Caregivers described having clients with very serious needs who do not receive the care they need because the short assessment determines they do not fit the criteria.

> *"I think that most of our clients have difficulties accessing mental health services. There's a lot of barriers for our clients, and a lot of stigma surrounding mental health. It's been really difficult for the clients that we feel that would meet criteria and would really benefit from those services, to take them to access, schedule the appointment, sit with them through the assessment, and then we find out that they don't meet criteria because they're not SMI [serious mental illness]. So I think that's been a huge barrier for a lot of our clients" — Community Outreach Caregivers*

Caregivers noted the following community needs for addressing substance use:

- **SUD treatment centers** for patients with Medi-Cal, noting they only have one option now

- **Post-treatment support** and improved transition plans for people once released from a SUD treatment program
- More **Medication-Assisted Treatment** options
- A medical facility for rehab or **medical detox,** explaining people have nowhere to be safely monitored while going through detox
- **Harm reduction programs**, such as a needle exchange

Caregivers noted the following community needs for addressing mental health challenges:

- **Bilingual and culturally responsive providers**: Caregivers emphasized a need for more mental health providers who speak Spanish and can be responsive to other cultures

*"Not having enough Spanish-speaking therapists. For them, this stigma around all that, just having even mental health issues and having someone they feel comfortable enough that will understand also their culture when it comes to mental health."—Community Outreach Caregivers*

- **Mental health crisis services in jail**
- Improved **integration of mental health** conversations into primary care
- **Mental health wraparound services**: They shared a need for purely mental health case management services to help with follow-through and compliance
- **Mental health providers for children**

Caregivers described a **lack of understanding** and **stigma** around behavioral health as barriers to accessing support services. They spoke to the importance of doing more community-based outreach, particularly to the Latino/a community, to help people understand what anxiety and depression are and the benefits of mental health care. They also noted bringing services to people using **mobile outreach** can be useful for normalizing the services and breaking down barriers, particularly for people experiencing homelessness.

Caregivers identified the following populations as needing additional mental health supports:

- **The Latino/a community**: Caregivers were primarily concerned about this population receiving culturally responsive and linguistically appropriate services. They noted mixed status families may not want to or be able to apply for Medi-Cal because of fear related to public charge but may also need mental health supports because of increased anxiety and stress related to employment.

*"I think with mental health it's huge, especially in the Latino community, again, lack of access to bicultural and bilingual providers that understand the culture and understand some of the issues that the community is dealing with." —Community Outreach Caregivers*

- **School-age children**: Caregivers shared a need for more counselors and therapists located in schools, particularly to meet the needs of McKinney-Vento students.
- **Older adults**: This population may experience more isolation and have fewer support networks.

Caregivers shared there are more mental health concerns as a result of the **COVID-19 pandemic**. They were concerned about increased stress, depression, distress, and suicidal ideation. They noted concern for **children at home** in negative environments and **older adults** who are isolated without visitors. Additionally, **mixed status families** may not qualify for public benefits, creating more financial stress and fear.

Caregivers noted **telehealth therapy sessions** do not work for everyone, particularly those without privacy at home. They shared the assessments over the phone for the county mental health services are less effective compared to in person. They also noted concern for people who are not able to participate in SUD support groups who may be lacking their usual community supports.

### *Community Outreach Caregivers: Medium Priority Unmet Health-Related Needs*

Two additional needs were often prioritized by caregivers, although with less frequency and importance than homelessness, access to health care, and behavioral health (in order of priority):

1. Food insecurity
2. Unemployment/ lack of living wage jobs

#### Food insecurity

Caregivers were primarily concerned with increased food insecurity as a result of the **COVID-19 pandemic**. They noted that as people have lost their jobs or wages, they are needing more food resources. The **food bank** has been doing a great job increasing food distribution, but they are stretched thin as it is and asking for financial support, noting that meeting the enormous need is not sustainable. Caregivers were also concerned that a family of 4 or 5 is not receiving sufficient food from food banks to meet their needs.

Other groups have also been working to provide food to the community. **Abode** has been distributing meals to people experiencing homelessness and **schools** have been providing take-away lunches during the school closure.

> *"I think now, well since COVID hit, I know that there's a lot of kids that would get their lunch, their breakfast from school, and so that's been a big issue. A couple of weeks ago, I actually went and volunteered during a lunch distribution at one of the elementary schools and they literally ran out of lunches fifteen minutes into the hour that they were supposed to be there. We had families still driving up and there were no more bag lunches for their kids. I don't know if the school district is going to continue to provide that during the summer but I think that's a huge gap, that especially right now with the pandemic, it has become a lot more visible where more families are needing to access those free food resources."—Community Outreach Caregivers*

Caregivers noted that food insecurity is connected to **obesity** and **diabetes**, sharing the importance of ensuring families have access to healthy and nutritious foods, as they are continuing to see childhood obesity increase.

**Older adults** are also experiencing increased food insecurity, particularly those who may be afraid to leave their house due to COVID-19. Caregivers noted a need for more home food delivery options.

Overall, caregivers explained that there are more food resources to address the current community needs, although there are often **long wait times**, making people nervous they will run out of food. They have seen the school run out of lunches, creating anxiety for families.

One positive though is that families have been able to apply for **CalFresh** over the phone and are being approved faster than before.

**Unemployment/ lack of living wage jobs**

Caregivers shared many people they support do not receive a **living wage**. Particularly due to the high cost of housing, families have little money remaining to meet their other basic needs. They shared even before the COVID-19 pandemic, there was a lack of living wage jobs and families were experiencing **economic insecurity**.

They were primarily concerned about **mixed status families** who have few economic support resources. Mixed status families often cannot access unemployment benefits, and due to fear related to public charge, do not access other public benefits, such as CalFresh.

> *"The undocumented have been affected a lot because they can't access unemployment, or they are afraid to access unemployment. Just financially, they've been struggling to pay their rent and the ends need at the end month." – Community Outreach Caregiver*

> *"It's hard enough for our low-income families that we serve and we try to help, but it's harder for the undocumented because when you have a residency or you were born here, you can apply for different services, but when you're undocumented and your total support is the job that you were laid off, then it is harder. A lot of families, a lot of our families work and live- well, a lot of families live paycheck by paycheck."—Community Outreach Caregiver*

Caregivers were also concerned about **older adults**, particularly those living on a fixed income that is typically not sufficient to meet their basic needs.

Caregivers shared the challenge of the **benefits cliff**, meaning as income increases, public benefits quickly taper off. They shared there is a group of people who make a little too much to qualify for Medi-Cal, but not enough to sustain life in Napa on their income. They shared income is connected to overall **health** and well-being; making a living wage is connected to housing, food security, access to care, and mental health.

Due to the **COVID-19 pandemic**, caregivers have seen increased loss of income and jobs, leading to more people having difficulty paying rent and buying food.

> *"I wanted to add to the lack of income that [another caregiver] brought up and say that that's obviously impacting families' abilities to put food on the table, pay rent. Then we have limited existing financial resources that can maybe help out with a month's worth of rent, but then families are still left struggling to figure out how to make ends meet. Even with the financial assistance that is available, you have to be patient because the wait time*

*to get help and actually get the financial assistance has been taking a lot longer because of the high need." – Community Outreach Caregiver*

New parents are needing supporting buying car seats, baby clothes, and other basics for their children. They are also seeing more people need help applying for unemployment.

### *Community Outreach Caregivers: Effects of COVID-19*

Caregivers shared concerns for how the COVID-19 pandemic has increased **economic insecurity**, leading to increased **housing instability** and **homelessness**, as well as **food insecurity**. They noted the pandemic has demonstrated that hotels can be used as transitional housing for people experiencing homelessness and hope this will influence strategies moving forward.

Caregivers were particularly concerned about the economic effects of the pandemic on the **Latino/a community** and **mixed status families**. They noted that mixed status families do not qualify for unemployment or the stimulus check. Many are experiencing job loss or increased financial instability and lack social safety nets. Due to public charge and fear, many do not feel safe applying for public benefits such as CalFresh.

**Access to care** challenges have increased as a result of the pandemic, with more people delaying care. They noted fewer children are receiving well-child checks and vaccines. Many people are not able to successfully engage in **telehealth** visits with their primary care or mental health provider due to lack of technology, Wi-Fi, comfort, or privacy. Particularly for older adults or people with low health literacy, they may not be comfortable using technology or navigating these new systems. Caregivers described many people opting to wait until they can be seen in person, leading to unmanaged and worseing conditions.

They also shared concerns for increasing **mental health** needs due to more social isolation. They shared they are seeing more stress, depression, and sucicidal ideation, with increased barriers to accessing mental health services. They noted particular concern for older adults isolated at home and children in negative environments.

### *Community Outreach Caregivers Identified Assets*

The following table lists all of the community organizations, programs, or services that were named by Community Outreach Caregivers during the interviews.

***Apx 2_Table 3. Identified Assets by Community Outreach Caregivers***

| Health-related need | Community program, organization, or services (number of times mentioned if more than 1) |
|---|---|
| Behavioral health | COPE (2)<br>Mentis<br>Supportive Outreach and Access to Resources<br>Teens Connect Napa |
| Care Coordination | CARE Network (5) |

| | |
|---|---|
| | Promotoras |
| Collaboratives | Care coordination meetings between service providers<br>Triple P Collaborative |
| COVID-19 Response | Community Organized Relief Effort |
| Domestic Violence and Abuse | Adult Protective Services |
| Education | Napa Valley Unified School District |
| Family and Child Support | California Highway Patrol (car seat support)<br>On the Move (Innovations Community Center)<br>Queen of the Valley Perinatal Program (including parenting classes)<br>UpValley Family Centers |
| Food Security | Community Action of Napa Valley<br>Meals on Wheels<br>Napa Food Bank (4) |
| Health Care | HIV Clinic with Ole Health and Queen of the Valley<br>Napa County Health & Human Services Agency (public health nurses, community aids, Medi-Cal office) (2)<br>Ole Health (5)<br>Oncology Center at Queen of the Valley (nurse navigators)<br>Patient Financial Assistance at Queen of the Valley (2)<br>William's Automotive (recycling durable medical equipment/ rentals) |
| Housing | Abode Housing (4)<br>NEWS Domestic Violence Housing First Program (2)<br>Nightingale Center (3) |
| Resources and Social Services | Catholic Charities<br>Chronicle Season of Sharing Fund (4)<br>Relationship with Probation Offices |
| Services for Individuals Identifying as LGBTQ+ | LGBTQ Connection<br>On the Move |
| Services for the Aging Population | Collabria Care (4)<br>Comprehensive Services for Older Adults<br>Continuum Care Hospice<br>In-Home Support Services Public Authority<br>Molly's Angels (2)<br>Napa Valley Share the Care (4)<br>St. Joseph Home Care Network |
| Services for the Armed Forces | Operation: With Love from Home (supported hospital PPE) |
| Services for the Latino/a Community | Puertas Abiertas (2) |

### *Community Outreach Caregivers: Opportunities to Work Together*

Participants were asked, "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?" Caregivers shared while some

community partners do work well together, they think there is a lot of opportunity to improve collaboration and break down silos. They shared the following components of improved collaboration:

- **Increased communication to improve relationships**: They saw the opportunity to do more networking, particularly between service providers in the community. This helps people know one another and the available community resources.

*"I think something that has helped in our collaboratives here in town has been, if we're working on a collaborative together, that it really doesn't necessarily belong to one particular agency, but that it's really a true community collaborative. I think that makes those efforts stronger. The relationships that are built amongst the people who are collaborating, the agencies that are collaborating, it makes them stronger, too." — Community Outreach Caregiver*

- **Check-ins on shared case management clients**: To improve client care, caregivers noted the importance of collaborating on services, particularly for complex clients. Importantly, having a universal consent would help facilitate easier collaboration. They noted having one consent for Napa County Health and Social Services Agency would be especially helpful.

*"I agree on that last part about universal consent. That could be really frustrating, especially if there's multiple agencies involved. I think it really slows down the process of trying to help somebody else. Universal consent with the county with four different departments would be really, really great." —Community Outreach Caregiver*

- **Identify point people at different organizations**: With staff turnover it is helpful to continue to have a specific person to reach out to at partner organizations. This also helps facilitate improved referrals and follow up.

*"The other thing that's difficult because we work with different agencies. If we don't have like an in with someone, it's hard to communicate. I feel like sometimes we're chasing our tails because we're like, 'Who does that person work with over there? Who is this person?' We're not all coming to the table for the client. We're all stepping on each other's toes and we're just wasting our time, honestly." —Community Outreach Caregiver*

- **Co-locate services when possible**: They advocated for more services co-located to reduce the need for clients to travel between agencies and facilitate improved collaboration.
- **Recognize many organizations are working towards the same goal:** Caregivers emphasized that most organizations in Napa County are working to reach the same goals and building upon this shared vision instead of competing will benefit the community.

*"I think just having strong partnerships, so that we're not all competing for the same funding dollars, we're not competing for the same audience or people being served, I think when we can combine our resources, we can definitely create a larger impact than trying to do it each individually in our own silos." —Community Outreach Caregiver*

*"From my experience working in the community, I feel that all of the agencies work together towards a same goal like we're looking for the well-being of the client or the community. We all tend to work together to help somebody have a better quality of life. From my experience working with the different agencies, I think that we all have the same goal."— Community Outreach Caregiver*

When collaborating, caregivers noted the importance of engaging people with **lived experience** in developing community solutions to ensure that initiatives are community driven.

Caregivers shared the following suggestions of how collaboration could be improved in Napa County:

- **Advocacy on health-related priorities**: Caregivers suggested leveraging resources and combining efforts to work together to advocate for health-related priorities, such as housing.
- **Mental health and primary care**: While somewhat improved, caregivers shared a need to continue to break down the silos between mental health and primary care to better provide whole person care.

*"If we're thinking three years out, the continued breaking down the silos of mental health versus medical care and continuing to join together to take care of the whole person, instead of seeing them as a mental health issue, or that's just, we can't help them because of their medical problems." – Community Outreach Caregiver*

- **Health care/ social services and police departments**: Caregivers suggested integrating a mental health mobile crisis unit into emergency response to better connect community members in crisis to community resources. Additionally, community based organizations can help build trust between the police department and community, improving relationships and people's sense of safety.

## FINDINGS FROM STAKEHOLDER INTERVIEWS

Stakeholders were asked to identify their top five health-related needs in the community. Two needs stood out as universally important to stakeholders and were categorized as high priority. Five needs were also frequently prioritized and categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs but will also be summarized in its own section.

### *Community Stakeholders: High Priority Unmet Health-Related Needs*

Across the board, stakeholders were most concerned about the following health-related needs (in order of priority):

1. Homelessness/ lack of safe, affordable housing
2. Behavioral health challenges (includes both mental health and substance use disorder) and access to behavioral health care

**Homelessness/ lack of safe, affordable housing**

Stakeholders described a "housing crisis" in Napa, which is only being exacerbated by COVID-19. They were primarily concerned with the lack of safe, affordable housing for individuals in the agriculture and hospitality sectors, which generally pay lower wages.

> "As I mentioned, housing being a critical need. Housing that's affordable that doesn't drive people into poverty or people into housing that's just not healthy housing if you will. It's compromised and people have to make compromised decisions based on housing." – *Community Stakeholder*

Key themes that emerged from people's description of housing challenges include the following:

- Housing and homelessness were most often talked about in connection with **unemployment and lack of living wage jobs**, highlighting the strong connection between economic security and housing stability. Housing is expensive and many families with low-incomes live in crowded, sub-standard housing.
- Housing is "foundational" to all other needs. It affects people's mental health, physical health, and overall well-being.

> *"Housing is number one. If you're worried about your housing, then your whole life is under tremendous stress." – Community Stakeholder*

- The housing crisis in Napa highlights racial and economic inequities in the community. Stakeholders were particularly concerned about **people with low incomes**, primarily **Latino/a community members**, who are disproportionately affected by a lack of jobs that pay a living wage and therefore, lack access to safe, affordable housing.

> *"I do believe that there is a lot of inequity in the community. I think that we see our Latinx community over-represented in terms of people who are living in poverty, people who have more limited access to care, people who are renters rather than homeowners, people that have trouble staying housed, for example, finding housing and people who are in low wage positions, for example. I do think that we have a fairly high degree of inequity."- Community Stakeholder*

Besides people with low incomes, stakeholders were also concerned about a lack of housing services for the following populations:

- **Survivors of domestic violence** who may be choosing between homelessness and living in a home with violence
- **Individuals in recovery** who cannot access a substance free shelter
- **Older adults** living on a fixed income who may need supportive services as they age
- **Individuals with chronic health conditions and behavioral health challenges** who need permanent supportive housing to stay successfully housed

Stakeholders identified a few key gaps in community resources that prevent people from accessing safe, affordable housing:

- A lack of affordable housing stock

- Upstream interventions to improve individuals' access to education and workforce development to improve their economic stability
- Rent assistance for individuals at risk of homelessness, particularly during the COVID-19 pandemic
- Shelter spaces for individuals needing a substance free shelter and families

*"Well, I would say clearly that our community has a great need for more affordable housing. I think that it's both a supply issue where we just need more units, as well as that there's the need for rental assistance because the units that are available are often not affordable to people of lower incomes in our community." – Community Stakeholder*

**Behavioral health challenges (includes both mental health and substance use disorder) and access to behavioral health care**

Almost every stakeholder identified behavioral health challenges as an issue that needs to be addressed. They described a growing need for behavioral health services that outpaces the system capacity.

*"Mental health would be one of the top ones, I would say. Interestingly, since COVID broke out, we've had a 58% increase in demand for mental health services. I think that will continue to rise. We couldn't meet the demand even prior to COVID. That's going to be a big, big challenge."- Community Stakeholder*

While they were concerned with both mental health and substance use, mental health was discussed much more frequently. Stakeholders emphasized the **COVID-19 pandemic** has created increased fear, anxiety, isolation, and depression. They discussed several populations and the associated gaps in services:

- **People identifying as LGBTQ+:** Finding mental health providers that are LGBTQ+-friendly is difficult to find in the area. Additionally, LGBTQ+ individuals do not always feel visible, safe, respected, and understood, contributing to mental health challenges.

  *"For students in the communities that are more vulnerable in general… there's a lot more anxiety in the world. There's been more disasters in the world. There's been more political upheaval and hate rhetoric. I think that just amplifies for any community that is less connected to supports and resources and LGBTQ people are one of those folks." – Community Stakeholder*

- **Mixed status families:** Families with members with a variety of documentation statuses experience added fear and anxiety related to immigration status. Stakeholders spoke to the hopelessness many immigrants are experiencing right now due to the political climate and lack of access to safety net services.
- **Young people:** Stakeholders were concerned about bullying in schools, substance use, particularly vaping, and increased isolation and anxiety due to the pandemic. They identified a gap in school-based mental health services, stating there are not enough mental health professionals in schools to support students on the scale that is needed.

*"We've seen a lot more suicide attempts amongst young adults and feelings of fear about reintegration and going back to school. I think mental health is going to be central to our ability to help people get their basic needs met, but then also reintegrate [post- COVID-19] and move into this new reality."- Community Stakeholder*

- **Older adults**: Stakeholders discussed the effects of social isolation for older adults, particularly during the pandemic, which contribute to poor mental and physical health.

*"I would say seniors, because we're trying to protect them, but we're isolating them and probably killing them because of the social isolation."- Community Stakeholder*

Stakeholder spoke to a general need for more behavioral health services and providers in the community. Specific gaps in services include the following:

- **Preventive mental health services for families**: Providing support to parents and preventing Adverse Childhood Experiences (ACEs) is an upstream approach to preventing early trauma
- **Crisis support:** Lacking immediate support intervention outside of the ED
- **Bilingual, culturally responsive mental health and substance use treatment** services, particularly for Spanish-speaking individuals
- **LGBTQ+-friendly mental health providers**
- **School-based mental health services** to meet the growing need

*"When there's a lot of stress in the home, we're finding children at younger and younger and younger ages are exhibiting mental health problems, and schools do not have the resources to provide the mental health services that kids need."- Community Stakeholder*

- **Free counseling services** that are accessible for people without insurance or those with low incomes who cannot afford co-payments
- **Access to SUD treatment:** Medi-Cal clients are often referred to Napa County Health & Human Services for substance use disorder treatment and care. Stakeholders recommended making these services more accessible to the Latino/a community by integrating them better in the community and recognizing that there is some immigration-related fear attached to accessing government services.

*"I'd say that finding mental health care that's affordable, that's available, particularly when you're dealing with someone and this type of a crisis, it can be difficult."- Community Stakeholder*

Barriers include cost of care, long wait times, lack of culturally responsive and linguistically appropriate clients, stigma, and transportation.

*"I'm just thinking about mental health needs. There may be some cultural differences in the way that mental health is perceived and mental health therapy. It might be a sign of weakness for certain cultural groups. It might not be as accepted and there may not be enough for what's needed."- Community Stakeholder*

*Community Stakeholders: Medium Priority Unmet Health-Related Needs*

Five additional needs (priority number 5 includes two needs that tied for importance) were often prioritized by stakeholders, although with less frequency and importance than homelessness and behavioral health (in order of priority):

3. Food insecurity
4. Unemployment/ lack of living wage jobs
5. Domestic violence and child abuse/neglect AND Racism/discrimination
6. Access to health care services

**Food insecurity**

Stakeholders shared food insecurity is a challenge in the community and the need is only exacerbated by COVID-19. Food insecurity is closely linked with **economic insecurity** and **housing instability**; families with low incomes or job loss are forced to make tradeoffs in how they spend their money, sometimes needing to prioritize housing, health care, or other needs above healthy, nutritious food. Accessing these nutritious foods close to home can also be a challenge.

> *"The other mention about access to food, it really is a challenge for many of our families that we talk to, to be able to access nutritious food in their community and because they might have a store that's close to them, that's a 711 or a Kmart or some kind of market but it's food that doesn't provide the nutrition the families are really seeking for their household. A lot of it is linked to their income, right? These are just complex conversations and issues because there's just so many parts to it."- Community Stakeholder*

Stakeholders identified **individuals with low incomes** and the **Latino/a community** as disproportionately impacted by food insecurity. The following themes emerged regarding barriers for individuals to get access to good quality, healthy foods:

- **Fear related to immigration and public charge**: Many mixed status families are choosing not to apply for any public assistance programs such as CalFresh and WIC because of fear their children might be taken away, fear of deportation, or fear of having to repay the benefits. The fear is not new, but it is heightened due to the current administration and the pandemic.

> *"We have a lot of families in our community, especially that aren't documented and mixed immigration status households because you don't necessarily have to be undocumented to feel really afraid to apply for public programs, because of the fear that you might be pursued. The fear that you might get deported, the fear that your children might be taken away, the fear that you might have to repay back the government for applying for public programs because of just the political rhetoric that existed in our times right now and not just recently but for decades now. But people are just really afraid now more than ever and we're seeing that right now people who are eligible for public programs and they refuse to enroll in them and that could be for health insurance, or for programs like CalFresh when I mean public when it comes to food, or the program like WIC as well." – Community Stakeholder*

- **Logistical challenges getting to food banks**: Transportation to a food distribution site, particularly if they have to travel outside of their community, and pick-up hours can be a challenge for families.

### Unemployment/ lack of living wage jobs

Stakeholders were both concerned with growing unemployment as a result of COVID-19, as well as individuals who are working but not paid a living wage. A living wage is defined as the minimum income necessary for a worker to meet their basic needs. Therefore, lack of a living wage was named as a key barrier to addressing almost every other need.

Unemployment and lack of a living wage was most often talked about in connection with **homelessness and housing instability**, **food insecurity**, and **mental health**. Stakeholders spoke to the interconnectedness of these needs, emphasizing the potential domino effect that can start with an individual losing their job. This can lead to difficulty paying rent, forcing families to make spending tradeoffs, contributing to stress and anxiety, and potentially resulting in homelessness.

*"We don't have a fair living wage here in California let alone in Napa. We've got a living wage that isn't a living wage or minimum salary that isn't a living wage. We've got the cost of living. The disparity between both has really increased the working poor and it's also increased our homelessness."- Community Stakeholder*

Stakeholders described a local economy heavily reliant on agricultural and hospitality workers, which are typically considered lower-income jobs. They were particularly concerned about the **Latino/a community** and **mixed status families**.

*"I would also say that with that inequity comes this issue of the lack of living wage jobs. I think that that's critical. We have a very one dimensional economy that is dependent on low wage jobs and that in turn plays out for many people of color in our community."- Community Stakeholder*

Stakeholders shared the following barriers to accessing higher paying jobs and improving financial security:

- Language
- Lack of job-related skills and formal education
- Fear related to immigration status preventing people from applying for safety net resources

*"There's a mismatch between the skills you need for the jobs that will pay you well and the skills that many of our [clients] have, which qualifies them for jobs in the service industry, which is obviously way lower paying."- Community Stakeholder*

### Domestic violence and child abuse/neglect

Stakeholders were both concerned with increasing domestic violence (DV) and child abuse/neglect during the pandemic, as well as the long term effects of violence and abuse on individuals' well-being and health. DV and child abuse/neglect were most often discussed in connection with **mental health**.

*"I would say that a pervasive issue that we see especially in our [mental health] outpatient work is that many of our clients have been exposed to violence in some way or another. It's either domestic violence, physical or sexual abuse, somewhere in that continuum, basically exposed to violence in some way."- Community Stakeholder*

Stakeholders noted that prioritizing interventions to address DV and child abuse/neglect would prevent **Adverse Childhood Experiences (ACEs),** which is a preventative way of addressing mental health challenges, substance use, and chronic diseases.

DV and **homelessness** are also connected, as survivors are sometimes forced to choose between homelessness and remaining in an unsafe home. More support services and **safe housing options** for survivors of DV is a community gap.

*"Living in precarious shelter situations where their housing is dependent on someone who may be abusing them, so fear of leaving that situation, often making a decision between homelessness or living in an abusive relationship, which definitely affects that long term trauma and that toxic stress that they're under has long term health effects."- Community Stakeholder*

Stakeholders were particularly concerned about DV and child abuse/neglect during the COVID-19 pandemic, stating that they believe the incidence of abuse has increased:

- Shelter-in-place mandates have forced people to remain in unhealthy and unsafe homes
- With schools closed, children are isolated at home and educators are unable to identify potentially abusive situations. Children also do not have opportunities to disclose abuse.

*"We're also worried about kids who, when they report abuse, oftentimes they report it at school… and the fact that the kids aren't having an outlet for disclosure is really a big concern of ours."- Community Stakeholder*

**Racism and discrimination**

Stakeholders acknowledged that the disproportionate impact of COVID-19 on communities of color as well as the national call for racial justice have highlighted the need for additional community conversations around racism and inequities.

Woven throughout almost every stakeholder interview were social inequities and systemic racism related to every need:

- **Income and employment opportunities**: Black, Brown, Indigenous, and People of Color (BBIPOC), particularly the Latino/a community, disproportionately work in jobs that do not pay a living wage. Lack of educational and skill-building opportunities prevent people from economic security.
- **Housing**: Due to lack of living wage jobs, Latino/a community members are disproportionately affected by housing instability and poor housing conditions.

- **Access to care**: Lack of culturally responsive and linguistically appropriate caregivers, as well as language barriers navigating systems, prevent people from receiving the high-quality health care they deserve. There is a lack of LGBTQ+-friendly providers.
- **Food insecurity**: Fear related to public charge prevents people from utilizing safety net services, such as SNAP and WIC.
- **Mental health and wellbeing**: Racism, xenophobia, and fear related to immigration take an emotional and physical toll on people, leading to hopelessness, depression, and anxiety. Individuals identifying as LGBTQ+ also experience challenges finding respectful and competent providers, as well as mental health challenges due to discrimination.

In addressing racism and discrimination, stakeholders noted the following needs:

- Conversations related to labor rights
- Community-based safety net services for immigrants who are undocumented
- Commitment to equity in all programs and collaborations
- Culturally responsive and linguistically appropriate providers
- LGBTQ-friendly providers and increased visibility of the LGBTQ community

**Access to care**

Stakeholders shared concerns about mixed status families accessing health insurance and the increasing number of people who are losing their insurance due to job loss. The following populations were named as disproportionately affected by access to care challenges:

- **Mixed status families:** Lack of health insurance and fear accessing health care services related to immigration was a top concern for stakeholders.

*"I would also mention that access to health and healthcare services, in particular for our undocumented adults who don't have access to health insurance, is a real concern in particular in light of COVID now."- Community Stakeholder*

- **School-age children**: Challenges getting to appointments during school hours and an under-utilization of well-child visits was a concern. Stakeholders discussed the potential benefits of having school-based health services.
- **Individuals identifying as LGBTQ+**: A lack of LGBTQ+-friendly providers in the community makes it really challenging for individuals to find respectful and understanding providers, creating fear and potentially harm.

*"We've had providers who have harmed people because they denied their identity or told them that they didn't exist and made people feel very uncomfortable on the worst side of things. On the better side of things, people have felt very invisible. Even if you did a Google search and tried to find a provider who understood LGBTQ people or had experienced, it's extremely difficult to find in our area."- Community Stakeholder*

- **People with limited English proficiency**: A lack of bilingual providers and culturally responsive services in the area, as well as a complex health care system, makes accessing appropriate health care services more difficult.

A variety of barriers exist in the community that prevent people from getting high-quality, timely care:

- Fear related to immigration
- Transportation
- Cost of care, particularly for individuals who are uninsured or underinsured
- Limited number of health care centers that accept Medi-Cal or Medicare
- Appointment times during working hours

> *"Accessing services during work time. I know that a number of people have told us that they will avoid accessing care sometimes because they need to go to work or go to school."- Community Stakeholder*

- Language and cultural barriers

A specific gap named in the community was **a lack of specialty care** in Napa County, leading many people to travel outside of the community, which only exacerbates the barriers named above.

During the **COVID-19 pandemic**, new barriers to care have emerged:

- The digital divide: A lack of technology or broadband, as well as discomfort using technology has prevented individuals from engaging with telehealth services.
- A lack of privacy for virtual appointments: Individuals do not always have a safe and private space to talk openly with providers.

> *"I think for us as health and mental health providers, especially that so much of our work is telehealth, is not everybody's got a safe space to engage in telehealth. I think that's also a barrier and a concern that we need to collectively be addressing with people to make sure not only they have the means to utilize a telehealth relationship or option, but do they have safe space to engage honestly with their medical and their mental health provider and be honest about what their experience is."- Community Stakeholder*

- Increased number of people uninsured: With job loss, some individuals have lost their insurance
- Fear accessing care: Many people have the perception that going to the doctor is not safe, creating a backlog of care and unmanaged conditions.
- Misinformation and confusion: There is a need for better information and outreach, particularly for the farmworker community on how to protect and prepare their families.

### *Community Stakeholders: Effects of COVID-19*

Almost universally, stakeholders spoke to community needs and challenges being "exacerbated" or "magnified" by the COVID-19 pandemic. Inequities in the community were also exacerbated.

> *"Yes. To me, it's not so much a question though of some new need popped up that just hadn't been on our radar. I think, if anything, it's exacerbated the issues across the board,*

*and perhaps exacerbated them in a really fundamental way. If you look at food insecurity, that has just skyrocketed and it's kind of right in your face in the midst of COVID. Housing issues also… it's tied to losses of jobs, that our county has been disproportionately hit because of our hospitality industry."- Community Stakeholder*

The two most common themes when discussing the effects of the pandemic were **mental health** and **unemployment**. Stakeholders were particularly concerned about a growing mental health crisis, sharing that people are feeling hopeless, afraid, stressed, anxious, and depressed. They were concerned about the system's capacity to address the long term effects of the current trauma people are experiencing. They also acknowledged the stress from COVID-19 is compounding trauma related to local fires.

*"I think the biggest point for me is that, within this health pandemic, there is a mental health crisis building. I really do see it. While we have not been overwhelmed yet, I do think the need is going to be pronounced and grow, and here's why: because the COVID pandemic has a traumatizing effect on people, and trauma plays out over a period of weeks and months. For example, when we had the fires, we were still seeing people a year, two years later dealing with the traumatic fallout from the fires. This is going to go on. We don't know how long."- Community Stakeholder*

Stakeholders were concerned about increased unemployment and economic insecurity, contributing to **housing instability, homelessness**, and **food insecurity**, forcing families to make spending tradeoffs. Not being able to meet one's basic needs leads to increased stress and mental health challenges.

Stakeholders shared many communities that have been disproportionately affected by the pandemic. **Latino/a** community members were most often noted, with particular concern for **mixed status families**. Fear of contact tracing for mixed status families is also a noteworthy challenge to COVID-19 testing.

*"I would say, race inequity. When I think of COVID-19 there's a disproportionate impact in our Latinx community. There's a lot of people that live in like tight congregate setting and travel a long distance for work, they travel in cars together, there's also people that are undocumented or, they're afraid to get tested because they're afraid of losing their job if they get sick or losing the ability to pay the rent, so I would say that's one."- Community Stakeholder*

### *Community Stakeholder Identified Assets*

The following table lists all of the community organizations, programs, or services that were named by community stakeholders during the interviews.

***Apx 2_Table 4. Identified Assets by Community Stakeholders***

| Health-related need | Community program, organization, or services (number of times mentioned if more than 1) |
|---|---|
| Behavioral health | COPE (3)<br>Mentis (3)<br>Napa County Mental Health (free mental health appointments) |

| | |
|---|---|
| | Perinatal Substance Use Program |
| Care Coordination | CARE Network (2) |
| Collaboratives | Calistoga Community Schools Initiative<br>Community Leaders Coalition (5)<br>Community Organizations Active in Disaster (7)<br>Intersections Initiative<br>Live Healthy Napa County (6)<br>Monarch Family Justice Center<br>Napa Citizenship Legal Services Collaborative<br>Napa Valley Community Foundation<br>Triple P Collaborative (2) |
| Domestic Violence and Child Abuse | Child Abuse Prevention Council (2)<br>NEWS Domestic Violence and Sexual Abuse Services |
| Education | Napa County Office of Education, special education programs<br>Parent University |
| Family and Child Support | Aldea Children and Family Services<br>Family Resource Center<br>First 5 Napa Network (4)<br>On the Move<br>UpValley Family Centers (2) |
| Food Security | Food bank (3)<br>Meals on Wheels<br>Napa County (support for WIC and CalFresh) |
| Health Care | Community Health Initiative (3)<br>OLE Health (5)<br>Queen of the Valley Hospital |
| Housing | Abode Services and their outreach team<br>Fair Housing<br>Gasser Foundation<br>NEWS Domestic Violence Housing First Program |
| Resources and Social Services | Catholic Charities |
| Services for Individuals Identifying as LGBTQ+ | LGBTQ Connection (2)<br>Rainbow Action Network |
| Services for the Aging Population | Collabria Care<br>Rianda House<br>The Healthy Aging Population Initiative (3) |
| Services for the Latino/a Community | Puertas Abiertas |

### *Community Stakeholders: Opportunities to Work Together*

Participants were asked, "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?" Stakeholders described a very collaborative and generous community.

*"We've got a lot of community generosity and I see that in the small things I do and at a grander scale. I would say that that's where our strength lies is the ability to work together." – Community Stakeholder*

Most shared they are already seeing a lot of great examples of collaboration, the most frequently mentioned being the **Napa Valley Community Organizations Active in Disaster (COAD).**

*"Well, gosh, I think we're just seeing such remarkable collaboration through COAD as an example right now. It's phenomenal quite frankly. When we interact at the county level with people who come in from other counties, folks from the state who get familiar with what's going on here, they're always amazed and impressed by what we've got going on"—Community Stakeholder*

They also noted that their relationships and strong collaborations have proven invaluable in response to fires and COVID-19, making them adaptable and resourceful in challenging times.

*"We have a lot of collaborative partnerships between health care or social services and other sectors that improve the social determinants of health. I think that we work collectively to improve the health of the community. I see this current strength as being adaptive to the COVID-19 response and helping with that as well. For a small county, we're able to handle the needs pretty well compared to other counties. I think it's-- Our strength is in our collaboration." – Community Stakeholder*

Stakeholders shared the following suggestions for improving community collaboration:

- **Create alliances of providers and/or organizations committed to certain causes**: They emphasized bringing together likeminded people/groups to make visible commitments to holding one another accountable. One specific example was bringing together providers committed to addressing inequities in LGBTQ+ health care. This could help organizations be more explicit and visible in committing to efforts and aligning on advocacy for related policies. Being visible, intentional, and accountable on issues important to the community is meaningful.

*"It could be anything where folks commit to not only knowing what's going on but making it easier for the community to access it and then advertising that. We had imagined like buses driving around with ads on it and signage explaining what does this mean that they're committed to this. Then at the actual locations, having visible signage that shows that those places are part of that network and collaborative. It could be for mental healthcare; it could be any of these things that we've been talking about." – Community Stakeholder*

*"I think I said it as part of another answer, but the community tells us that, in general, anyone doing anything LGBTQ on purpose makes a difference or starts to make a difference."—Community Stakeholder*

- **Foster most cross-sector collaboration**: Stakeholders wanted to see more explicit commitments to collaboration that reduces silos and creates more non-traditional collaborations to address broad community needs. They especially thought bringing together government and nonprofit

organizations to build common goals and trust with the community could help address needs. This could also be an opportunity to leverage shared resources. A good example of this type of cross-sector collaboration is the First 5 Napa Network.

*"I think that the continued collaboration, public and private, is really important to try to address the gaps as we see them. Also, because many people that we serve are distrustful, in particular, of government institutions, or have a reticence to come forward. If that's the case, it's those kinds of partnerships where community-based organizations have a different relationship can potentially help reduce access issues and help people get the resources that they need." – Community Stakeholder*

*"For example, when we talked about social determinants of health earlier, we talked about transportation. Transportation isn't a historic thing that a hospital does or a Health and Human Services Agency does. It's part of our community and it's part of our functions that we provide. You built a community, you built an environment, so we need to really be thinking about non-traditional ways of working together and who should be at the table." – Community Stakeholder*

*"When you look at what's going on in our world right now with social and civil unrest, those issues affect all of us. They implicate issues of structural discrimination and historic racism. All of that has to, I think, be addressed in a framework where, again, government, elected officials, non-elected officials, appointed people, hospital leaders, Health and Human Services leaders, behavioral health providers, public works departments, planning departments, really do need to be coming together to figure out how we can map out everything we're all doing and have a broader vision for the community of Napa." – Community Stakeholder*

- **Engage people with lived experience and community members in solutions**: Stakeholders discussed the importance of ensuring those affected by a community challenge have a voice at the table and that decisions are driven by community.

*"I think the message that I want to highlight is that at the end of the day, it's not about one agency. At the end of the day, it's about our community. We all work for that community. We don't even work for a system. We work for our community." – Community Stakeholder*

- **Invest in upstream solutions**: Investments in early development and education and efforts to reduce ACEs have a strong return on investment in preventing future community challenges.

*"I just would say in light of this, some of our traditional health indicators that we're always looking at like obesity and diabetes might not be as pertinent as these broader overarching and really truly the economic hardship that people are going to face. It would be nice if we could think a little outside the box of what is possible for us to do on a community level to really address well-being and quality of life in light of a global pandemic that none of us have [chuckles] had any experience dealing with because there's going to be so many different levels of consequences." – Community Stakeholder*

- **Streamline efforts to reduce duplication and create shared goals and strategies**: Stakeholders shared they consider Napa County to be a small and close community, meaning there is always a need to ensure organizations are working together to achieve change and not duplicating services or working against one another. They shared a need to better align priorities across organizations by engaging in one another's strategic planning processes. Organizations should align along the entire spectrum of a community need. For example, organizations responding to mild to moderate mental health challenges can align with organizations responding to severe mental health challenges. This also allows for shared resources and making the most of funding opportunities.

*"I think we're a small community. There's so much intersectionality between all of these issues, how might we bring the resources, people together, be creative, like I said, I don't have the answers but figure out a way to streamline and more heavily resource. Three entities that are going to carry forth as opposed to spreading these resources pretty thin across multiple initiatives. Then, just in terms of events and activities, making sure that things are not piling on top of each other. We've seen a little bit of this happen as it relates to food distribution for the COVID. There's been multiple food distributions happening on the same day and just ensuring that we all have a commitment to working together, leveraging the resources, staying in our lane. I think that that would be helpful."— Community Stakeholder*

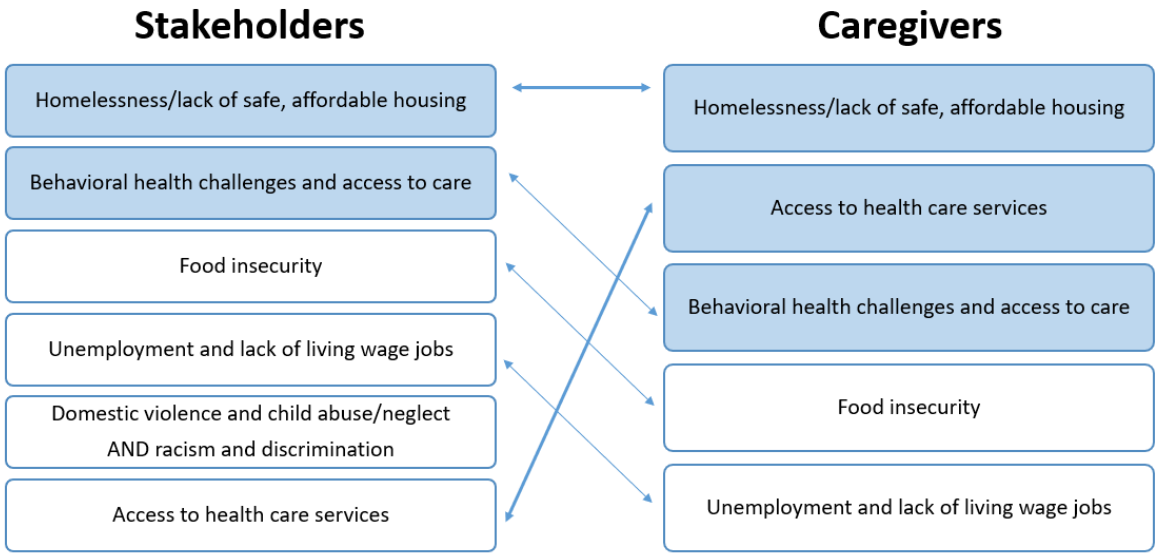
*"I'm not sure that that's the best way to do it but I do get the sense that we are still in some ways duplicating efforts and resources to achieve the same end. There could be better and more strategic ways to leverage what each of us does best in our respective spot on the continuum of health care, but it does start with conversations like this. Like really making sure that as we're looking at our data and our strategy that there's alignment." – Community Stakeholder*

Stakeholders recognized that to address **health inequities** and **social injustices** organizations must align and collaborate. They suggested having more intentional conversations to ensure that equity and social justice are included in all efforts. They also suggested better leveraging data to target services to populations and geographies to address inequities.

### DATA BLENDING

Both stakeholders and Community Outreach Caregivers prioritized homelessness and lack of safe, affordable housing as the most pressing concern in Napa County. They also both frequently prioritized behavioral health challenges. Caregivers emphasized access to health care services as a more pressing challenge than stakeholders. See figure below for a side by side comparison of how stakeholders and caregivers prioritized needs:

***Apx 2_Figure 1. Comparison of Needs as Prioritized by Stakeholders and Caregivers***




Based on the findings above, health-related needs were categorized into the following categories, representing the shared prioritization of both stakeholders and caregivers:

***Apx 2_Figure 2. Shared Priority Needs Based on Community Input***

**Shared high-priority health needs**

- Homelessness/ lack of safe, affordable housing
- Behavioral health challenges and access to care (includes both mental health and substance use disorders)
- Access to health care services

**Shared medium-priority health needs**

- Food insecurity
- Unemployment and lack of living wage jobs

**Other themes from stakeholders**

- Racism and discrimination
- Domestic violence and child abuse/neglect

## LIMITATIONS

While stakeholders were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a stakeholder.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

## STAKEHOLDER INTERVIEW AND LISTENING SESSION QUESTIONS

1. How would you describe your organization's role within the community?
2. How would you describe the community your organization serves? Please include the geographic area.
3. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health, such as housing, transportation, and access to care, just to name a few.
4. Can you prioritize these issues? What are your top concerns*?*
5. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]
6. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
7. Are there specific populations or groups in your community who are disproportionately affected by these unmet health-related needs?
8. Please identify and discuss specific gaps in community services for the persons you serve that contribute to the unmet health-related needs you identified earlier.
9. Please identify and discuss specific barriers for the persons you serve that contribute to the unmet health-related needs you identified earlier.
10. What existing community health initiatives or programs in your community are helpful in addressing the health-related needs of the persons you serve, especially in relation to the health-related needs you identified earlier? Can you rank them in terms of effectiveness?
11. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
12. Is there anything else you would like to share?

| **Question 5: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important).** | | | |
|---|---|---|---|
| | Aging problems (e.g. memory/ hearing/ vision loss) | | Access to oral health care |
| | Air quality (e.g. pollution, smoke) | | Access to safe, nearby transportation |
| | Obesity | | Lack of community involvement |
| | Bullying/ verbal abuse | | Affordable daycare and preschools |

| | | | |
|---|---|---|---|
| | | | |
| | Domestic violence, child abuse/ neglect | | Job skills training |
| | Few arts and cultural events | | Accessibility for people with disabilities |
| | Firearm-related injuries | | Safe and accessible parks/ recreation |
| | Gang activity/violence | | Behavioral health challenges and access to care (includes both mental health and substance use disorders) |
| | HIV/ AIDS | | Poor quality of schools |
| | Homelessness/ lack of safe, affordable housing | | Racism/discrimination |
| | Food insecurity | | Unemployment/lack of living wage jobs |
| | Access to health care services | | Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits) |
| | | | Other: |

# Appendix 3: Community Resources Available to Address Significant Health Needs

Queen of the Valley Medical Center cannot address all of the significant community health needs by working alone. Improving community health requires collaboration across community stakeholders and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

***Apx 3_Table 1. Community Resources Available to Address Significant Health Needs***

| Organization Type | Organization or Program | Description of services offered | Street Address (including city and zip) | Significant Health Need Addressed |
|---|---|---|---|---|
| Homeless Service Provider | Abode Housing Services | Abode Services has been working in Napa County since 2017, operating an emergency shelter and providing outreach, housing support, and rental assistance, as well as managing affordable housing units. | 100 Hartle Ct, Napa, CA 94559 | Housing & Homelessness |
| Hospital | Adventist Health St. Helena Hospital | A faith-based hospital providing a wide range of services, aimed at transforming the health experience of our communities by improving health, enhancing interactions and making care more accessible. | 10 Woodland Rd, St Helena, CA 94574 | Access to Health Care |
| Mental Health Service Provider | Aldea Children & Family Services | The essential community partner for children and families in crisis, Aldea provides Behavioral Health and Social Services to families in need. | 1546 1st St. Napa, CA 94559 | Mental Health |
| Addiction treatment | Alternatives for Better Living | Alternatives seeks to make substance use treatment | 701 School St, Napa, CA 94559 | Substance Use Services |

| | | | | |
|---|---|---|---|---|
| and recovery center | | services more available and accessible, particularly to people with the greatest need and the fewest resources. One-on-one and group sessions provided. | | |
| Health coverage resource center | Community Health Initiative Napa County | CHI works to improve access to health care services through health insurance enrollment, education, advocacy, and resource support. They aim to ensure that all children in our community have access to comprehensive, quality healthcare. | 2140 Jefferson St Ste D, Napa, CA 94559 | Health Equity |
| Children & Family Service Provider | First 5 Napa County | First 5 Napa County supports our community in developing and enhancing coordinated, integrated, and equitable systems that care for, support, educate and respect families and children 0-5 years of age. | 5 1st St<br>Napa, CA 94559 | Health Equity |
| Housing services | Housing Authority of the City of Napa | Administer housing and rental assistance programs for City of Napa residents. | 1115 Seminary St, Napa, CA 94559 | Housing & Homelessness |
| Clinic | Kaiser Health Clinic | Outpatient medical offices for Kaiser patients in Napa County. | 3285 Claremont Way, Napa, CA 94558 | Access to Health Care |
| Community Resource Center | LGBTQ Connection | A multi-county initiative fostering healthy, diverse and inclusive communities, driven by youth and other emerging leaders in Napa and Sonoma counties. The organization is a hub of LGBTQ information and a thriving center of the | 780 Lincoln Ave, Napa, CA 94558 | Health Equity |

| | | | | |
|---|---|---|---|---|
| | | community, aimed toward increasing awareness, visibility & wellness. | | |
| Mental Health Service Provider | Mentis | Dedicated to the emotional health and wellbeing of all Napa County residents, Mentis provides bi-lingual, affordable mental health services to people of every age, stage and income level. | 709 Franklin St. Napa, CA 94559 | Mental Health |
| Government, Safety Net Programs | Napa County Health & Human Services | Napa County HHS provides a wide range of services to the vulnerable residents of the county. Specific needs are addressed through various divisions and teams, including:<br>Alcohol & Drug Services<br>Crisis Stabilization<br>Housing Authority<br>Public Health<br>Self Sufficiency | 2751 Napa Valley Corporate Dr. Napa, CA 94558 | Access to Health Care; Health Equity; Mental Health & Substance Use Services; Housing & Homelessness |
| Clinic, FQHC | Ole Health | Federally Qualified Health Center that provides primary care for youth and adults, optometry and dental care, behavioral health, women's health, pediatric health, nutrition and pharmacy services; primarily serving Medi-Cal beneficiaries throughout all of Napa County. | 1141 Pear Tree Ln Napa, CA 94558<br><br>300 Hartle Ct Napa CA, 94559<br><br>1222 Pine St, A St Helena, CA 94574 | Access to Health Care; Health Equity |

# Appendix 4: Queen of the Valley Medical Center's Community Benefit Committee

***Apx 4_Table 1. Community Benefit Committee Members***

| Name | Title | Organization | Sector |
|---|---|---|---|
| Greg Bennett | Trustee | St. Joseph Health | Finance |
| Jenna Bolyarde | Manager | Abode Housing Services | Housing |
| Angela Carreon | Nurse Practitioner | Ole Health | FQHC / Healthcare |
| Lark Ferrell | Housing Manager | City of Napa, Housing Division | Housing / Government |
| Eva Garcia | Community Member | City of American Canyon | Lived Experience |
| Elba Gonzalez-Mares | Executive Director | Community Health Initiative | Health Insurance/ Access |
| Ed Farver | Trustee | St. Joseph Health | Vintner |
| Amy Herold | Chief Medical Officer | St. Joseph Health | Healthcare |
| Tim Herman | Trustee | St. Joseph Health | Entrepreneur |
| Sr. Nadine McGuinness | Chair & Trustee | St. Joseph Health | Congregation Sisters of St. Joseph of Orange |
| Ian Posades | Program Director | LGBTQ Connection | Education & Social Justice |
| Rosie Perez | Chief Mission Officer | Providence St. Joseph Health | Healthcare, Mission Integration |
| Rev. Linda Powers | Reverend | Covenant Presbyterian Church | Faith-based |

| | | | |
|---|---|---|---|
| Dr. Karen Relucio | Public Health Officer | Napa County Public Health | Government |
| Sr. Christine Schleich | Trustee | St. Joseph Health | Congregation Sisters of St. Joseph of Orange |
| Dr. Colleen Townsend | Regional Medical Director | Partnership Health Plan | Healthcare, Managed Care |
| Rob Weiss | Executive Director | Mentis | Mental Health |
| Jennifer Yasumoto | Director | Napa County HHSA | Government |
| Rachelle Yeates | Chief Mission Officer | St. Joseph Health | Healthcare, Mission Integration |

# Appendix 5: Quantitative Data

## HEALTH INDICATORS SOURCES

***Apx 5_Table 1. Data Sources for Health Indicators***

| Indicator | Data Source |
|---|---|
| **Socioeconomic Indicators** | |
| Median Household Income | County Health Rankings, 2018 |
| Children eligible for free or reduced lunch (enrolled in public schools) | County Health Rankings, 2017-2018 |
| Children in poverty | County Health Rankings, 2018 |
| Veteran status | American Community Survey, 2018 |
| **Physical Environment** | |
| More than 1 occupant per room | American Community Survey, 2018 |
| Severe housing problems | County Health Rankings, 2012-2016 |
| Pollution Burden | California Health Interview Survey, 2008-2012 |
| Air pollution- particulate matter | County Health Rankings, 2014 |
| Violent crimes (rate per 100,000 inhabitants) | County Health Rankings, 2014 and 2016 |
| **Health Outcomes** | |
| Self-reports of fair or poor health (age-adjusted) | County Health Rankings, 2017 |
| Self-reports of fair or poor health (ages 65+) | California Health Interview Survey, 2016 |
| Asthma in children (ages 1-17) | California Health Interview Survey, 2016 |
| Asthma in adults (ages 18+) | California Health Interview Survey, 2016 |

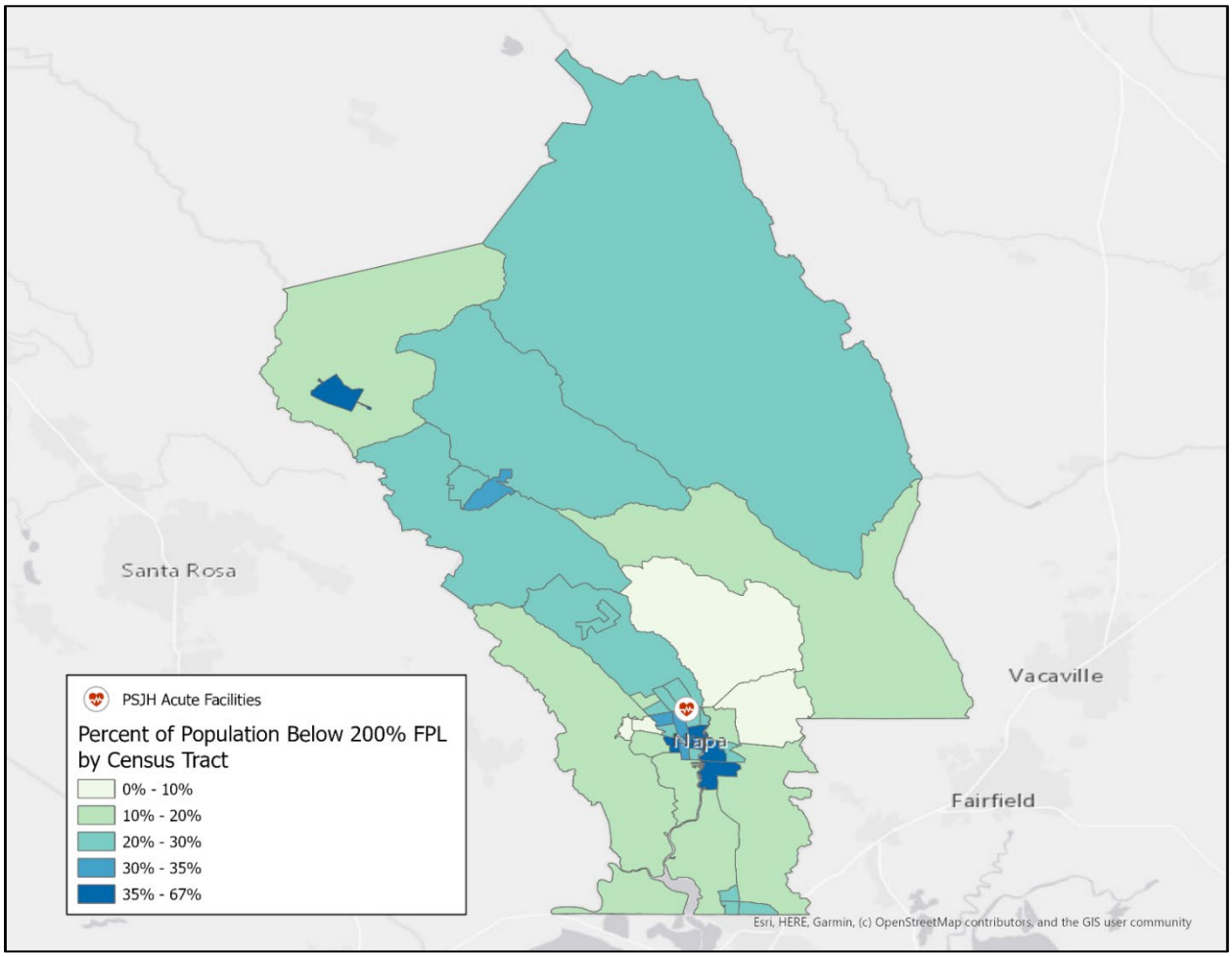
| | |
|---|---|
| Diabetes in adults (ages 18+) | California Health Interview Survey, 2016 |
| Heart disease (ages 18+) | California Health Interview Survey, 2016 |
| Serious psychological distress (ages 18+) | California Health Interview Survey, 2016 |
| **Health Behaviors** | |
| Overweight (ages 2-11) | California Health Interview Survey, 2016 |
| Overweight or obese (ages 12-17) | California Health Interview Survey, 2016 |
| Obese (ages 18+) | California Health Interview Survey, 2016 |
| Sugary drink consumption (ages 18+) | California Health Interview Survey, 2016 |
| Regular physical activity (ages 5-17) | California Health Interview Survey, 2016 |
| Youth alcohol/drug use in the past month (7th grade) | California Health Kids Survey and California Student Survey, 2011-2013 |
| Youth alcohol/drug use in the past month (9th grade) | California Health Kids Survey and California Student Survey, 2011-2013 |
| Youth alcohol/drug use in the past month (11th grade) | California Health Kids Survey and California Student Survey, 2011-2013 |
| Current smoker (ages 18+) | County Health Rankings, 2017 |
| **Clinical Care** | |
| Uninsured (ages 0-17) | County Health Rankings, 2017 |
| Uninsured (ages 18-64) | County Health Rankings, 2017 |
| First trimester prenatal care | California Department of Public Health, 2012 |
| # of people per primary care physician | County Health Rankings, 2017 |
| # of people per non-physician primary care provider | County Health Rankings, 2019 |
| # of people per dentist | County Health Rankings, 2018 |
| # of people per mental health provider | County Health Rankings, 2019 |

## POPULATION LEVEL DATA

***Apx 5_Table 2. Population Below 200% FPL for Napa County Service Areas***

| Indicator | Broader Service Area | High Need Service Area | Napa County |
|---|---|---|---|
| **Percent of Population Below 200% Federal Poverty Level**<br>Data Source: American Community Survey<br>Year: 2019 | 20.2% | 29.3% | 24.6% |

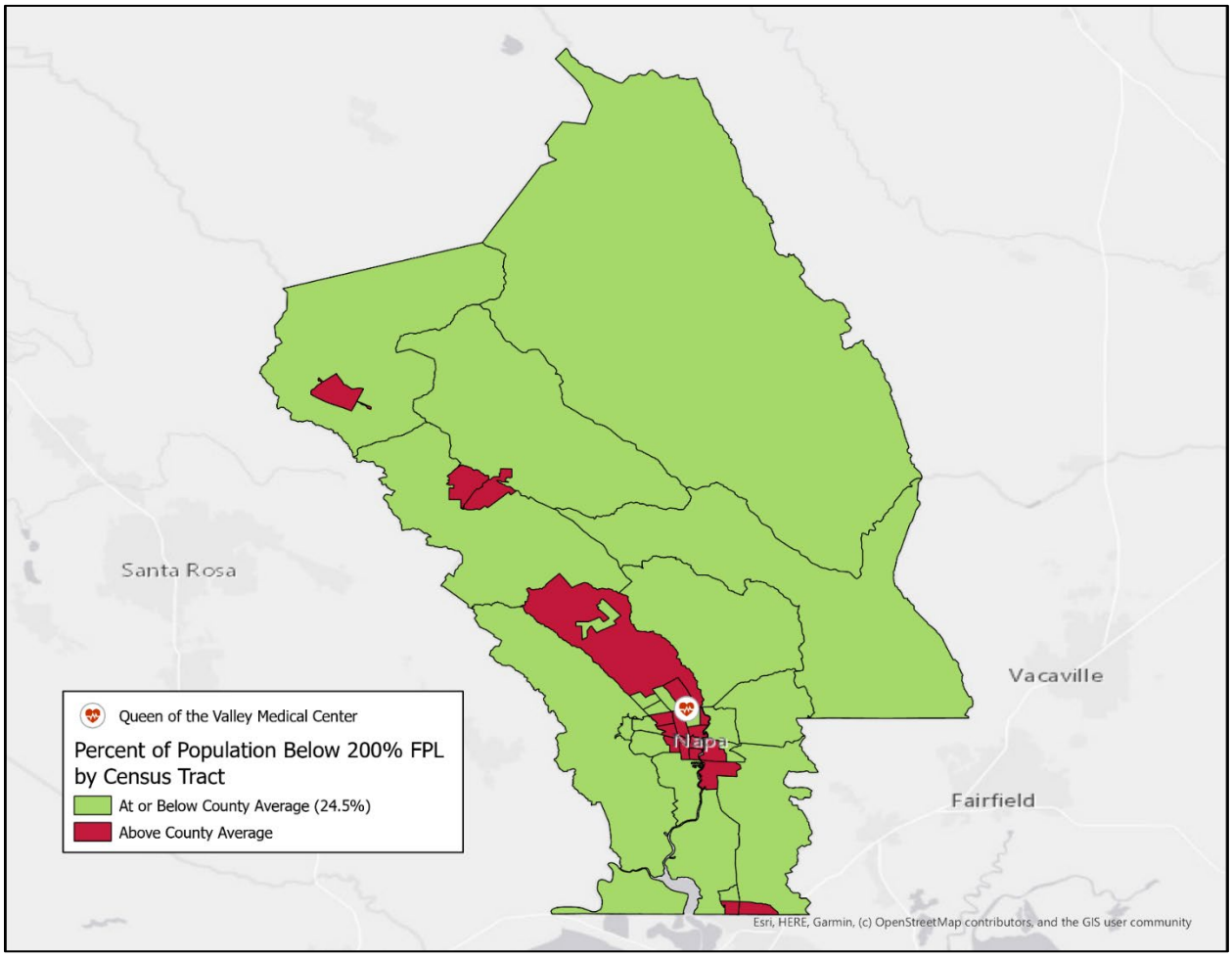
***Apx 5_Figure 1. Percent of Population Below 200% FPL by Census Tract***




- The high need service area for Napa County has a slightly larger proportion of population living below 200% FPL, 29%, compared to Napa County, 25%.
- The gap is even wider between the high need service area, 29%, and the broader service area, 20%, when comparing percent of population living below 200% FPL.

In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red.

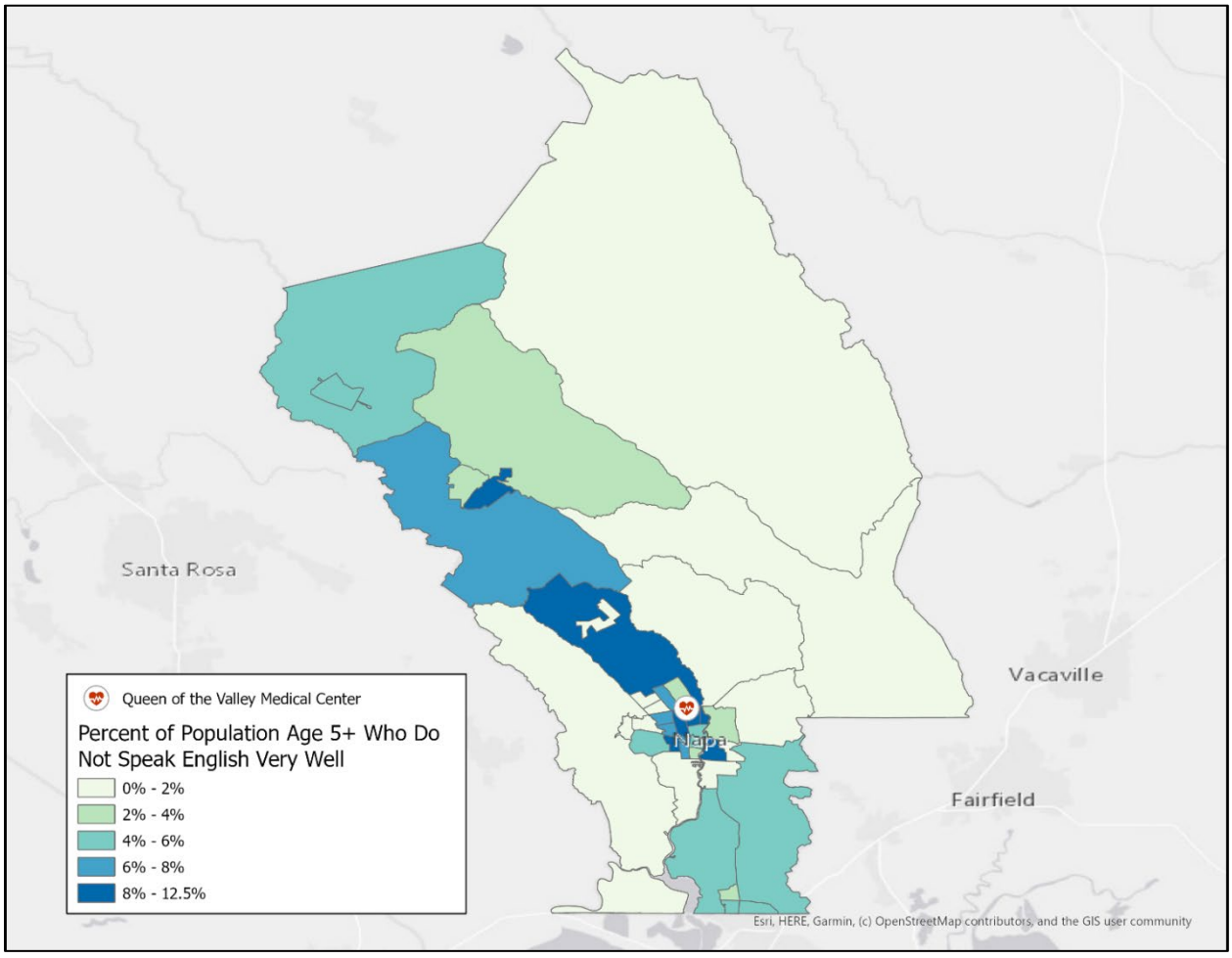
***Apx 5_Figure 2. Comparison of Census Tracts to County Average Based on Percent of Population Below 200% FPL***



***Apx 5_Table 3. Population Age 5 and Older that Does Not Speak English Very Well for Napa County Service Areas***

| Indicator | Broader Service Area | High Need Service Area | Napa County |
|---|---|---|---|
| **Percent of Population Age 5+ Who Do Not Speak English Very Well**<br>Data Source: American Community Survey<br>Year: 2019 | 3.3% | 7.5% | 5.3% |

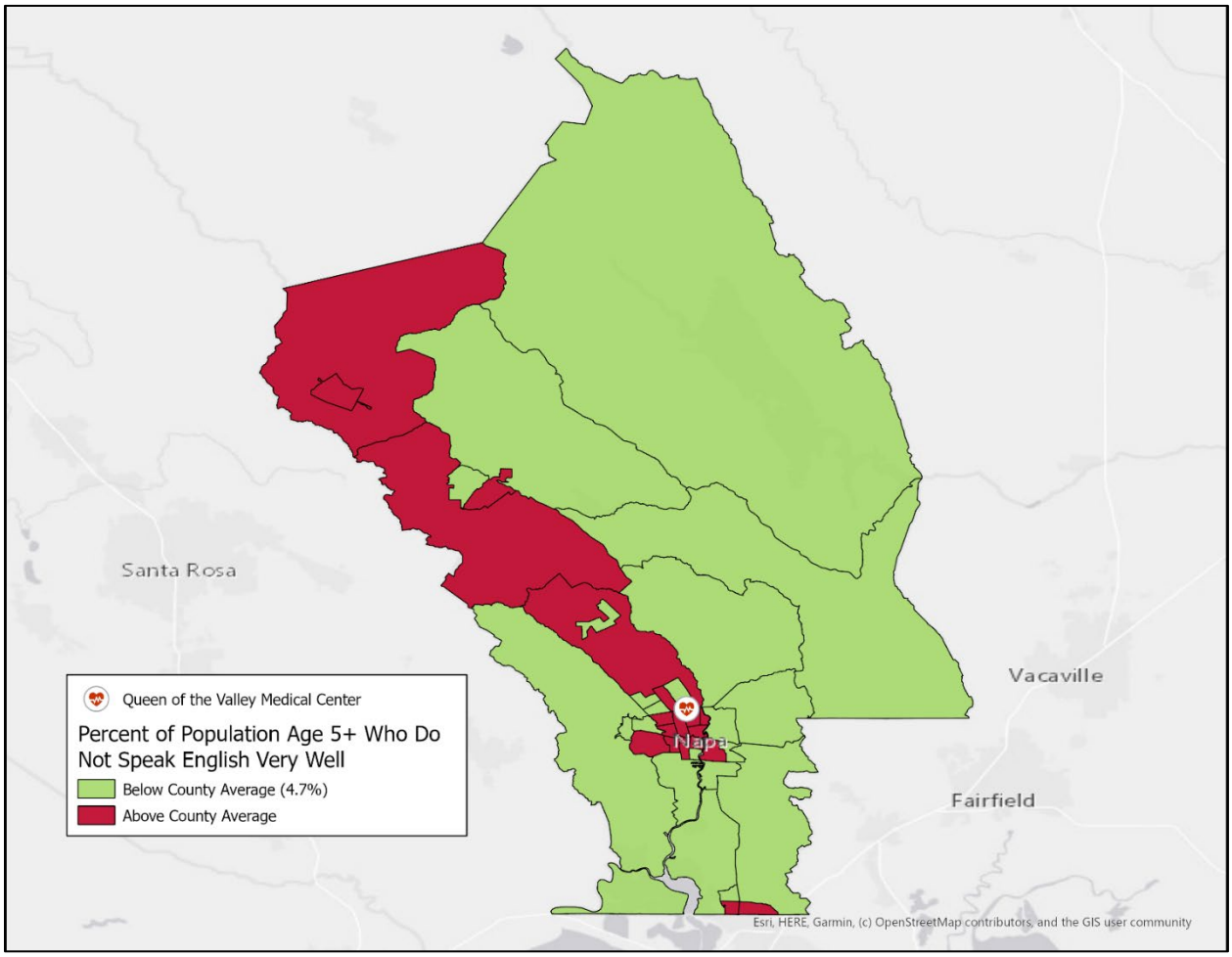
***Apx 5_Figure 3. Percent of Population Age 5 and Older that Does Not Speak English Very Well by Census Tract***




- The high need service area has a higher proportion of population that does not speak English very well, 8%, compared to Napa County, 5%.

In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red.

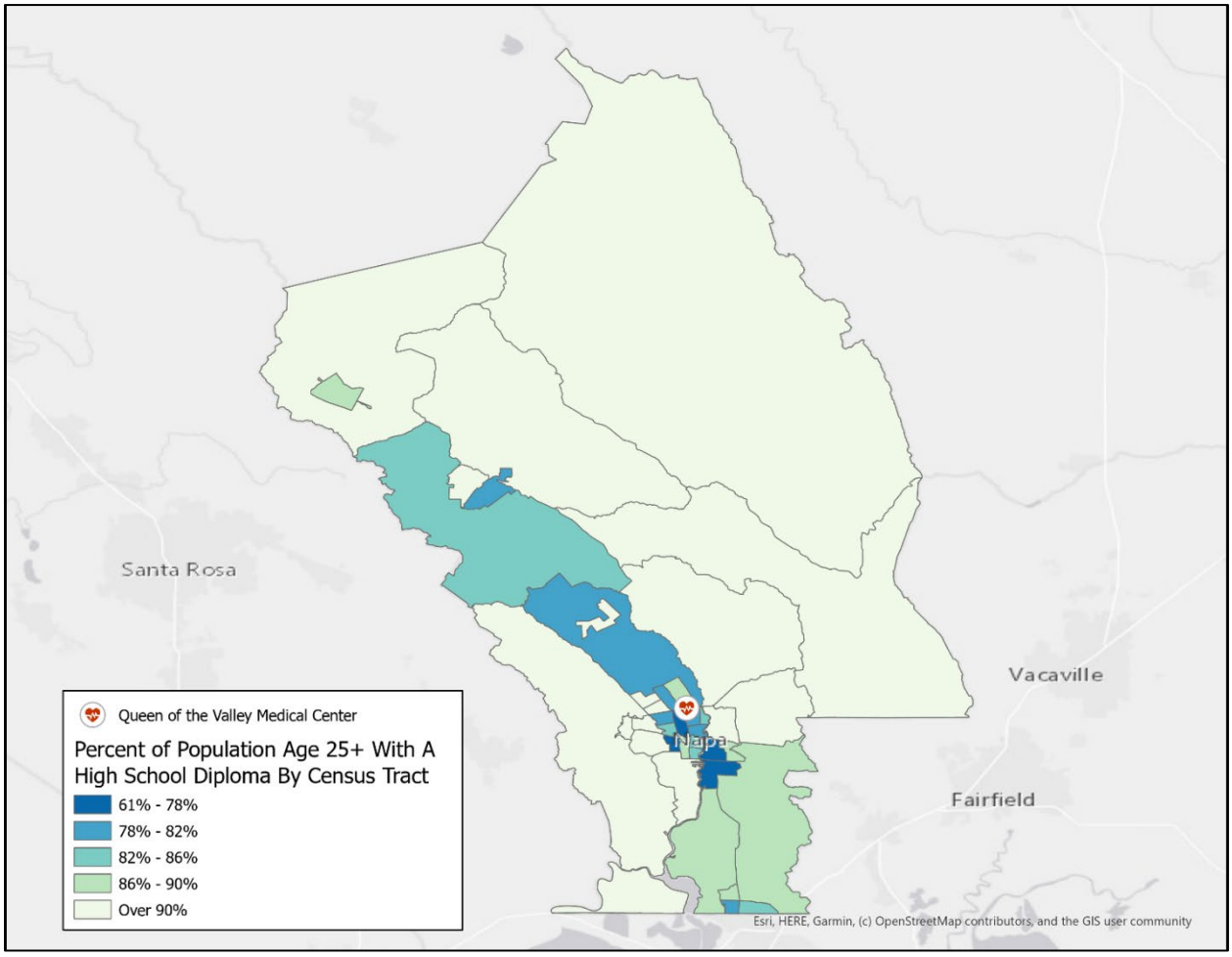
***Apx 5_Figure 4. Comparison of Census Tracts to County Average Based on Percent of Population Age 5+ Who Do Not Speak English Very Well***



***Apx 5_Table 4. Population with a High School Diploma for Napa County Service Areas***

| Indicator | Broader Service Area | High Need Service Area | Napa County |
|---|---|---|---|
| **Percent of Population Age 25+ With A High School Diploma**<br>Data Source: American Community Survey<br>Year: 2019 | 91.2% | 79.8% | 86.0% |

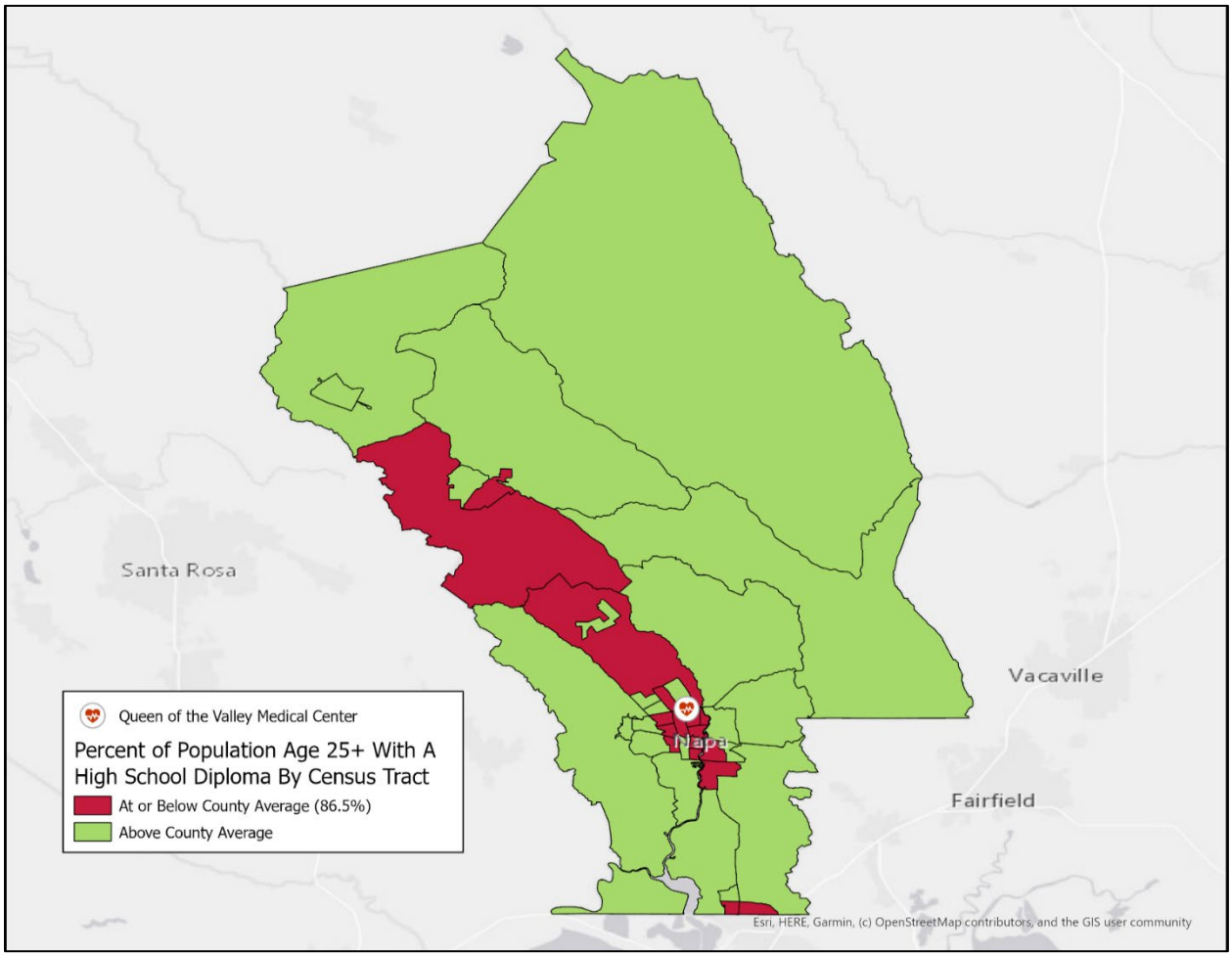
***Apx 5_Figure 5. Percent of Population with a High School Diploma by Census Tract***




- About 80% of people living in the high need service area who are over 25 years have a high school diploma compared to 91% in the broader service area.
- Some census tracts within Napa County have a proportion of less than 75%.

In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red.

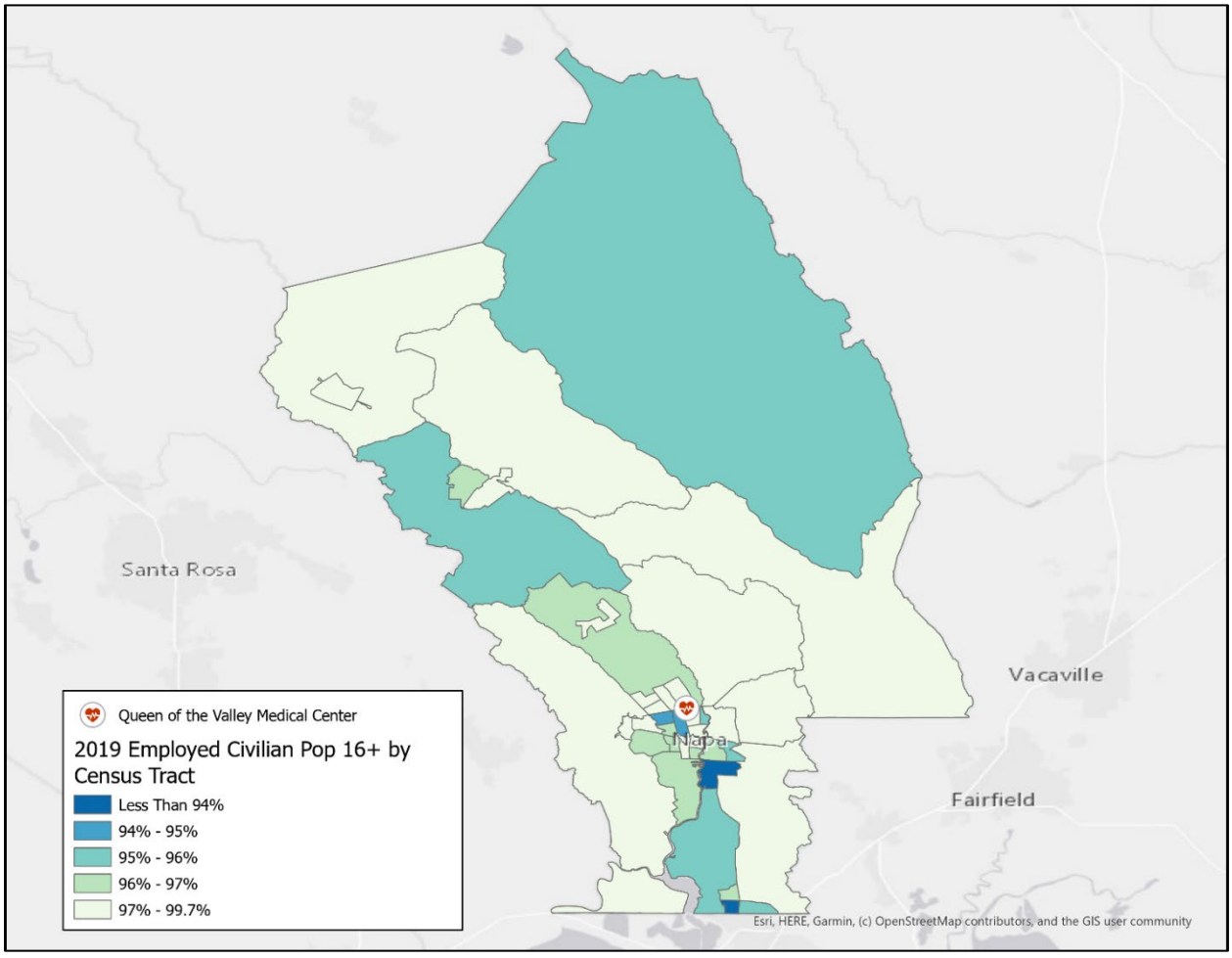
***Apx 5_Figure 6. Comparison of Census Tracts to County Average Based on Percent of Population with a High School Diploma***



***Apx 5_Table 5. Percent of Labor Force Employed for Napa County Service Areas***

| Indicator | Broader Service Area | High Need Service Area | Napa County |
|---|---|---|---|
| **Percent of Population Age 16+ Who Are Employed**<br><br>Data Source: American Community Survey<br>Year: 2019 | 97.9% | 96.0% | 97.0% |

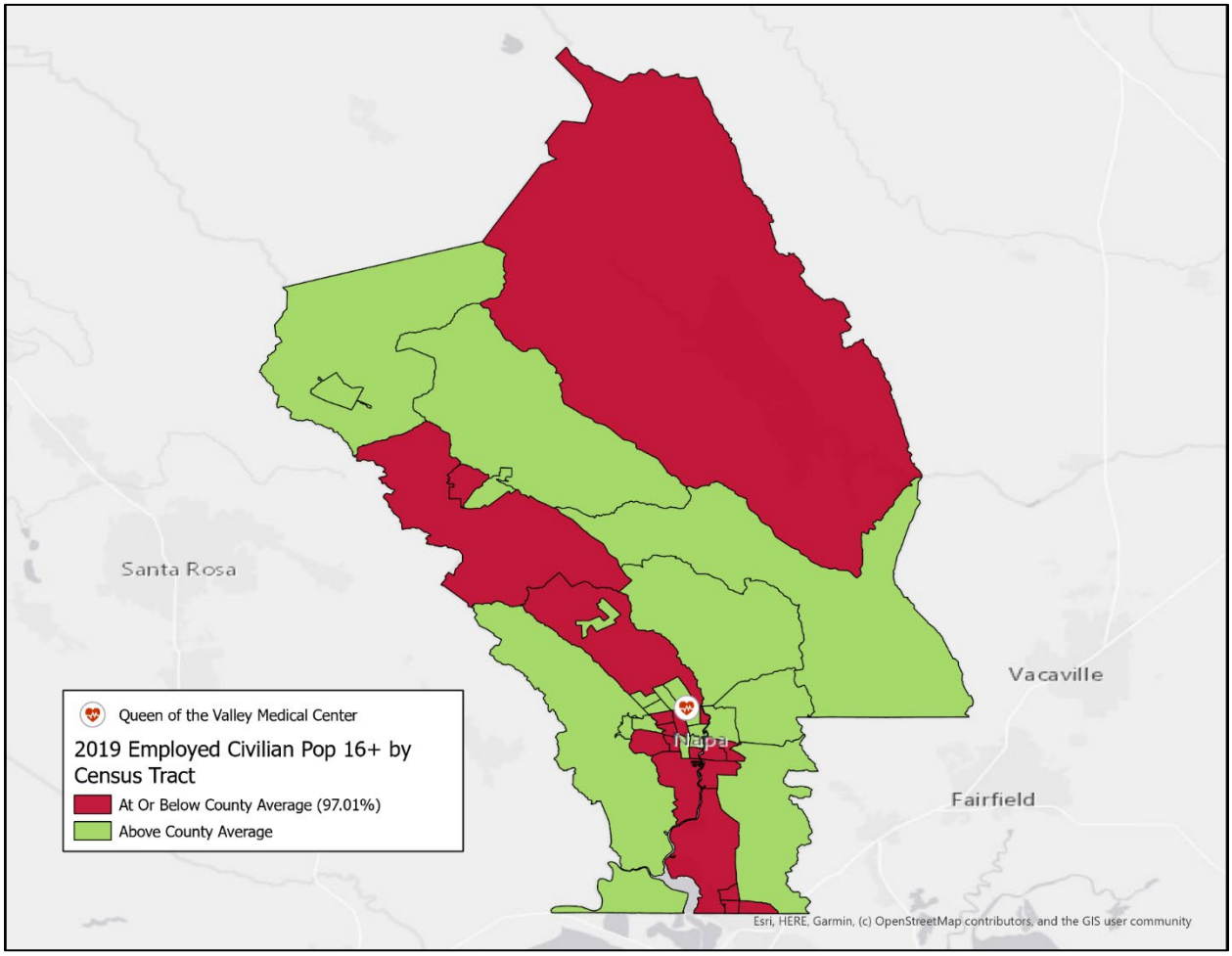
***Apx 5_Figure 7. Percent of Population Age 16+ Employed in 2019 by Census Tract***




- Employment across Napa County is relatively high. All census tracts in Napa County have at least 93% of people age 16+ employed.
- The high need service area has 96% of people employed, compared to 98% in the broader service area.

In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red.

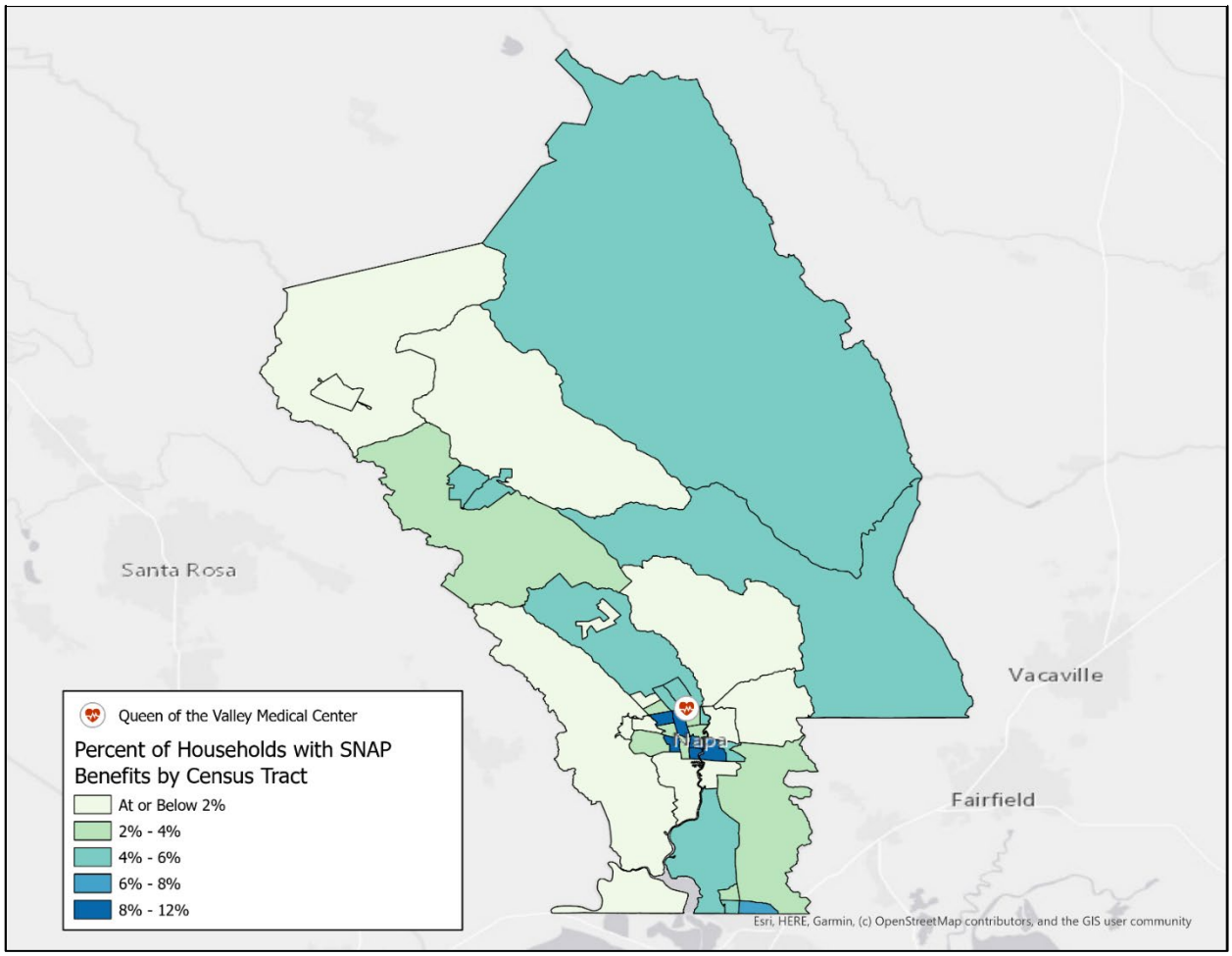
***Apx 5_Figure 8. Comparison of Census Tracts to County Average Based on Percent of Population Age 16+ Employed in 2019***



*Apx 5_Table 6. Percent of Households Receiving SNAP Benefits for Napa County Service Areas*

| Indicator | Broader Service Area | High Need Service Area | Napa County |
|---|---|---|---|
| **Percent of Households Receiving SNAP Benefits**<br>Data Source: American Community Survey<br>Year: Estimates based on 2013 – 2017 data | 2.3% | 6.4% | 4.1% |

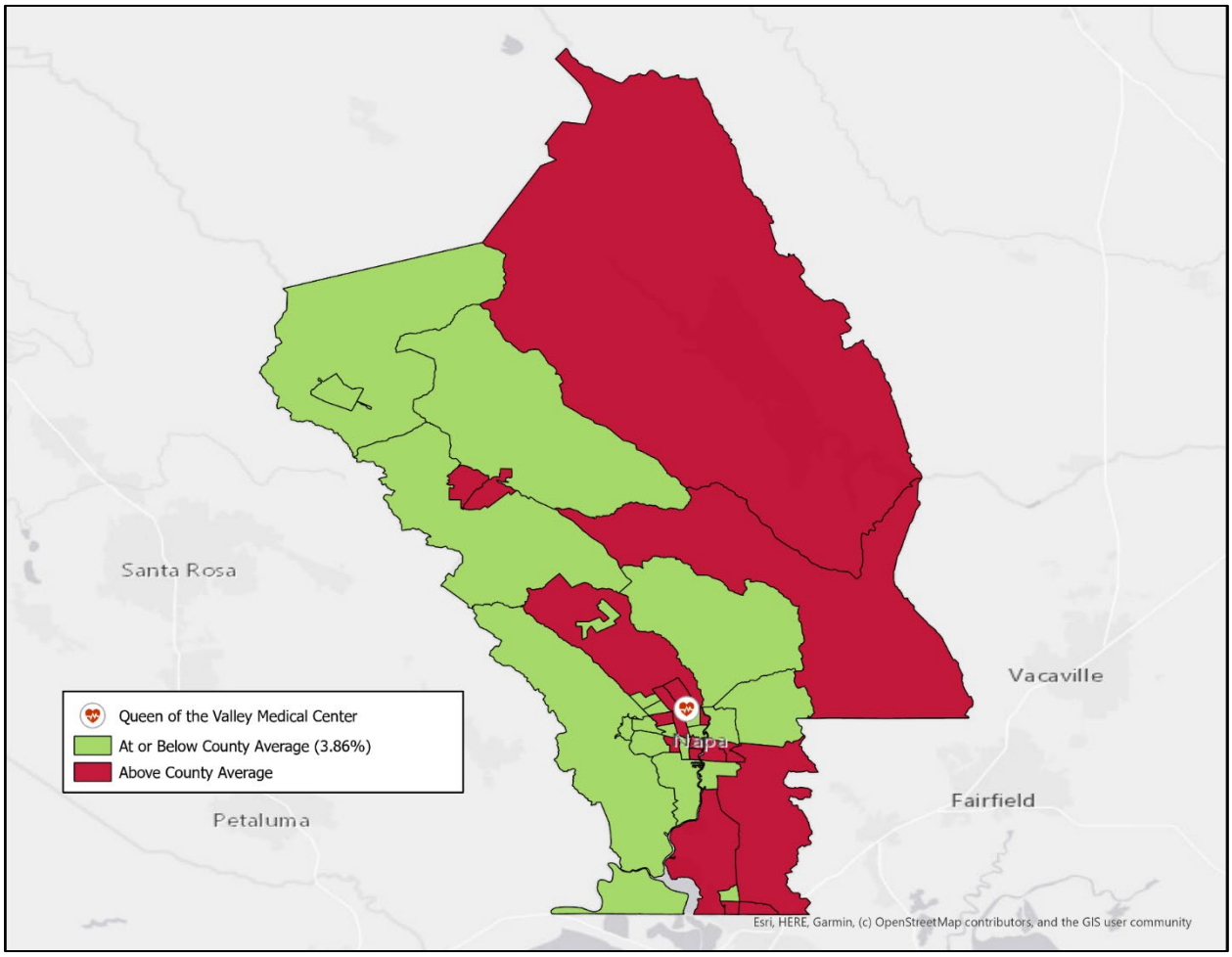
*Apx 5_Figure 9. Percent of Households Receiving SNAP Benefits by Census Tract*




- The high need service has about three times the percent of households receiving SNAP benefits as the broader service area.
- Census tracts near Queen of the Valley Medical Center have percentages of SNAP enrollments almost six times greater than the broader service area's average.

In the map below, census tracts that perform better than the county average are colored in green while census tracts that perform worse are in red.

***Apx 5_Figure 10. Comparison of Census Tracts to County Average Based on Percent of Households Receiving SNAP Benefits***




## HOSPITAL LEVEL DATA

### *Avoidable Emergency Department (AED) Visits*

Emergency department discharges for the year 2019 were coded as "avoidable" per the Providence St. Joseph Health definition for Queen of the Valley Medical Center and nearby PSJH hospitals. Avoidable emergency department (AED) are based on the primary diagnosis for a discharge and includes diagnoses that are deemed non-emergent, primary care treatable or preventable/avoidable with better managed care.

***Apx 5_Table 7. Avoidable Emergency Department Visits by Northern California Ministry***

| Facility | Non-AED Visits | AED Visits | Total ED Visits | AED % |
|---|---|---|---|---|
| Petaluma Valley Hospital | 11,765 | 5,100 | 16,865 | 30.2% |
| Queen of The Valley Medical Center | 16,902 | 8,188 | 25,090 | 32.6% |
| Redwood Memorial Hospital | 7,458 | 4,307 | 11,765 | 36.6% |
| Santa Rosa Memorial Hospital | 23,898 | 12,610 | 36,508 | 34.5% |
| St. Joseph Hospital Eureka | 16,880 | 11,307 | 28,187 | 40.1% |
| **Grand Total** | **76,903** | **41,512** | **118,415** | **35.1%** |

***Apx 5_Table 8. Avoidable Emergency Department Visits by Facility and Race***

| Facility and Race | Non-AED Visits | AED Visits | Total ED Visits | AED % |
|---|---|---|---|---|
| **Queen of The Valley Medical Center** | **16,902** | **8,188** | **25,090** | **32.6%** |
| Asian | 322 | 123 | 445 | 27.6% |
| Black/African American | 399 | 170 | 569 | 29.9% |
| Nat American/Eskimo/Aleutian | * | * | * | * |
| Other | 323 | 156 | 479 | 32.6% |
| Pacific Islander/Nat Hawaiian | 35 | 17 | 52 | 32.7% |
| Unknown | 264 | 109 | 373 | 29.2% |
| White | 15,546 | 7,609 | 23,155 | 32.9% |
| (blank) | * | * | * | * |

*Data suppressed if <10.

***Apx 5_Table 10. Avoidable Emergency Department Visits by Facility and Age Group***

| Facility and Age Group | Non-AED Visits | AED Visits | Total ED Visits | AED % |
|---|---|---|---|---|
| **Queen of The Valley Medical Center** | **16,902** | **8,188** | **25,090** | **32.6%** |
| Under 18 | 2,821 | 1,520 | 4,341 | 35.0% |
| 18 - 44 | 5,800 | 2,897 | 8,697 | 33.3% |
| 45 - 64 | 4,007 | 2,046 | 6,053 | 33.8% |
| 65+ | 4,274 | 1,725 | 5,999 | 28.8% |

***Apx 5_Table 11. Top 5 Zip Codes for Avoidable Emergency Department Visits at Queen of the Valley Medical Center***

| Facility and Top 10 Zip Codes | Non-AED Visits | AED Visits | Total ED Visits | AED % |
|---|---|---|---|---|
| **Queen of The Valley Medical Center** | **16,902** | **8,188** | **25,090** | **32.6%** |
| 94558 | 8,941 | 4,435 | 13,376 | 33.2% |
| 94559 | 3,224 | 1,655 | 4,879 | 33.9% |
| 94503 | 706 | 385 | 1,091 | 35.3% |
| 94599 | 640 | 225 | 865 | 26.0% |
| ZZZZZ | 348 | 359 | 707 | 50.8% |

- The top 10 zip codes made up 88.4% of all emergency department visits in 2019 for Queen of the Valley Medical Center.
- Patients with a zip code of 'ZZZZZ' are typically patients who are experiencing homelessness. Of the 707 ED encounters with a zip code of 'ZZZZZ', 359 of these encounters were classified as an avoidable visit. This population has the highest avoidable visit rate compared to all other zip codes, age groups and races.

### *Prevention Quality Indicators*

Prevention Quality Indicators were developed by the Agency for Healthcare Research and Quality to measure potentially avoidable hospitalizations for Ambulatory Care Sensitive Conditions (ACSCs). ACSCs are conditions for which hospitalizations can potentially be avoided with better outpatient care and which early intervention can prevent complications.

More info on PQIs can be found on the following links:

https://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx

https://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx

Queen of the Valley Medical Center had a below average rate of potentially avoidable hospitalizations in the PSJH Northern California services areas (142.97 per 1,000 compared to an average of 160.05). The top three PQIs for the Queen of the Valley Medical Center were the following:

1. Heart Failure: 42.01 per 1,000 visits
2. Dehydration: 34.35 per 1,000 visits
3. Diabetes Composite (includes uncontrolled diabetes, diabetes short-term complications, and diabetes long-term complications): 24.92 per 1,000 visits

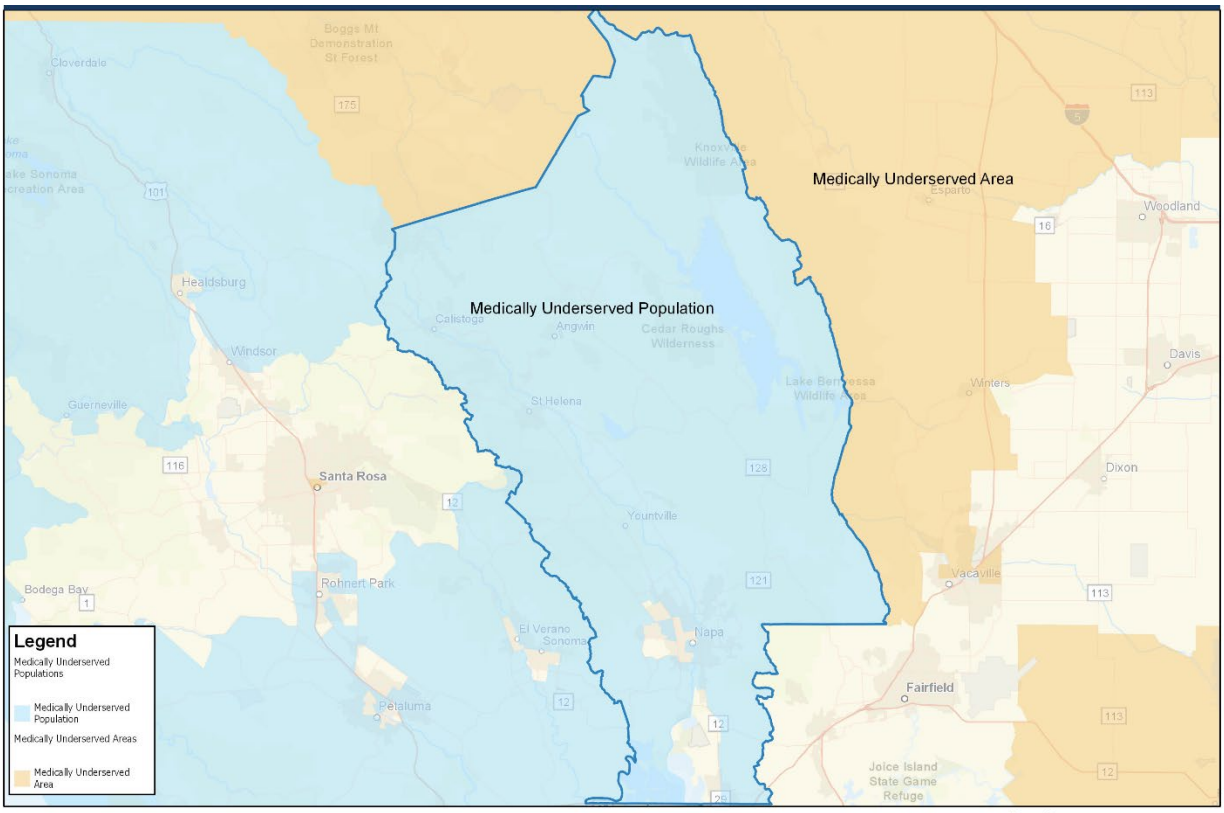
***Apx 5_Figure 11. Napa County HPSA Facilities and Areas***

## MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set and no renewal process is necessary.

Napa County also has a Medically Underserved Population, low income; indicating that people with low incomes in this geographic area have a shortage of primary care health services. The following map depicts the same service area as the HPSA:

***Apx 5_Figure 12. Napa County Medically Underserved Areas and Populations***




See the designation here: https://data.hrsa.gov/tools/shortage-area/mua-find