ST. JOSEPH HEALTH, QUEEN OF THE VALLEY COMMUNITY HEALTH NEEDS ASSESSMENT*

St. Joseph Health
Queen of the Valley

CHNA data was collected in partnership with Kaiser Permanente, St. Helena Hospital and the Napa County Public Health Department

* Updated to align with The Patient Protection and Affordable Care Act (Pub. L. 111-148) which added section 501(r) to the Internal Revenue Code. Section 501(r) imposes new requirements on non-profit hospitals. Section 501(r)(3) requires a hospital organization to conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to meet the community health needs identified through such assessment. The CHNA must (1) take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health and (2) be made widely available to the public. Section 501(r)(3)(B). St. Joseph Health, Queen of the Valley relied on Notice 2011-52: *Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals* to meet the requirements.

St. Joseph Health, Queen of the Valley
Community Health Needs Assessment

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EXECUTIVE SUMMARY

For over fifty years St. Joseph Health, Queen of the Valley (referred in this document as Queen Medical Center (QVMC)) has been a vital resource and integral part of the Napa Valley community. A full service acute care 191-bed medical center, Queen of the Valley employs approximately 1,509 employees. The medical center is located within the City and County of Napa, and is the major diagnostic and therapeutic medical center for Napa County and the surrounding region.

Whereas Queen of the Valley Medical Center's primary and secondary service areas (PSA and SSA) include locations outside of Napa County, the community benefit primary and secondary service areas are defined by the geographic boundaries of Napa County. In general, the county is divided into four regions: North County consisting of Calistoga, St. Helena, Deer Park, Rutherford, and Oakville; East County consisting of Angwin, Pope Valley, and Lake Berryessa; Central County consisting of Napa and Yountville, and South County consisting of American Canyon. Approximately 69% of all county residents live in the City of Napa while the remainder lives in the balance of the county. While Napa is not considered a "poor" county relative to other counties, including those with large agricultural areas, about 11.3% of children and 7.2% of seniors age 65+live below the poverty level. Many more live below 200% of poverty. Twenty-five percent of households speak Spanish as their primary language. An estimated 18,000 are not U.S. citizens; this can swell during the growing season.

St. Joseph Health, Queen of the Valley's Community Health Needs Assessment[1] is a result of a communitywide partnership between St. Joseph Health, Queen of the Valley, Kaiser Permanente, St. Helena Hospital and the Napa County Public Health Department. The 2010 Napa County Community Health Needs Assessment was a combined collaborative of area hospitals (Queen of the Valley Medical Center, Kaiser Permanente, St. Helena Hospital) and the County Public Health Department.

Priority Community Health Needs identified through engagement with community stakeholder include initiatives to address:

1. Childhood obesity prevention
2. Access to dental care particularly for low income children
3. Behavioral health services for low income adults, older adults and all pregnant women
4. Chronic disease management for low income adults and older adults
5. Community health/prevention education and health literacy

Services will primarily be directed toward those with disproportionate unmet health needs and address access barriers such as language and transportation. In addition, a commitment to partnerships for community health improvement will focus on collaborative governance, community assessment, and systems and policy improvement.

[1] Section 501(r)(3) requires a hospital organization to conduct a community health needs assessment (CHNA) every three years and adopt an implementation strategy to meet the community health needs identified through such assessment. The CHNA must (1) take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health and (2) be made widely available to the public. Section 501(r)(3)(B). St. Joseph Health, Queen of the Valley relied on Notice 2011-52: *Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-Exempt Hospitals* to meet the requirements.

MISSION, VISION AND VALUES

Our Mission
To extend the healing ministry of Jesus in the tradition of the Sisters of St. Joseph of Orange by continually improving the health and quality of life of people in the communities we serve.

Our Vision
We bring people together to provide compassionate care, promote health improvement and create healthy communities.

Our Values
The four core values of St. Joseph Health- Service, Excellence, Dignity and Justice are the guiding principles for all we do, shaping our interactions with those whom we are privileged to serve.

INTRODUCTION

St. Joseph Health, Queen of the Valley (referred in this document as Queen Medical Center (QVMC) has been a vital resource and integral part of the Napa Valley community. A full service acute care 191-bed medical center, Queen of the Valley employs approximately 1,509 employees. The medical center is located within the City and County of Napa, and is the major diagnostic and therapeutic medical center for Napa County and the surrounding region. We recognize and embrace the social obligation to create, collaborate on and implement programs that address identified needs and provide benefits to the communities we serve. Our mission guides us to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance.

Key medical center services include a community cancer center accredited by the American College of Surgeons with commendations, regional heart center, robotic and minimally invasive surgery center, acute rehabilitation center, women's health center, and the area's only neonatal intensive care unit. The Queen is committed to community wellness and is one of the first acute care providers to successfully develop and implement a medical fitness model Community Wellness Center on the medical center campus.

Since its beginning, Queen of the Valley Medical Center extended its role far beyond the traditional medical model and has dedicated itself to serving as a catalyst in promoting and safeguarding the health of the community. We continue our commitment to work collaboratively as a key community partner to enhance the health and quality of life for Napa County's most vulnerable communities. The health of our community depends on the creation and maintenance of strong physical and social structures, which promote and contribute to the wellbeing of those who live in Napa County. I

Recent initiatives have addressed dental care for underinsured children, chronic disease management, childhood obesity, access to mental health services for at-risk adults, health literacy for Spanish-speakers, and healthy aging policies and programs. Community Outreach works in concert with community partners to expand access, leverage resources and address broad community concerns.

COMMUNITY

Definition of The Community Benefit Service Area

Whereas Queen of the Valley Medical Center's primary and secondary service areas (PSA and SSA) include locations outside of Napa County, the community benefit primary and secondary service areas are defined by the geographic boundaries of Napa County. In general, the county is divided into four regions: North County consisting of Calistoga, St. Helena, Deer Park, Rutherford, and Oakville; East County consisting of Angwin, Pope Valley, and Lake Berryessa; Central County consisting of Napa and Yountville, and South County consisting of American Canyon. Approximately 69% of all county residents live in the City of Napa while the remainder lives in the balance of the county. While the population of Napa County increased overall since 2000, the city of American Canyon has nearly doubled in size and is already the second-largest city in Napa County. Services for residents in this area are still being established—and various community agencies continue to work to understand what individuals and families in this expanding community need.

While Napa is not considered a "poor" county relative to other counties, including those with large agricultural areas, about 11.3% of children and 7.2% of seniors age 65+live below the poverty level. Many more are live below 200% of poverty. A greater proportion of children live in poverty in the cities of Napa (14.9%), Anguin (11.9%), Yountville (17.8%) than in other cities in the county. Twenty-five percent of households speak Spanish as their primary language. An estimated 18,000 are not U.S. citizens; this can swell during the growing season. With 15% of the population is over 65 years of age, Napa County has a higher proportion of older adults compared to California as a whole and the third highest proportion of those 75 and older. 22.5% of the population is 17 years of age and younger. Nearly 58% of the population is White, 31.8% are Latino, 6.15% are Asian, 1.87% are African American, 3.62% are other. (Source: Community Benefit Service Area Mapping of Need, St. Joseph's Health System, February 2011)

Community Benefit is characterized as programs or activities that promote health and healing in response to identified community needs. In order to accurately define community need, we used the Community Need Index define community need.

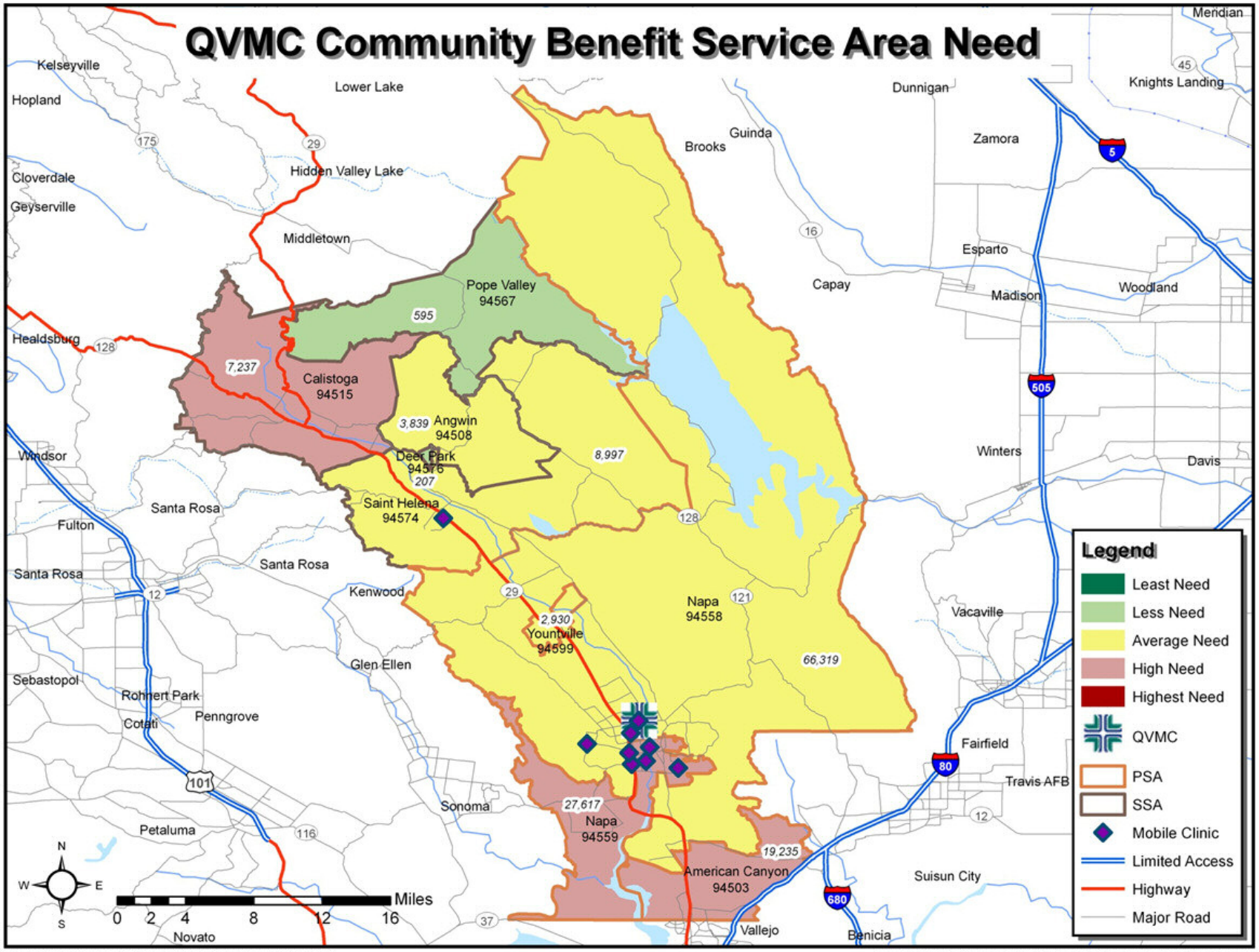
The Community Need Index (CNI) was developed by Dignity Health and Solucient (an information products company). CNI aggregates five socioeconomic indicators that contribute to health disparity (also known as barriers). Barriers include: Income; elder poverty, child poverty and single parent poverty; Culture, non-Caucasian limited English; Education, % population without HS diploma; Insurance, unemployed and uninsured; and Housing, renting percentage.

CNI demonstrates need at the zip-code level where each zip is assigned a score from 1 (low need) to 5 (high need) for each barrier. For barriers with more than one measure, the average of the measures is used as the barrier score. Once each zip code is assigned a score from 1 to 5 for each of the five barriers, the average score is calculated to yield the CNI.

Color-Coded Maps

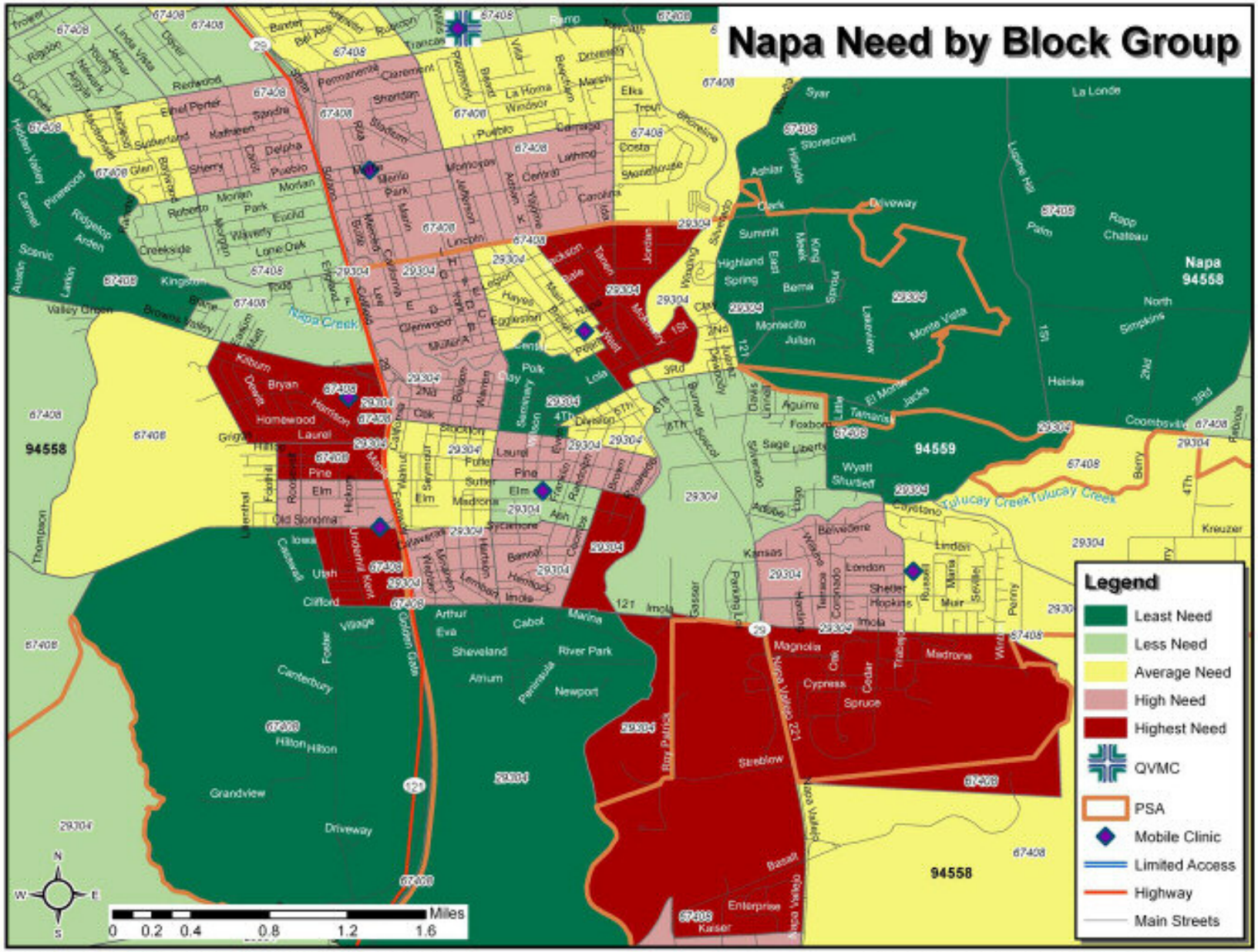
- **Red- Highest Need (CNI scores: 4.2-5)**
- **Pink- High Need (CNI scores: 3.4-4.1)**
- **Yellow- Average Need (CNI scores: 2.6-3.3)**
- **Light Green- Less Need (CNI Scores: 1.8-2.5)**
- **Dark Green- Least Need (CNI Scores: 1-1.7)**

The map below depicts the CBSA highlighting those areas of the county where need is greater including Calistoga in north county and Napa and American Canyon in south county.



Source: Community Need Index, Catholic Healthcare West, 2011

Prepared by the St. Joseph Health System Community Health Department



Source: Intercity Hardship Index, The Nelson A. Rockefeller Institute of Government, 2007

Prepared by the St. Joseph Health System Community Health Department

St. Joseph Health, Queen of the Valley Service Area: City Profile

	PSA					SSA					
	American Canyon	Angwin	Calistoga	Deer Park	Napa	Pope Valley	Saint Helena	Yountville	Napa County	CA	U.S.
Population	19,235	3,839	7,237	207	93,936	595	8,997	2,930	136,976	37,853,428	309,038,999
Average HH Size	3.32	2.68	2.54	NA	2.65	NA	2.41	2.01	2.64	2.91	2.60
Age (%)											
0-17	24.32	15.21	22.52	19.81	22.91	22.52	22.09	10.51	22.55	25.48	24.26
65+	14.41	9.85	17.29	14.49	14.07	13.95	16.43	45.87	15.00	11.45	13.16
Race/Ethnicity (%)											
White	37.72	64.42	52.19	83.09	59.96	75.97	65.90	84.51	57.57	40.91	64.71
Latino	22.69	13.21	42.93	8.21	33.06	15.63	30.22	10.41	30.79	37.11	15.82
African American	7.89	3.26	0.47	0.97	0.87	0.34	0.56	0.75	1.87	5.89	12.07
Asian	25.21	14.30	2.25	4.83	2.80	0.84	1.54	2.53	6.15	12.07	4.35
All Others	6.49	4.82	2.16	2.90	3.30	7.23	1.78	1.81	3.62	4.02	3.05
Foreign born (%)	27.1	19.6	33.5	NA	23.2	NA	24.0	7.5	21.5	26.8	12.4
Not U.S. Citizen	1,758	404	1,328	NA	12,030	NA	950	112	17,958	5,446,823	21,425,851
Spanish- Primary Language Spoken at Home (%)	20.4	16.1	24.3	NA	31.0	NA	23.0	7.1	25.0	28.2	12.1
25+ with no HS diploma (%)	18.59	8.20	24.67	3.23	20.63	8.72	15.55	15.20	19.73	19.75	15.27
% HH with Gross Rent ≥35% Income	44.5% of 542	30.9% of 304	38.7% of 754	NA	40.7% of 4,292	NA	39.2% of 996	23.0% of 365	38.6% of 15,318	45.0% of 4,876,882	41.0% of 34,472,293
% Children Below Poverty	4.4	11.9	1.0	NA	14.9	NA	1.3	17.8	11.3	18.3	18.6
% 65+ Below Poverty	3.7	3.6	3.9	NA	7.9	NA	5.3	2.7	7.2	8.4	9.8
% Families Below Poverty	3.2	6.3	2.2	NA	6.9	NA	0.9	4.1	5.5	9.8	9.9
Female Headed HH with Children <18 (%)	4.8	2.5	4.8	NA	5.3	NA	4.0	3.1	4.3	7.1	7.3

HH: Household
NA: Not Available
Source: American Community Survey 2005-2009, Claritas 2010

METHODOLOGY

Analytic Methods Used

A community health needs assessment is conducted every 3 years to assist hospitals and county public health in determining health priorities, emerging gaps and ongoing needs. The 2010 Napa County Community Health Needs Assessment was a combined venture of area hospitals (Queen of the Valley Medical Center, Kaiser Permanente, St. Helena Hospital) and the County Public Health Department.

Quantitative and qualitative methods were used to collect information for this assessment, which included both primary and secondary data sources. Community needs assessments and environmental scanning—which involves gathering, analyzing and *applying* information for strategic purposes—provide the necessary information to inform decision makers and funders about the challenges they face in improving community health, and the priority areas where support is most needed. The information is also useful for community organizations by having comprehensive, local data located in one document.

Existing Document and Data Review

A document review collected relevant information about the community, health status, where health services are obtained, other related services, and gaps in services. This information was found in documents and records of facilities such as data from local clinics and state government, reports from earlier needs assessments conducted related to health, and reports about specific health programs or services.

Existing data were collected from all applicable existing data sources including government agencies (e.g., California Department of Finance, Office of Statewide Health Planning and Development, California Department of Health Care Services), and other public and private institutions. These data included demographics, economic and health status indicators, and service capacity/ availability. All needs assessments are dependent on access to timely and reliable data. While data at the national and state level are generally available for community health-related indicators, local data—from counties and cities—are less accessible and sometimes less reliable. For example, small sample sizes can result in statistical "instability," and well-meaning data collection methods without appropriate "rigor" may limit the value of the findings. Because data from publicly-available sources typically lag by at least 2 years—because it takes time for reported data to be received, reviewed, approved, analyzed, and prepared for presentation—data may not always be as current as needed. And, some data may only be reported as 3-year averages, not annually.

Community Input

Three primary methods of collecting input from the community were used in the collaborative needs assessment process: Community questionnaires, focus groups, and key informant interviews. A questionnaire developed in English and Spanish for the general public inquired about most-important health needs, ideas for responsive solutions, and habits they used to maintain their own personal health. Certain questions that served as markers for access to services were also included. The survey was distributed in hard copy by the consultants and members of the

Collaborative to locations where the groups of interest would best be reached, such as at health fairs, branches of public libraries, and Boys and Girls Clubs, and family resource centers throughout the county. In addition, the survey was made available by computer (English/Spanish) and notices about the online version were posted on various organizations' websites and in their newsletters including, to a limited degree, Spanish-speaking media outlets. All of the electronic and hard-copy survey data were cleaned, coded, and entered into an Excel spreadsheet and analyzed using SPSS Version 15.0.

Four locations—Napa, Calistoga, St. Helena, and American Canyon—were chosen to ensure geographic representation and 9 community focus groups were conducted at sites intended to draw populations that typically gathered there. Key community-based organizations were identified by the Collaborative and asked to host a focus group. Focus groups were co-scheduled at the sites among participants who were already meeting there for other purposes (e.g., young mothers at a parenting class) to facilitate access and promote attendance. Although the participants constituted a convenience sample, there was the expectation that *in the aggregate* the groups would be diverse and include the populations of highest interest.

To ensure that working people could attend, some of the meetings were held in the evening. One meeting was held in the early morning to accommodate people coming to drop their children off at a preschool, and other daytime meetings were held for seniors or others who had difficulty driving at night or did not like to go out after dark. The groups were facilitated in English and Spanish with a bilingual/bicultural facilitator using a set of key questions (Appendix 4). The questions were generally open-ended; prompting with information or data was limited to reduce the potential for bias or leading of participants to any conclusions. Participants were not asked to "vote" or otherwise rank the items they identified as needs, problems or solutions. The focus group data were recorded on a flip chart by the facilitator during the meetings then transferred to written summary formats where it was coded and analyzed.

In-depth telephone interviews using a structured set of questions were conducted, primarily individually, with a representative group of 20 individuals whose perceptions and experience were intended to inform the assessment. The interviews provided an informed perspective from those working "in the trenches," increased awareness about agencies and services, offered input about gaps and possible duplications in service, and solicited ideas about recommended strategies and solutions. The interviews also focused the needs assessment on particular issues of concern where individuals with particular expertise could confirm or dispute patterns in the data and identify data and other studies of which the Collaborative might not otherwise be aware.

For full CHNA report go to Appendix 4

Prioritization Process and Criteria

Countywide Priority Setting Process

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

Assets and Needs (Source: 2010 Napa County Community Health Needs Assessment)

The public and community leaders identified important factors that act to promote (assets) or hinder (challenges) health in Napa. These include the unusually high degree of collaboration among organizations was widely recognized as one of the most important assets relative to planning and delivering services in the county. Below is a table describing characteristics that contribute to or impact negatively community health.

The community members made many recommendations about where additional support was needed to improve health in Napa County; the most frequently suggested strategies and solutions—which tie to the needs they identified—are listed below in frequency of mention.

Community Health Survey	Community Focus Groups	Key Informant Interviews
Availability of low-cost health insurance	Availability of low-cost health insurance	Expand community-based mental health services
Access to wellness-type centers/services (especially those that promote exercising)	Availability of low-cost dental services (especially for adults, seniors)	Use mobile dental to deliver more services; support free/low-cost dental for adults and seniors
Year-round activities for youth (that youth can relate to)	Efforts that improve school lunches; that teach kids healthier food choices (gardens)	Address youth substance abuse, especially re. use of alcohol
Efforts to increase cleaner environment (air, water)	Support more options for affordable housing	Provide food as a basic need (food banks, community gardens)
Low-cost mental health counseling services	Promote health education (especially for Spanish-speaking and teens re. risk behaviors)	Support services for the elderly (homebound, frail, low-income)
Support services for the elderly (homebound, frail, low-income)	Support affordable exercise options (low-cost gyms, free bicycles)	Support efforts that increase awareness of services/where to go for help

Much of the infrastructure needed to provide health services appears to be in place in Napa County, particularly for those with employer-based insurance. A comprehensive community health clinic, widely recognized as being a major safety net provider, serves the neediest residents along with two non-profit hospitals and a public health system.

The provision of clinical services is not the only thing that contributes to health: numerous nonprofit

organizations play unique and critical roles. An adequate number of primary care physicians and general dentists practice in the community. Health insurance is available for low-income children, at least in the short term, from the progress made by the Children's Health Initiative.

The gaps are most evident in the limitations to the infrastructure relative to affordability, accessibility, distribution, flexibility, or emphasis of the following: community-placed mental health services; dental services for adults; health care for adults without insurance, not eligible for Medi-Cal, and unable to pay sliding fees; providers in some specialty areas, willingness of physicians and dentists to accept Medi-Cal; transportation options; bilingual healthcare workforce; and comprehensive communitywide preventive health in all aspects of community life in Napa County.

Other assets and resources to address community health and wellbeing were catalogued in the needs assessment survey of the community. While Napa has a strong nonprofit community, many are stretched as government and philanthropic resources are less available to support provision of their services.

Recommended Priorities of the Countywide Needs Assessment

(Source: 2010 Napa County Community Health Needs Assessment)

The Needs Assessment Collaborative agreed that an important opportunity exists in Napa County for all health partners—regardless of their own organization's mission and priorities—to focus on the following 4 priority areas (in no order of significance):

- Strategies that address the growing epidemic of obesity and all of the health and cultural factors that contribute to the problem;

- Senior support services that encompass mental, social, and physical health and well being, including needed support for caregivers;

- Substance abuse as an issue for families, schools, businesses, and the safety of the community—ranging from use during pregnancy to underage drinking to abuse of prescription drugs by seniors and other adults—that recognizes and integrates biological and socio-cultural factors into models of prevention and care;

- Mental and emotional health and its relationship to overall health that needs to be more adequately understood, addressed, and resources provided for.

Identification and Selection of DUHN Communities

Communities of disproportionate unmet need in Napa County include low-income children, adults and elders in need of dental care and mental health services, chronic disease management, and access to community-based services, youth and adults at risk of alcohol abuse and culturally and linguistically appropriate health education, and prevention of childhood obesity, including:

1. Low income children including Latino children and their families where English is limited and access to information and services is difficult
   a. Expand access to affordable, quality oral health services
   b. Child and family health education to promote wellness, prevent obesity and reduce asthma risks

c. Access to affordable health care
d. Parent education and leadership development to participate more fully in supporting their children's academic success

2. Low income pregnant women particularly those who do not speak English
   a. Access to prenatal education to improve birth outcomes and infant care
   b. Reduction of risk factors associated with perinatal depression

3. Low income adults and older adults
   a. Access to services to improve quality of life and disease management
   b. Access to affordable, community-based mental health services for depression and other behavioral health issues
   c. Access to affordable primary health care

4. Low income older adults
   a. Access to affordable, quality dental care
   b. Access to mental health services
   c. Access to community-based support

The table on page 14 describes DUHN populations, key needs and community assets:

DUHN GROUPS AND KEY COMMUNITY NEEDS AND ASSETS SUMMARY TABLE		
DUHN Population Group	**Key Community Needs**	**Key Community Assets**
Low income children **Latino children and their families**	Continued access to affordable, quality oral health services including preventive services and education	QVMC Mobile Dental Van Sister Anne's Dental Clinic Community sites Head Start
	Prevention and early intervention to improve nutrition, physical activity and prevent obesity	QVMC Bilingual community education program Children & Weight Coalition Healthy for Life Program Schools QVMC Wellness Center Parent University Family Resource Centers
	Access to affordable healthcare	Children's Health Insurance Initiative Gardiner & Associates Community Clinic Ole
	Reduce educational opportunity gap (social determinant of health): Increase education parental involvement in schools	Title I schools Bilingual health education Parent University On the Move
Low income pregnant women particularly women who do not speak English	Access to prenatal education to improve birth outcomes, encourage breastfeeding including number of low birth weight infants	QVMC Perinatal Spanish Workshops Healthy Moms and Babies Linkage to clinical care programs for pregnant women
	Access to screening and early intervention for perinatal depression	Perinatal Mood Disorders program) QVMC
Low income adults, including Spanish-speaking adults	Chronic disease management: Access to care, support, education and mental health services to improve quality of life and disease management	QVMC Care Network QVMC (hospital) Community Clinic Ole Family Service of Napa Valley Wellness Center
	Access to affordable, community-based behavioral health services for depression and other behavioral health issues	Family Service of Napa Valley Clinic Ole County Mental Health Services Family Resource Centers
	Access to affordable dental care	Sister Anne's Dental Clinic
	Access to affordable health care	Community Clinic Ole QVMC

Low income seniors	Access to affordable, quality dental care	Sister Anne's Dental Clinic
	Access to affordable mental health services including preventive programs	Family Services of Napa valley Area Agency on Aging Adult Day Services CSOA
	Chronic disease management	QVMC CARE Network QVMC Community Clinic Ole Family Service of Napa Valley Wellness Center
	Access to community-based supports for independent living	AAA CANV CSOA IHSS Senior Centers Home Health care agencies

The St. Joseph Health, Queen of the Valley Community Benefit Committee convened a representative Planning Committee including staff, community members, professionals and hospital trustees to review the community needs assessment and determine how best to align the community benefits efforts of the Queen of the Valley over the next three years to address the unmet needs in the community.

The Planning Committee convened in two meeting over 6 hours and developed criteria for selection of priorities and prioritized health needs using these criteria.

The processes included reviewing and discussing:

- SB697 guidelines and core principles
- The Ministry Goals
- Past and current community benefit activities including charity care contribution
- Community Health Needs Assessment
- Communities and populations where disproportionate health needs exist.

To determine priority initiatives the committee identified:

- Key health issues for consideration, current trends/community context and common themes;
- Findings that were unexpected and surprising as well as assumptions that were supported by the Needs Assessment data
- Trends
- Challenges and barriers and determining specific opportunities for Queen of the Valley to contribute to improving community health in Napa County, particularly for those with disproportionate need.

Prior to the convening of the Planning Committee, Community Outreach staff conducted a comprehensive cost benefit analysis of current initiatives and programs. To assess ongoing

community need, effectiveness and efficiency of the services provided, and leveraging of community resources. The Planning Committee reviewed these existing community benefit programs addressing DUHN communities and identified health priorities.

Implications from a discussion about trends and the context for planning resulted in some themes to guide initiative development and success factors for addressing community health more broadly:

Themes:

1. Coordination and collaboration is more important than ever to conserve and utilize resources

2. Strong linkages and continuums of care and services among organizations and agencies are critical to support effective use of resources

3. Leadership is needed to promote systematic approach to addressing community issues and needs.

Vision for Community Health in Napa County

The St. Joseph Health, Queen of the Valley Community Benefit Committee articulated a shared vision adopted by the Community Benefits Committee to serve as an overall guidepost for the plan.

COMMUNITY HEALTH VISION FOR NAPA COUNTY
+ *Napa County becomes a model for community health* ○ We have widely shared vision of community health ○ Community health planning is collaborative ○ We are preventing health problems upstream ○ We are meeting Healthy People 2020 objectives ○ Health of the community is taken into account in all policies; e.g., physical environment, food access, housing, transportation + *We have a strong, accountable continuum of health care* + *Important services and programs have been sustained* + *Health reform is implemented effectively and more people have access to care* + *People know where and how to access services*

Priority Setting for Specific Initiatives

The Planning Committee discussed and agreed upon specific initiatives and strategies to address the unmet and ongoing health needs based on the criteria in the table below. The following criteria were used to select priority health initiatives. The proposed initiatives were developed through an individual ranking and consensus process.

INITIATIVE SELECTION CRITERIA
The Initiative should: • Align with ASACB Core Principles • Build upon and aligns current programs with identified priority community health needs

- Be appropriate to our mission, goals and expertise
- Serve most vulnerable
- Leverage and align with hospital resources and goals
- Provide opportunities for linkages with other organizations, institutions and stakeholders
- Have potential for high impact on issue/individuals
- Be cost effective
- Inspire passion and commitment to address
- Is achievable with sufficient resources available to address
- Be able to be implemented utilizing best practices and innovation
- Be Measurable
- Address multiple factors: environmental, individual, root causes

The highest priorities identified were consistent with ongoing community health needs, QVMC goals and strategic initiatives, and new or emerging health needs identified in the 2010 Community Health Needs Assessment.

Ongoing Community Health Needs (evident in 2007 and 2010 Community Health Needs Assessment) included the following:

1. Access to Dental Care
2. Chronic Disease Management
3. Childhood Obesity
4. Access to Mental Health Services and Supports
5. Community Health Education (focused on preventing heath problems and addressing barriers to health and health care access.)

In addition, the Committee recommended two efforts to build community capacity and governance to understand and address issues affecting access to care and health of the whole community and particularly those with disproportionate health needs.

1. Assuring a strong, accountable continuum of affordable health care, particularly for low income and un- or underinsured residents
2. Building a community health vision and partnership to take action to address health inequities based on an understanding of how where we live, work and play has an impact on health, may accumulate over individuals' lifetimes and continue unbroken through generations.

In addition, the Community Needs Assessment identified youth at risk of abuse of alcohol, tobacco and other drugs. Recommended needs included the following:

a. Community awareness to reduce high rates of underage drinking
b. Community policies to reduce access to alcohol
c. Risk reduction for driving accidents and violence associated with alcohol and drug use

Primary leadership for this issue will be undertaken by County Substance Abuse Services, the Vintners'' Association and a community coalition focused on policy change. QV will support these endeavors.

Recommendations from the Planning Committee were presented to the Community Benefits Committee in the form of a framework depicting initiatives and potential programs. In addition, rationale for the initiatives was articulated in 3W template form for the Community Benefit Committee review and discussion. This Community Benefits plan framework was approved prior to the development of the plan.

Community Outreach Department staff developed logic models (4Es) for each initiative describing outcomes, strategies, measures and tools for evaluation. They conducted cost analysis and considered ways to leverage internal and external resources to increase impact of the initiatives. The plan was then presented to the Community Benefit Committee for approval and forwarded to the QVMC Board of Trustees.

Information gaps

No information gaps have affected St. Joseph Health, Queen of the Valley's ability to reach reasonable conclusions regarding community health needs.

In the following sections, detailed attachments provide a summary of the needs assessment findings and a listing of the key community stakeholders consulted.

Collaborative Agencies

This needs assessment was made possible through a partnership between St. Joseph Health, Queen of the Valley and the following organizations:

- Kaiser Permanente
- St. Helena Hospital
- Napa County Public Health Department

PRIMARY DATA

As previously mentioned, three methods of collecting input from the community were used in the assessment process.

Community Questionnaire
A questionnaire was developed in English and Spanish for the general public that inquired about most-important health needs, ideas for responsive solutions, and habits they used to maintain their own personal health (See CHNA in Appendix 4 for results). Certain questions that served as markers for access to services were also included. The survey was distributed in hard copy by the consultants and members of the Collaborative to locations where the groups of interest would best be reached, such as at health fairs, branches of public libraries, and Boys and Girls Clubs, and

family resource centers throughout the county. In addition, the survey was made available by computer (English/Spanish) and notices about the online version were posted on various organizations' websites and in their newsletters including, to a limited degree, Spanish-speaking media outlets. All of the electronic and hard-copy survey data were cleaned, coded, and entered into an Excel spreadsheet and analyzed using SPSS Version 15.0.

Community Focus Groups
Four locations—Napa, Calistoga, St. Helena, and American Canyon—were chosen to ensure geographic representation and 9 community focus groups were conducted at sites intended to draw populations that typically gathered there. Key community-based organizations were identified by the Collaborative and asked to host a focus group. Focus groups were co-scheduled at the sites among participants who were already meeting there for other purposes (e.g., young mothers at a parenting class) to facilitate access and promote attendance. Although the participants constituted a convenience sample, there was the expectation that *in the aggregate* the groups would be diverse and include the populations of highest interest. To ensure that working people could attend, some of the meetings were held in the evening. One meeting was held in the early morning to accommodate people coming to drop their children off at a preschool, and other daytime meetings were held for seniors or others who had difficulty driving at night or did not like to go out after dark. The groups were facilitated in English and Spanish with a bilingual/bicultural facilitator using a set of key questions. The questions were generally open-ended; prompting with information or data was limited to reduce the potential for bias or leading of participants to any conclusions. Participants were not asked to "vote" or otherwise rank the items they identified as needs, problems or solutions. The focus group data were recorded on a flip chart by the facilitator during the meetings then transferred to written summary formats where it was coded and analyzed. Colorful gift bags containing practical and other items (e.g., canvas grocery bag, toothbrush, toothpaste, water bottle, magnetized refrigerator clips, Blue Diamond® almonds) were offered in appreciation for participation. Agencies and organizations that sponsored the community meetings helped to publicize the meetings and promote attendance. A flyer in English and Spanish was provided to the organization to post if desired (Appendix 6 contains a sample).

Key Informant Interviews
In-depth telephone interviews using a structured set of questions were conducted, primarily individually, with a representative group of 20 individuals whose perceptions and experience were intended to inform the assessment (See CHNA in Appendix 4 for results). The interviews provided an informed perspective from those working "in the trenches," increased awareness about agencies and services, offered input about gaps and possible duplications in service, and solicited ideas about recommended strategies and solutions. The interviews also focused the needs assessment on particular issues of concern where individuals with particular expertise could confirm or dispute patterns in the data and identify data and other studies the Collaborative might not otherwise be aware of.

SECONDARY DATA

Communities commonly measure their health against statewide averages and national objectives such as Healthy People 2010. Community health indicators include demographic and socioeconomic factors, which play out in diverse ways; death and disease rates; conditions related to births; oral health; mental health; safety; substance abuse; and health prevention activities. Indicators where Napa County compares favorably or unfavorably are shown in the chart on the

following page. *Even areas where county levels of health are similar to state and national averages may still warrant more attention.*

How does Napa County Compare on Common Community Health Status Indicators?

Indicator	2010 Napa County Needs Assessment Compared to:	
	California	National Health Objective (Healthy People 2010)
⇧ = *More favorable* (e.g., better than state average, exceeds national benchmark). ⇩ = *Less favorable* (e.g., worse than state average, does not meet national benchmark). ⇔ = *Similar* (e.g., the same or close to state average, meets national benchmark)		
Self-Rated Health Status		
Total population reporting excellent/very good/good	⇧	N/A
% of seniors 65+ reporting excellent/very good/ good	⇧	N/A
Morbidity (Disease and Illness)		
AIDS incidence	⇧	⇩
Chlamydia incidence	⇧	N/A
Prevalence of heart disease	⇩	N/A
Prevalence of diabetes	⇩	⇩
Prevalence of obesity	⇩	⇩
Asthma (children and adolescents)	⇩	N/A
Mortality (Death)		
All cancers	⇩	⇩
Lung cancer	⇩	⇩
Colorectal (colon) cancer	⇩	⇩
Female breast cancer	⇔	⇔
Coronary heart disease	⇧	⇧
Diabetes	⇔	N/A
Chronic liver disease and cirrhosis	⇩	⇩
Maternal Health Factors		
Low infant birth weight	⇧	⇩
Adequate prenatal care/early entry into care	⇔	⇩
Birth to teen mothers	⇧	N/A
Tobacco, Alcohol and Drug-Related		
Adult arrests for driving under-the-influence	⇩	N/A
Alcohol-involved motor vehicle accidents	⇩	N/A
Adults who currently smoke	⇔	⇩
Teens who currently smoke	⇩	
Underage alcohol use	⇩	⇩
Protective/Preventive Factors		
Children who visited a dentist last year	⇧	⇧
Children with complete immunizations	⇧	⇧
Breastfeeding	⇧	⇧
Breast cancer screening	⇔	⇧
Colorectal screening	⇧	⇧
Flu Shot	⇧	N/A

Note: Measures are for the overall population; differences may exist for age, race/ethnic and other groups.

For full CHNA report results with data go to Appendix 4

COMMUNITY NEEDS

Health Needs Identified through CHNA

- Lack of Affordable Accessible Care
- Lack of Affordable Dental Care

Community Collaborative Identified Priority Areas:

- Strategies that address obesity
- Senior Support Services
- Substance abuse
- Mental & emotional health

Other identified needs/gaps in the CHNA

- Health Insurance (more affordable medical and dental services)
- Dental for seniors and adults
- Prevention related (nutrition, exercise, weight control)
- Basic needs (housing)
- Basic needs (jobs)
- Basic needs (transportation)
- Basic needs (environmental)

Health Needs Identified through CHNA

- Specific health conditions (chronic disease)
- Lack of awareness of health prevention services
- Senior supportive services
- Senior mental health

Appendix 1.

a. Public Health Experts Interviewed

Name	Title	Affiliation or Organization	Special Knowledge or Expertise
Dr. Karen Smith, MD, MPH	Public Health Officer/ Deputy Director	Napa County Public Health	Over 20 years' experience in local public health; knowledge of: public health practice; community health assessment; health equity and health disparities; public health law and advocacy.
Randy Snowden, JD	Director Napa County Health and Human Services	Napa County Health and Human Services	Director, Napa County Health and Human Service Agency, 2005-present Member, Board of Directors, Partnership HealthPlan of California (PHC), 2005-present Program Director, The Wolfe Center adolescent substance abuse program, Napa, California 2003-2004 Behavioral Healthcare Manager, Napa County Health and Human Services Agency, 1999-2003 Director, Alcohol and Drug Policy Institute, 2001-2003 Administrator, Thunder Road adolescent substance abuse program, Oakland, California1987-1996 Partner, Coombs & Dunlap, Napa, California 1978-1990 BA and BS, University of California, Davis 1971 JD, University of California, Davis 1974
Jaye Vanderhurst, MSW	Director Napa County Mental Health Division	Napa Co HHS	CSU Sacramento Master's degree, Social Work

Appendix 1. (continued)

b. Individuals from Health Departments and Agencies Interviewed

Name	Title	Affiliation or Organization
Dr. Robert Moore MD, MPH	Medical Director	Community Health Clinic Olé, Local Federally Qualified Health Center (FQHC) http://www.clinicole.org/
Dr. James Cotter, MD	Chief Physician	Kaiser Permanente, Napa Medical Offices http://mydoctor.kaiserpermanente.org/ncal/provider/jimcotter
Laura Ryan	Administrator, Assessment and Intervention	Napa Valley Unified School District http://www.nvusd.k12.ca.us/instruction

c. Community Leaders Interviewed

Name	Title	Affiliation or Organization	Nature of Leadership Role
Diane Dillon	Supervisor- District 3, Napa County	Napa County Board of Supervisors	Supervisors for District 3 - Napa Country
Captain Conrad Perez	Captain	City of Napa Fire Department	Fire Department Captain http://www.cityofnapa.org/
Drene Johnson	Executive Director	Community Action Napa Valley	Oversees all county homeless shelters and majority of food safety net services http://www.canv.org/about.html
Lori Pesavento	Executive Director	Family Service Napa Valley	Leader in mental health services for underserved

Appendix 1. (continued)

d. Other Interviewees Representing the Broad Interests of the Community

Name	Title	Affiliation or Organization
Joelle Gallagher	Executive Director	COPE Family Resource Center
Kristen George	Executive Director	St Helena Family Resource Center
Stephanie Perry	Executive Director	Calistoga Family Resource Center
Tim Mitchell	Senior Pastor	Pacific Union College Church, Angwin
Tom Amato	Executive Director	Angwin Community Teen Center
Mark Diehl	Executive Director	Children's Health Initiative
Margaret Payne	Director Quality Management	St. Helena Hospital Behavioral health
Mark Fowler	Director HR	St. Helena Hospital
Walt Mickens	Trustee, President and CEO	St. Joseph Health, Queen of the Valley

e. Contracted Third Party

Name	Title	Affiliation or Organization
Kathy Tabor	Consultant	Napa County Healthy Aging Planning Initiative
Barbara Aved, PhD, MBA	Consultant	Barbara Aved Consulting

Brief description of Contracted Third party

Barbara M. Aved, PhD, MBA

Barbara M. Aved, PhD, MBA, is President of BAA. She is an experienced public health professional, consultant, manager, evaluator, and trainer. Until 1986, Dr. Aved was Chief of the California Department of Health Services Managed Care Operations Branch where she oversaw 250 Medi-Cal contracts with California hospitals and managed care plans.

For 8 years prior to that, she served as regional consultant and then Chief of the California Office of Family Planning, where she earned recognition for her expertise and advocacy for reproductive health issues. Her knowledge and experience with government and community-based organizations, the legislative process and public policymaking--complemented by strong analytical and organizational skills--make her a valued resource to health and human service organizations and providers.

Dr. Aved's early career as a nurse practitioner and clinic director created a strong personal interest in and continuing commitment to issues that affect the diversity of California's population. At the State and local level she has been instrumental in improving access, broadening the scope of services and strengthening quality of care.

Dr. Aved has taught classes at California State University, Sacramento, and the University of Oregon. She serves on various state and community advisory committees and volunteers with church, community, and cultural arts boards. When her sons were born she and a colleague co-founded and co-managed a preschool. She has authored a number of professional publications, and is a recipient of the California Department of Health Services Superior Accomplishment Silver Award for bringing about $1.5 million in savings for a pharmaceutical volume purchasing plan the state implemented.

Barbara earned a bachelor's degree in nursing from Loma Linda University and a master's in community health from California State University, Fresno. She holds a PhD in health science from the University of Oregon, and an MBA from California State University, Sacramento. For fun, she recently earned degrees in art and art history.

http://barbaraavedassociates.com/president.html

Appendix 2.

a. SJH, Queen of the Valley Community Benefit Committee Roster

Name	Title	Affiliation or Organization
Community Benefit Committee		
Sr. Pat Hayhurst, CSJ	Chair	Sisters of St. Joseph of Orange
Sr. Judith Fergus, CSJ	Vice Chair	Sisters of St. Joseph of Orange
Dorothy Arata	Member	Community Member
Joseph Carrillo, M.D.	Trustee	St. Joseph Health, Queen of the Valley, Board of Trustees
Frank Collin	Trustee	St. Joseph Health, Queen of the Valley, Board of Trustees
Terry Gonsalves	Community Member	Community Member
Donald Hitchcock, M.D.	Medical Director	St. Joseph Health, Queen of the Valley, Community Outreach
Br. Thomas Jones	Trustee	St. Joseph Health, Queen of the Valley, Board of Trustees
Pam Kindig	Trustee	St. Joseph Health, Queen of the Valley, Board of Trustees
Sharon Macklin	Field Representative	Field Rep., Assemblymember Michael Allen, 7th Assembly District, California State Legislature
Chris Manson	Northern California Advocacy Director	St. Joseph Health
Walt Mickens	Trustee, President and CEO	St. Joseph Health, Queen of the Valley
Frances Ortiz-Chávez	Center Director	Puertas Abiertas (Open Doors)
Sr. Suzanne Sassus, CSJ	Trustee	St. Joseph Health, Queen of the Valley, Board of Trustees and Sisters of St. Joseph of Orange
Sr. Marian Schubert, CSJ (Executive Sponsor)	VP of Mission Integration	St. Joseph Health, Queen of the Valley, Executive Sponsor
Susan Schwegman	Attorney	Legal Aide
Sally Sheehan-Brown	Executive Director	First Five Napa

Appendix 2. (continued)

a. SJH, Queen of the Valley Community Benefit Committee Roster

Name	Title	Affiliation or Organization
Karen Smith, M.D., MPH	Public Health Officer/ Deputy Director	Napa County Public Health
Colleen Townsend, M.D.	Chief Medical Officer	Community Health Clinic Olé,
Rob Weiss	Executive Director	Family Services of Napa Valley
Staff		
Liz Alessio (Recorder)	Coordinator, Community Outreach	St. Joseph Health, Queen of the Valley
Jaynie Boren	No. California Regional Director, Strategic Services	St. Joseph Health, Queen of the Valley
Dana Codron	Executive Director, Community Outreach	St. Joseph Health, Queen of the Valley
Vanessa DeGier	Director, Marketing and Communications	St. Joseph Health, Queen of the Valley
Vincent Morgese, MD	Ex. VP Chief Operations Officer & Chief Medical Officer	St. Joseph Health, Queen of the Valley
Jill Moss	Manager, Community Outreach	St. Joseph Health, Queen of the Valley
Jaime Penaherrera	Director, Diversity and Community Partnerships	St. Joseph Health, Queen of the Valley

Appendix 3.

a. Facilities that provide healthcare in Napa County

The following are other facilities providing health care in Napa County region. This list is not exhaustive.

Organization	Address	Description
St. Helena Hospital Center for Behavioral Health	525 Oregon Street Vallejo, CA 94590	A free-standing, 61-bed facility offering active and structured therapeutic mental health programs, including crisis evaluation, inpatient treatment and outpatient programs for adults and children.
Kaiser Permanente Napa Medical Offices	3285 Claremont Way Napa, CA 94558	Napa medical offices provide service for the departments of Adult Medicine, Allergy, Dermatology, Occupational medicine, pediatrics, and women's health. No emergency or acute hospitalization services. http://www.permanente.net/homepage/kaiser/pages/d147-top.html
Napa County Public Health	2344 Old Sonoma Road Napa, CA 94558	Communicable disease and surveillance and control, maternal and child health program, Women, Infants and Children (WIC) program, public health clinical services including immunizations and HIV counseling and testing.
Community Health Clinic Ole: St. Helena	661 Main St. St. Helena, CA 94574	Clinic Ole provides primary and preventive medical services for people of all ages.

Source:
http://napa.networkofcare.org/ph/services/index.aspx

For an additional listing of Napa County resources and assets go to assets/resources listed in pages 88 -105 of Napa County Health Needs Assessment in Appendix 4, below.

Appendix 4. 2010 Napa County Community Health Needs Assessment

IDENTIFYING PRIORITY HEALTH NEEDS

NAPA COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT

Prepared for the Napa County Collaborative of Health Organizations and Community Funders

Researched and Written by
BARBARA AVED ASSOCIATES

October 2010

Table of Contents

EXECUTIVE SUMMARY

"I can't take time off for medical appointments; I'm afraid of losing my job if I'm not there."—Focus group participant

"The economic downslide of the last couple of years has exacerbated an already stretched health system."—Key Informant interviewee

Introduction

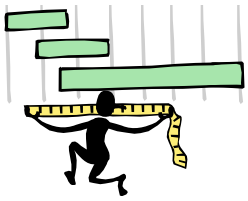
One of the best ways to gain a better understanding about health needs, disparities and available resources is to conduct a comprehensive needs assessment. A community health needs assessment provides the foundation for all community health planning, and provides appropriate information on which policymakers, provider groups, and community advocates can base improvement efforts; it can also inform funders about directing grant dollars most appropriately.

In 2010, the Napa County hospitals and Kaiser Vallejo—joined by Napa County Public Health and others—re-formed as the Collaborative established in 2006 which sponsored an earlier community health needs assessment. The purpose was to plan for an updated needs assessment that could continue to track trends, and assist healthcare organizations, individually and collaboratively, in improving community health and maximizing resources. The assessment was also intended to guide the hospitals in developing their Community Benefits Plans to meet SB 697 requirements.

BARBARA AVED ASSOCIATES, a Sacramento-based consulting firm, was again retained to conduct the community health needs assessment. Two primary data sources were used in the process: the most recently-available demographic, socioeconomic, and health indicators commonly examined in needs assessments; and, data from a community input process to help put a "human face" on the statistics. The community input—a widely distributed online and hard-copy survey; focus groups; and key informant interviews intended to solicit opinions about health needs and suggestions for improvements—validated and enriched the statistical data. It is an unavoidable fact that any report of this type will soon have some data that are not the most up-to-date.

This *2010 Napa County Community Health Needs Assessment* presents the community with an overview of the state of health-related needs and benchmarks from which to gauge progress. It also provides documentation for decision-making to direct funding towards the highest-priority health needs in the community.

Highlights of Findings



Demographics

- Mirroring California, Napa County's estimated 2010 population of 138,917 is becoming increasingly diverse. Twenty-eight percent of the overall population identifies themselves as Hispanic or Latino, while among children age 0-5 the proportion is closer to 50%.
- Napa and Santa Clara counties have the largest concentrations of immigrant children ages 5-17 in the state, at 12% (about 8% of California children ages 5-17 are foreign born).
- With 15.7% of all residents over the age of 65, the county has a higher proportion of older residents than California as a whole.
- There is a continuing projected trend for considerable population growth in American Canyon.

Socioeconomic Factors

- Up from 9.9% in 2005, 11.5% of Napa County children ages 0-17 in 2008 were estimated to live in families with incomes less than 200% of the official federal poverty level. The percentage of seniors living in poverty also rose during the 3-year period 2006-2008.
- The percentage of children enrolled in the free and reduced-price lunch program in Napa County, 41% in 2008-09, has remained fairly steady since 2005 and is lower than the state rate.
- Rises in unemployment and uninsured have had a significant influence on the region's manufacturing, leisure and hospitality industries. The unemployment rate in Napa County was estimated at 9.4% in August 2010, above the year-ago estimate of 8.6% and tripled from 3.6% in 2007.
- Napa County's rates of uninsured for health are more favorable than the statewide rate. 2009 figures show 17.2% of the population was uninsured for health all or part of the year compared to 24.3% in California.

Key Health Factors

Communities commonly measure their health against statewide averages and national objectives such as Healthy People 2010. Community health indicators include demographic and socioeconomic factors, which play out in diverse ways; death and disease rates; conditions related to births; oral health; mental health; safety; substance abuse; and health prevention activities. Indicators where Napa County compares favorably or unfavorably are shown in the chart on the following page. *Even areas where county levels of health are similar to state and national averages may still warrant more attention.*

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Prevalence of diabetes	⇩	⇩
Prevalence of obesity	⇩	⇩
Asthma (children and adolescents)	⇩	N/A
Mortality (Death)		
All cancers	⇩	⇩
Lung cancer	⇩	⇩
Colorectal (colon) cancer	⇩	⇩
Female breast cancer	⇔	⇔
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Maternal Health Factors		
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Birth to teen mothers	⇧	N/A
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Adults who currently smoke	⇔	⇩
Teens who currently smoke	⇩	
Underage alcohol use	⇩	⇩
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Children who visited a dentist last year	⇧	⇧
Children with complete immunizations	⇧	⇧
Breastfeeding	⇧	⇧
Breast cancer screening	⇔	⇧
Colorectal screening	⇧	⇧
Flu Shot	⇧	N/A

Note: Measures are for the overall population; differences may exist for age, race/ethnic and other groups.

Input from the Community

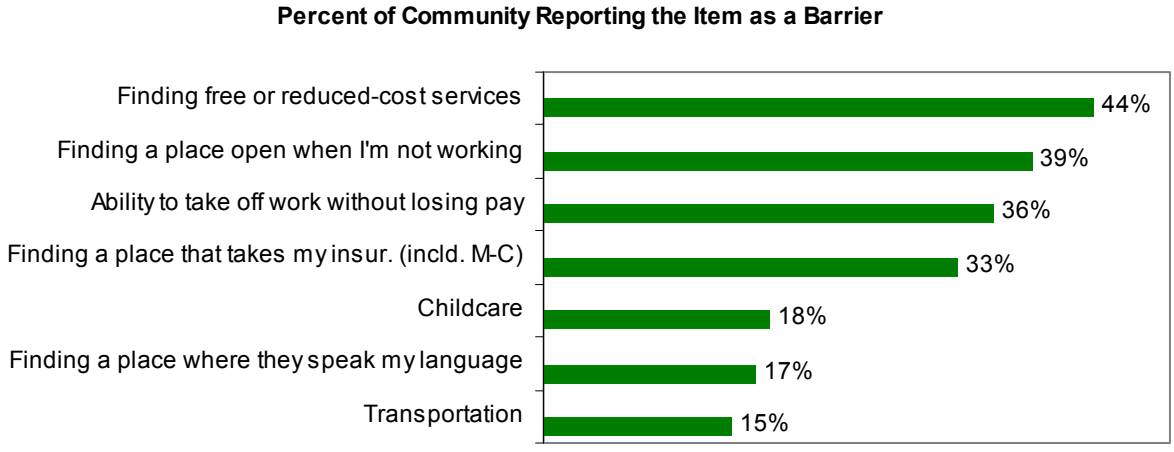
The tables below describe what the community identified as the most important unmet health needs in Napa County and suggested for improvement. The findings are consistent with recent needs assessments, studies, and surveys conducted by others in Napa County.

Unmet Health Needs

The highest-priority unmet health needs and problems for people in Napa County, according to the different groups asked, were the following, in order of mention.

Community Health Survey	Community Focus Groups	Key Informant Interviews
Health insurance; more affordable medical and dental services	Affordable dental services (especially for seniors and other adults)	Affordable community-based mental health services (depression, anxiety)
Prevention related (nutrition, weight control, exercise)	Health insurance; more affordable medical and dental services	Health insurance; more affordable medical and dental services
Alcohol and drug related (preventive education, enforcement, treatment)	Affordable community-based mental health services (depression, anxiety)	Affordable dental services (especially for seniors and other adults)
Basic needs (housing, jobs, transportation, environmental)	Alcohol and drug related (preventive education, enforcement, treatment)	Prevention related (nutrition, wt. control, exercise)
Specific health conditions (diabetes, cancer, asthma)	Lack of awareness of availability/type/location of health and prevention services	Supportive services for seniors (to remain independent, engagement for mental health)

Some of the following barriers were "*usually* a problem" when seeking medical or dental services for the people who responded to the Community Health Survey:



Suggested Strategies and Solutions

The community made many recommendations about where additional support was needed to improve health in Napa County; the most frequently suggested strategies and solutions—which tie to the needs they identified—are listed below in frequency of mention.

Community Health Survey	Community Focus Groups	Key Informant Interviews
Availability of low-cost health insurance	Availability of low-cost health insurance	Expand community-based mental health services
Access to wellness-type centers/services (especially those that promote exercising)	Availability of low-cost dental services (especially for adults, seniors)	Use mobile dental to deliver more services; support free/low-cost dental for adults and seniors
Year-round activities for youth (that youth can relate to)	Efforts that improve school lunches; that teach kids healthier food choices (gardens)	Address youth substance abuse, especially re. use of alcohol
Efforts to increase cleaner environment (air, water)	Support more options for affordable housing	Provide food as a basic need (food banks, community gardens)
Low-cost mental health counseling services	Promote health education (especially for Spanish-speaking and teens re. risk behaviors)	Support services for the elderly (homebound, frail, low-income)
Support services for the elderly (homebound, frail, low-income)	Support affordable exercise options (low-cost gyms, free bicycles)	Support efforts that increase awareness of services/where to go for help

Important factors that act to promote (assets) or hinder (challenges) health in Napa County were identified by the general public and community leaders. The unusually high degree of collaboration among organizations was widely recognized as one of the most important assets relative to planning and delivering services in the county.

Unique Characteristics about Napa County that are Believed to Affect Health and Well-Being
Assets
▪ Natural beauty/clean environment ▪ Slower pace of life; feeling of tranquility ▪ Many opportunities to exercise (e.g., plenty of open spaces, bikeways) ▪ Wealth of high-quality community services/resources ▪ Availability of fresh food/produce (e.g., Farmers' Market) ▪ Unusually high degree of collaboration/non-competiveness among community organizations
Challenges
▪ "Alcohol promoting" culture ▪ Tourism-created hazards (e.g., traffic congestion, DUIs) ▪ Perception of environmental hazards (e.g., pesticides) ▪ High cost of living in the area ▪ Insufficient number of bilingual workforce in health and human services

Health Resource Availability

Much of the infrastructure needed to provide health services appears to be in place in Napa County, particularly for those with employer-based insurance. A comprehensive community health clinic, widely recognized as being a major safety net provider, serves the neediest residents along with two non-profit hospitals and a public health system. The provision of clinical services is not the only thing that contributes to health: numerous non profit organizations play unique and critical roles. An adequate number of primary care physicians and general dentists practice in the community. Health insurance is available for low-income children, at least in the short term, from the progress made by the Children's Health Initiative.

The gaps are most evident in the limitations to the infrastructure relative to affordability, accessibility, distribution, flexibility, or emphasis of the following: community-placed mental health services; dental services for adults; health care for adults without insurance, not eligible for Medi-Cal, and unable to pay sliding fees; providers in some specialty areas, willingness of physicians and dentists to accept Medi-Cal; transportation options; bilingual healthcare workforce; and comprehensive community-wide preventive health in all aspects of community life in Napa County.

Conclusions and Recommended Priorities

After evaluating all of the data collected from the needs assessment process, certain key findings emerged, including:

Positives

- Low rates of effects from pesticide use
- Relatively high community awareness about the value of prevention and taking responsibility for their own health
- The relatively high percentage of children covered by health insurance
- High rates of screening for some cancers
- Earlier entry into prenatal care

Challenges

- The degree of substance use/abuse reported by school-age children and youth
- The extent to which anxiety and depression ("life stressors") exist across the community
- The growing trend of obesity and diabetes

Recommended Priorities

The Collaborative agreed that an important opportunity exists in Napa County for all health partners—regardless of their own organization's mission and priorities—to focus on the following 4 priority areas (in no order of significance):

- Strategies that address the growing epdemic of **obesity** and all of the health and cultural factors that contribute to the problem;

- **Senior support services** that encompass mental, social, and physical health and well being, including needed support for caregivers;

- **Substance abuse** as an issue for families, schools, businesses, and the safety of the community—ranging from use during pregnancy to underage drinking to abuse of prescription drugs by seniors and other adults—that recognizes and integrates biological and socio-cultural factors into models of prevention and care;

- **Mental and emotional health** and its relationship to overall health that needs to be more adequately understood, addressed, and resources provided for.

INTRODUCTION

"This community does an amazing job making people aware of services."—Key Informant Interview

"They should put a huge lit up rotating sign out in the middle of Napa so people would be aware of the services."—Focus group participant

Every individual and every institution in a community has a stake in health. Poor health is costly to individuals trying to hold down a job, employers who pay for sickness in high rates of absenteeism or higher health insurance costs, and entire societies, which suffer economic losses when citizens are ill. As a result, all individuals and institutions benefit by addressing the social, environmental, and behavioral determinants of health.[1]

Health status is closely related to a number of socioeconomic characteristics. Individuals of different socioeconomic status show profoundly different levels of health and incidence of disease, and race and ethnicity matter in complex ways. Social and economic variables that have been shown to affect health include income, education, employment and even literacy, language and culture.

"Health literacy," for instance, is a concept that links a person's level of literacy with their ability to act upon health information and, ultimately, to take control of their health. Individuals with poor health literacy—who tend to be poorly educated, immigrants, elderly or members of racial/ethnic minority groups—are at risk for unsafe care when important health care information is communicated using medical jargon and unclear language that exceed their literacy skills. These individuals can have problems reading materials such as prescription bottles, educational brochures, and nutrition labels and are more likely to have higher rates of complications than people who are more literate.[2]

It is important for communities to understand that "health" is a multi-dimensional concept. Individual health status can be rated along any of several dimensions, including presence or absence of life-threatening illness, risk factors for premature death, severity of disease and overall health. It may also be assessed by asking the person to report his or her overall perception of health. The health of an entire population is determined by aggregating data collected on individuals. The commonly used measures of population health status are morbidity (incidence and prevalence of

[1] Kottke TE, Pronk NP. Taking on the Social Determinants of Health: A Framework for Action. *Minnesota Medicine*, February 2009.

[2] Weiss BD, et al. *Health status of illiterate adults: relation between literacy and health status among persons with low literacy skills.* J Am Board Fam Pract 1992 May-June;5(3):257-64.

disease) and mortality (death rates). Judgments regarding the level of health of a particular population are usually made by comparing one population to another, or by studying the trends in a health indicator within a population over time.

One of the best ways to gain a better understanding about health needs, disparities and available resources is to conduct a comprehensive needs assessment. A community health needs assessment provides the foundation for all community health planning, and provides appropriate information on which policymakers, provider groups, and community advocates can base improvement efforts; it can also inform funders about directing grant dollars most appropriately. One of the most important aspects of the community health needs assessment is obtaining information and views from community members themselves. This involves surveying a certain percentage of the community to find out which health problems are most prevalent and soliciting their ideas about strategies to address them. It also explores the factors that affect the design of programs and services to effectively address the identified health problems.

The U.S. Public Health Service established two overarching health goals for the year 2010: (1) increase quality and years of healthy life; and (2) eliminate health disparities.[3] To achieve these two goals, a comprehensive set of objectives was established (Healthy People 2010), and 10 leading health indicators were identified and used over the last decade to set priorities and measure health (see box below).[4] These indicators, selected on the basis of their ability to motivate action, the availability of data to measure progress, and their importance as health issues for the public, influenced the development of the Napa County community health needs assessment.

Leading Health Indicators from *Healthy People 2010*

1. Physical Activity
2. Overweight and Obesity
3. Tobacco Use
4. Substance Abuse
5. Responsible Sexual Behavior
6. Mental Health
7. Injury and Violence
8. Environmental Quality
9. Immunization
10. Access to Health Care

[3] U.S. Department of Health and Human Services. *Healthy People 2010*. Washington, DC: U.S. Department of Health and Human Services, 2000.

[4] Every 10 years, the U.S. Department of Health and Human Services applies scientific insights and lessons learned from the past decade, along with new knowledge of current data, trends, and innovations, and updates the Healthy People Objectives. The HP 2020 Objectives were under final review at the time of this report; they are anticipated to be released in late 2010.

This report presents the results of a comprehensive Napa County community health needs assessment that spanned approximately 9 months. Various other reports and assessments of Napa County may contain similar data because some of the data are publicly available and may be used by other groups for similar purposes.

BACKGROUND

In 2006, the Napa County hospitals and Kaiser Vallejo—joined by Napa County Public Health and others—formed a collaborative to identify data that could assist healthcare organizations, individually and collaboratively, in improving community health and maximizing resources. The data assessment was also intended to guide the hospitals in developing their Community Benefits Plans to meet SB 697 requirements.[5] The result of that collaboration was the 2007 *Napa County Community Health Needs Assessment* which over the last 3 years has benefited public and non-profit organizations in Napa County in numerous ways. For example, many organizations have drawn from the rich source of local qualitative and quantitative data when making presentations to policymakers and preparing grant applications; some agencies may even have aligned their own priorities with those recommended in the report.

In 2009, the Collaborative organizations (listed in Appendix 1) re-formed and guided the development of the *2010 Napa County Community Health Needs Assessment,* following the same process as in the 2007 assessment for consistency and because it was effective.

Purpose

The goals of the Napa County community health needs assessment were to help document and understand the following:

- The unique characteristics of the community that contribute to or threaten health;
- The health habits people think contribute most to maintaining their own health;
- The kinds of health problems and needs (physical, mental, social) that members of the community are experiencing, and which are the highest needs;
- What contributes to or causes these problems (including barriers);
- The resources (organizations, funding, community expertise, other strengths and assets) that are available to address these health problems, and the biggest gaps;
- How the highest-ranked needs can most effectively be met—identifying priorities for strategies and solutions for community investment.

[5] Under SB 697 legislation, California non-profit hospitals are required to conduct community needs assessments every 3 years, and based on the results develop and implement a Community Benefits Plan.

Uses for the Needs Assessment

The Napa County Community Health Needs Assessment is intended to be useful to leaders and organizations involved in addressing the health needs of county residents by:

1. Providing documentation for decision-making by policymakers;

2. Presenting the community with an overview of the state of health-related needs and benchmarks from which to gauge progress;

3. Directing funding towards the highest-priority health needs in the community.

Scope of the Assessment

While many factors, complex and interrelated, impact community health and well being, for pragmatic not philosophical reasons the Collaborative made the decision to limit the collection and presentation of secondary data to physical and mental health issues. Very little of the environmental and other conditions affecting health (e.g., air, water and housing) were included in the analysis. Particular emphasis was paid to population groups with recognized disproportionate needs (e.g., low-income groups, seniors, Latinos).

Limitations of the Published Data

There are several ways to present data just as there are multiple ways to identify health needs: by age group (children, adolescents, seniors), by issue (access, uninsured) or problem (asthma, infant mortality), by ethnic group (Latinos, Asians), by systems (hospitals, clinics). Regarding the published data (referred to as “secondary data”), this assessment looked at the community health indicator data typically collected in community needs assessments, added to it, and highlighted populations and issues of interest where the data already existed. Where data were available by more than one variable (for instance, age and racial/ethnic group) they are generally presented.

Using secondary data requires collecting information from many sources. Data availability varies among different data sources; new data are continually being released. Any report of this type will soon have certain data that are not the most up-to-date. (For example, 2009 data from CHIS, the California Health Information Survey, which is a rich data source for community health needs assessments, is expected to be released in early 2011, a few months after this report is released.) Also, reporting periods can vary by calendar year, frequency and fiscal year; consistency varies, especially over time and among agencies and organizations; and data are not always collected in the format that is best suited to the purposes of the report.

This assessment relied on data that could be collected and analyzed to determine if and to what degree a problem or need existed. In some cases, data did not exist that directly applied to a certain need or condition; in other cases, no indicators were readily available to describe a potential need. The community input process (referred to as

"primary data") provided some opportunity to identify such needs and ensured that they were considered in the priority-setting process.

The availability (or lack) of services can substantially influence reporting. Some data were not collected, such as the availability of services from private medical groups, and therefore could not be counted in the capacity assessment.

In some cases, statistics and information that others compiled have been included in this report. However, it was not always possible to authenticate all of that data. In some cases, expert opinion was included in the analysis regarding the state or condition of a certain issue. And, while funding strategies and solutions to address unmet needs were identified by participants in the community input process, there was no attempt by the Collaborative to evaluate these suggestions for appropriateness or endorse them relative to best practices and evidence-based effectiveness.

Finally, no one data set in this report really tells the whole story about Napa County's unmet or under-met health needs; all of the data collected by this process—the statistics, feedback from the community questionnaire, focus group input and key informants' perspectives—*collectively* paint the picture. It is therefore suggested that readers consider the entirety of the findings when drawing conclusions or making policy changes and funding decisions.

Study Team

BARBARA AVED ASSOCIATES (BAA), a Sacramento-based consulting firm, was again retained to carry out the community health needs assessment. BAA designed the project, developed the data collection instruments, collected and analyzed the data, and prepared the final products: the comprehensive needs assessment report and a 2-page Overview document to facilitate sharing highlights of the assessment. The consultant team included Barbara M. Aved, RN, PhD, MBA, an expert in community health and evaluation; Mechele Small Haggard, MBA, a research and evaluation consultant based in Napa; Beth Shipley, MPH, a public health professional with expertise in maternal, adolescent, and child health programs; and, Anita Garcia-Fante, BA, a bicultural/ bilingual communications professional.

PROCESS (METHODS)

"I called and they told me it would be a 1-week wait. I really wanted to be seen so I went to the emergency room.."'—Focus group participant

"We need to become our own advocates when it comes to our health." —Respondent to the community health survey

DATA COLLECTION

Quantitative and qualitative methods were used to collect information for this assessment, which included both primary and secondary data sources.[6] Community needs assessments and environmental scanning—which involves gathering, analyzing and *applying* information for strategic purposes—provide the necessary information to inform decision makers and funders about the challenges they face in improving community health, and the priority areas where support is most needed. The information is also useful for community organizations by having comprehensive, local data located in one document.

DOCUMENT REVIEW

A document review was undertaken that collected relevant information about the community, health status, where health services are obtained, other related services, and gaps in services. This information was found in documents and records of facilities such as data from local clinics and state government, reports from earlier needs assessments conducted related to health, and reports about specific health programs or services.

SECONDARY DATA: PUBLICLY-AVAILABLE STATISTICS

Existing data were collected from all applicable existing data sources including government agencies (e.g., California Department of Finance, Office of Statewide Health Planning and Development, California Department of Health Care Services), and

[6] *Quantitative* data are numeric information such as statistics (e.g., the number of vehicular crashes, the percentage of low birth weight babies born). *Qualitative* data help shed additional light on the issues being studied by providing information such as people's attitudes and opinions. *Secondary* data are the statistics and other data already published or reported to government agencies. An example of this would be rates of childhood obesity. New data gathered to investigate and help solve a problem are called *primary* data. An example of this would be the percentage of focus group participants who ranked obesity as a top-10 health problem.

other public and private institutions. These data included demographics, economic and health status indicators, and service capacity/ availability. To emphasize a point made in the previous chapter, all needs assessments are dependent on access to timely and reliable data. While data at the national and state level are generally available for community health-related indicators, local data—from counties and cities—are less accessible and sometimes less reliable. For example, small sample sizes can result in statistical "instability," and well-meaning data collection methods without appropriate "rigor" may limit the value of the findings. Because data from publicly-available sources typically lag by at least 2 years—because it takes time for reported data to be received, reviewed, approved, analyzed, and prepared for presentation—data may not always be as current as needed. And, some data may only be reported as 3-year averages, not annually.

PRIMARY DATA: COMMUNITY INPUT PROCESS

Three primary methods of collecting input from the community were used in the assessment process.

Community Questionnaire

A questionnaire was developed in English and Spanish for the general public that inquired about most-important health needs, ideas for responsive solutions, and habits they used to maintain their own personal health (Appendix 8). Certain questions that served as markers for access to services were also included. The survey was distributed in hard copy by the consultants and members of the Collaborative to locations where the groups of interest would best be reached, such as at health fairs, branches of public libraries, and Boys and Girls Clubs, and family resource centers throughout the county. In addition, the survey was made available by computer (English/Spanish) and notices about the online version were posted on various organizations' websites and in their newsletters including, to a limited degree, Spanish-speaking media outlets. All of the electronic and hard-copy survey data were cleaned, coded, and entered into an Excel spreadsheet and analyzed using SPSS Version 15.0.

Community Focus Groups

Four locations—Napa, Calistoga, St. Helena, and American Canyon—were chosen to ensure geographic representation and 9 community focus groups were conducted at sites intended to draw populations that typically gathered there. Key community-based organizations were identified by the Collaborative and asked to host a focus group. Focus groups were co-scheduled at the sites among participants who were already meeting there for other purposes (e.g., young mothers at a parenting class) to facilitate access and promote attendance. Although the participants constituted a convenience sample, there was the expectation that *in the aggregate* the groups would be diverse and include the populations of highest interest.

To ensure that working people could attend, some of the meetings were held in the evening. One meeting was held in the early morning to accommodate people coming to

drop their children off at a preschool, and other daytime meetings were held for seniors or others who had difficulty driving at night or did not like to go out after dark. The groups were facilitated in English and Spanish with a bilingual/bicultural facilitator using a set of key questions (Appendix 4). The questions were generally open-ended; prompting with information or data was limited to reduce the potential for bias or leading of participants to any conclusions. Participants were not asked to "vote" or otherwise rank the items they identified as needs, problems or solutions. The focus group data were recorded on a flip chart by the facilitator during the meetings then transferred to written summary formats where it was coded and analyzed.

Colorful gift bags containing practical and other items (e.g., canvas grocery bag, toothbrush, toothpaste, water bottle, magnetized refrigerator clips, Blue Diamond® almonds) were offered in appreciation for participation. Agencies and organizations that sponsored the community meetings helped to publicize the meetings and promote attendance. A flyer in English and Spanish was provided to the organization to post if desired (Appendix 6 contains a sample).

Key Informant Interviews

In-depth telephone interviews using a structured set of questions were conducted, primarily individually, with a representative group of 20 individuals whose perceptions and experience were intended to inform the assessment (Appendix 7). The interviews provided an informed perspective from those working "in the trenches," increased awareness about agencies and services, offered input about gaps and possible duplications in service, and solicited ideas about recommended strategies and solutions. The interviews also focused the needs assessment on particular issues of concern where individuals with particular expertise could confirm or dispute patterns in the data and identify data and other studies the Collaborative might not otherwise be aware of.

PRIORITY SETTING PROCESS

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

ASSESSMENT RESULTS

"I go to community exercise classes. They are very helpful for reducing isolation and building community support as well as getting good exercise."– Elderly focus group participant

Section I. Demographic and Socioeconomic Characteristics

There are large health disparities among certain groups and across socioeconomic lines. Research shows that race and ethnicity, for example, matter in complicated ways. To address these disparities, approaches are needed—identified and planned for through comprehensive needs assessments—that include a focus on the "upstream" causes, such as income inequity, poor housing, racism, and lack of social cohesion.[7]

COUNTY PROFILE

Napa County, located 50 miles northeast of the San Francisco Bay Area, is one of the most renowned agricultural as well as premium wine-producing regions in the world. The wine and vineyard industries are the county's largest and responsible for nearly 40,000 jobs. The Napa River flows north to south through the valley and is navigable from the city of Napa to the San Francisco Bay. The county is bordered by mountains on the north, east, and west making it difficult to access the adjoining counties' population centers. Highways that pass into surrounding Lake, Sonoma, Yolo, and

[7] Brownson RC, et al. Evidence-Based Public Health. 2003. New York: Oxford University Press.

portions of Solano counties are occasionally impassable in winter due to snow, ice, or slides in heavy rain. Portions of the southern and southeastern borders of Napa County are non-mountainous allowing for easy access to the city of Vallejo in Solano County. However, the stretch from north to south county is at least 30 miles, presenting access barriers for people with limited transportation options.

Highway 29 (about 15 miles from Interstate 80) is the main thoroughfare for the county. In general, the county is divided into four regions:

- North County: Calistoga, St. Helena, Deer Park, Rutherford, Oakville
- East County: Angwin, Pope Valley, Lake Berryessa
- Central County: Napa, Yountville
- South County: American Canyon

Napa County

According to California labor market data (which has not been updated since 2000), about 36% of people who live in Napa County also work within the county (Table 1 on the next page). While the population size of Napa County was estimated as 137,723 residents in 2009, the population can swell to more than 200,000 with daytime work commuters and seasonal tourists; many people live in Solano County (primarily Vacaville and Fairfield) but work in Napa County. Employers in the county rely on 11,000 commuters from neighboring Solano County.[8]

[8] QVMC Annual Market Assessment 2009. Internal document provided to the author.

Table 1. County-to-County Commute Patterns

Year	Time Period	Area of Residence	Area of WorkPlace	Number of Workers
2000	Census	Napa County , CA	Napa County , CA	44,341
2000	Census	Solano County , CA	Napa County , CA	8,256
2000	Census	Napa County , CA	Solano County , CA	3,756
2000	Census	Sonoma County , CA	Napa County , CA	3,030
2000	Census	Napa County , CA	Sonoma County , CA	2,146
2000	Census	Napa County , CA	Contra Costa County , CA	1,974
2000	Census	Napa County , CA	San Francisco County , CA	1,305
2000	Census	Napa County , CA	Alameda County , CA	1,229
2000	Census	Contra Costa County , CA	Napa County , CA	1,094
2000	Census	Napa County , CA	Marin County , CA	894

Source: U.S. Census Bureau, 2000.

POPULATION DATA

Demographic trends help to project potential needs for health care and other services for children, adults, and the elderly.

Approximately 57% of all county residents live in the City of Napa while the remainder lives in the balance of the county. Population estimates beyond the 2000 Census are displayed in Table 2 and show the continuing projected trend for considerable population growth in American Canyon. While the population of Napa County increased overall since 2000, the city of American Canyon has nearly doubled in size and is already the second-largest city in Napa County. Services for residents in this area are still being established—and various community agencies continue to work to understand what individuals and families in this expanding community need.

Table 2. Population Estimates of Napa County Cities, 2003-2010 with 2000 Benchmark

City	4/1/2000	1/1/2003	1/1/2004	1/1/2005	1/1/2006	1/1/2007	1/1/2008	1/1/2009	1/1/2010
American Canyon	9,774	12,377	13,169	14,269	14,948	16,031	16,241	16,521	16,836
Calistoga	5,190	5,256	5,197	5,209	5,252	5,302	5,284	5,335	5,370
Napa	72,585	75,000	75,997	76,160	76,639	76,997	76,857	77,917	78,791
St Helena	5,950	6,064	6,001	5,991	5,983	5,993	5,905	5,969	6,010
Yountville	3,297	3,289	3,267	3,251	3,261	3,290	3,257	3,267	3,257
Subtotal Incorporated	96,796	101,986	103,631	104,880	106,083	107,613	107,544	109,009	110,264
Balance Of County (Unincorporated)	27,483	28,276	28,124	28,094	28,243	28,356	28,732	28,714	28,653
County Total	124,279	130,262	131,755	132,974	134,326	135,969	136,276	137,723	138,917

Source: California, Department of Finance, *E-4 Population Estimates for Cities, Counties and the State. May 2010.*

City/county population estimates with annual percent change between January 2009 and January 2010 show a positive growth for the county overall (Table 3 on the next page). Between the two periods, Napa County had an estimated overall 0.9 % change in population. Among the cities, American Canyon had the highest percent change, while Yountville and the balance of the county experienced negative change.

Table 3. Population Estimates with Annual Percent Change

County/City	Total Population		Percent Change
	1/1/2009	1/1/2010	
Napa County Total	137,723	138,917	0.9
American Canyon	16,521	16,836	1.9
Calistoga	5,335	5,370	0.7
Napa	77,917	78,791	1.1
St Helena	5,969	6,010	0.7
Yountville	3,267	3,257	-0.3
Balance Of County	28,714	28,653	-0.2

Source: *California Department of Finance, E-1 Population Estimates for Cities, Counties and the State with Annual Percent Change. January 1, 2009 and 2010. May 2010.*

Population by Age and Race/Ethnicity

Mirroring California, Napa County's estimated 2010 population of 138,917 is becoming increasingly diverse. Napa County population by age group and race/ethnicity based on the 2000 census and the 2010 projected population estimates are shown in Table 4. The projected percent changes in population are shown for each group in Figure 1 that follows the table. Twenty-eight percent of the overall population identifies themselves as Hispanic or Latino, while among children age 0-5 the proportion is closer to 50%. With 15.7% of all residents over the age of 65, the county has a higher proportion of older residents than California as a whole.[9]

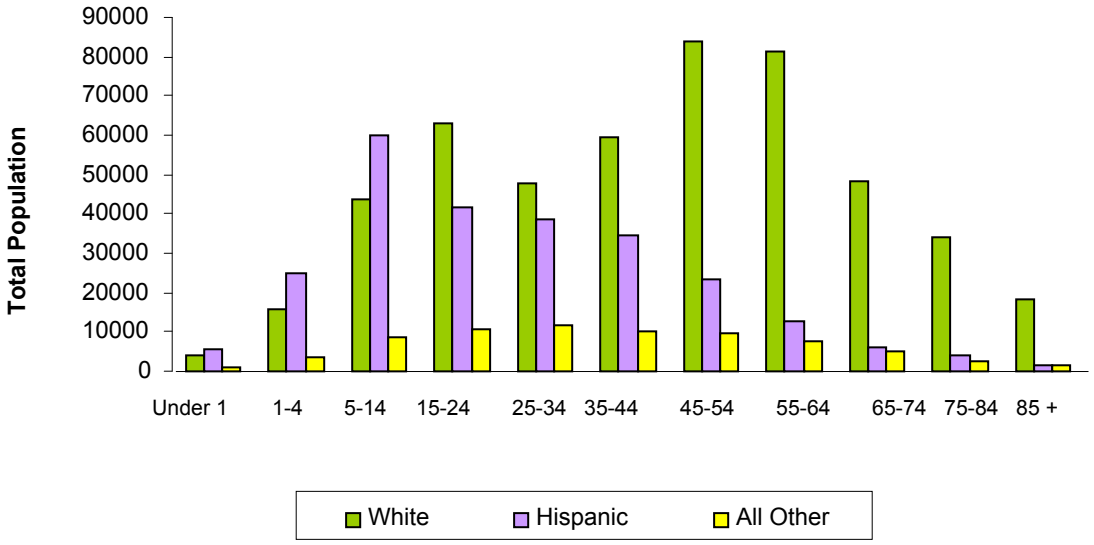
Table 4. Population by Age and Race/Ethnicity, 2000 and 2010 Projected

Age Group	Total		White, non Hispanic		Hispanic		Asian/ Pacific Islander		African American		Native American		Multirace	
	2000	***2010***	***2000***	***2010***	***2000***	***2010***	***2000***	***2010***	***2000***	***2010***	***2000***	***2010***	***2000***	***2010***
All	124,945	142,121	86,411	84,735	29,940	43,542	4,097	6265	1,637	2,830	713	2,114	2,147	2,635
<5	7,546	8,268	3,716	3,600	3,264	3,746	192	374	122	220	35	125	217	203
5-14	17,235	17,230	9,872	7,235	6,073	8,147	464	613	251	463	105	265	470	507
15-19	8,652	9,779	5,146	4,528	2,746	4,238	342	360	150	253	45	177	223	223
20-64	72,307	84,712	50,278	51,093	16,855	25,114	2627	4,072	986	1652	470	1367	1091	1,414
65-84	16,202	17,903	14,575	14,438	902	2,162	429	739	115	190	54	157	127	217
85+	3,003	4,229	2,824	3,841	100	135	43	107	13	52	4	23	19	71

Source: California Department of Finance, *Population Estimates with Race/Ethnic Detail, May 2007.*

[9] California Department of Finance, Population Projections for California and Its Counties 2000-2050, by Age, Gender and Race/Ethnicity, Sacramento, California, July 2007.

Figure 1. Napa County Age Distribution by Race/Ethnicity, 2010



Source: State of California, Department of Finance

In 2008, an estimated 24.6% of Napa County's young adults (ages 18-24) were born outside the U.S., compared to 12.2% of children ages 5-17, and 2.1% of children ages 0-4. Among adults ages 25-64, 31.3% were foreign-born. Napa County's percentage of foreign-born residents somewhat mirrors the state proportions except for the age group 65+, which is 29.7% for California and 17.5% for Napa County. Of interest, Napa and Santa Clara counties have the largest concentrations of immigrant children ages 5-17, at 12% (about 8% of California children ages 5-17 are foreign born).

Table 5. Percent of the Foreign-Born Population by Age Group, 2006-2008

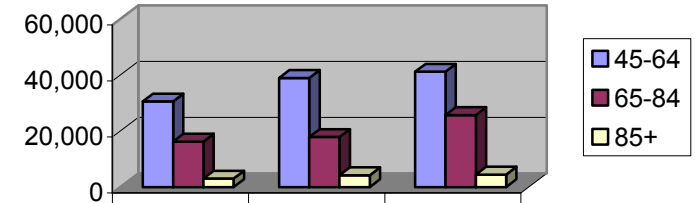
Age Group	Percent	Range: 0 - 75.0%
Ages 0-4	2.1%	
Ages 5-17	12.2%	
Ages 18-24	24.6%	
Ages 25-64	31.3%	
Ages 65 and Above	17.5%	

Source: U.S. Census Bureau, American Community Survey, accessed at http://factfinder.census.gov/home/saff/main.html?_lang=en.

Seniors

With 15% of all residents over the age of 65, Napa County has a higher proportion of older residents than California as a whole (11.3%). According to Department of Finance data, between 2000 and 2008 the population age group 65 and over grew from 4,386 to 4,701, a 7.6% change. Yountville, largely due to the presence of the California Veteran's Home, has a higher proportion of seniors living there followed by the cities of Calistoga and St. Helena.

Figure 2. Adult/Senior Population 2000-2020



	2000	2010	2020
45-64	30,571	38,986	41,187
65-84	16,202	17,903	25,737
85+	3,003	4,229	4,440

State of California, Department of Finance, *Population Projections by Race/Ethnicity, Gender and Age for California and Its Counties 2000-2050,* Sacramento, California, May 2004.

Children

Of the estimated 135,969 residents living in Napa County in 2007,[10] 6.3% were children under age 5 years old, and 22.5% below age 18. According to First 5 Napa, the most significant current demographic trend for children and families in Napa County continues to be the rapid growth of families with young children moving to the south county community of American Canyon.

Farmworker Population

With a peak agricultural labor force of approximately 6,790 farm workers, approximately one of every 20.3 Napa County residents is a farmworker. A profile of farmworkers working in Napa County found 3,744 worked in Napa County for 7 months or more (defined as "regular workers"), 1,258 worked in Napa County for 3 to 6 months (defined as "seasonal workers"), and 1,788 worked in Napa County for less than 3 months (defined as "temporary workers"). Assuming the sample in this profile was representative, nearly one in three (31%) of farmworker households includes children under the age of 18 with a mean number of children per household of 2.0, and a range of 1 to 6. Among households with children, 24% had three or more children.[11]

[10] California Department of Finance population estimates with annual percentage change, May 2007.
[11] Strochlic R, et al. *An Assessment of the Demand for Farm Worker Housing in Napa County*. California Institute for Rural Studies. March 2007.

Anticipated Population Changes

Napa County's population is estimated to increase by more than half by 2030. As the region's population expands, its demographic makeup is expected to shift significantly as well. In particular, the number of older and non-White residents will increase dramatically—and disproportionately—compared to the rest of the population.

Age Shifts

Napa County's senior population is rising at a faster rate than California as whole. The over-85 population is also growing at a significantly faster rate than the total county population. In Napa County, population projections through 2030 for older residents include:[12]

- An increase of 46% for the 45-64 age group;
- An increase of 99% for the population of 65-80 year olds.

The anticipated significant growth in these age groups will put a larger burden on the health care system and local economy, which may not have sufficient community services or tax base to support it.

Cultural/Ethnic Shifts

Corresponding to the growth in population, Napa County's population is projected to become increasingly diverse in coming years. Some highlighted increases estimated for Napa County by 2030 include:[13]

- The Hispanic population is projected to increase by 165% (from 37,051 to 79,435)
- The African American population is projected to increase 289% (from 2,212 to 6,361)
- The Asian population is projected to increase by 206% (from 4,892 to 11,688)

SOCIOECONOMIC FACTORS

Socioeconomic characteristics include measures that have been shown to affect health status, such as income, education and employment and the proportion of the population represented by various levels of these variables. There is considerable evidence that individuals with higher incomes have better health.[14] Some of the ways in which poverty contributes to poor health are immediately obvious. Absolute deprivation leading to poor nutrition may lead to susceptibility to infection and chronic disease, and

[12] Data excerpted from California Department of Finance, reported in *The Coming Wave: Solano and Napa Counties Brace for Elderly Population Boom*. Solano Community Foundation and United Way, report undated.
[13] Ibid.
[14] Pritchett L, Summers L.H. Wealthier is healthier. *Journal of Human Resources* 31, 841-868, 1997.

crowded housing may increase disease transmission. Higher incidences of unplanned or unwanted pregnancies, higher rates of low-birth-weight babies, infant deaths and low immunization rates are all associated with poverty along with a myriad of other adverse health outcomes.

According to one model of ranking the various factors associated with good health, social and economic factors contribute 40% toward community health outcomes.[15] Applying this model, Napa County ranked 10th of 56 counties on social and economic factors.[16]

Economic Well-Being

Self-sufficiency income is defined as the minimum income a household must earn in order to adequately meet the basic needs of the family without being obligated to use public or private assistance. The self-sufficiency income for a family of two adults, one preschooler, and one school age child living in Napa County was $57,728 per year in 2008.[17] In 2007, Napa County ranked 11th best in the state on economic well-being, with only 24% of households below the self-sufficiency standard (Table 6).[18]

Table 6. Household Self-Sufficiency by County Ranking

Area	2007 County Ranking	2007 % of households below Self-Sufficiency	2008 Median Family Income	Median Income as a % of Self-Sufficiency
Napa County	11	24%	$64,829	112%
California	N/A	31%	$61,017	N/A*

*Statewide Self-Sufficiency income in dollars is not calculated; it is only available by county.
Sources: *Overlooked and Undercounted 2009: Struggling to Make Ends Meet in California.* US Census Bureau, State and County Quick Facts

While these data are favorable overall, they tend to mask the picture of poverty for the low-income. Although Napa County is not considered a "poor" county—and is better off economically than most agricultural counties in California—the substantial wealth of a disproportionate number of Napa Valley residents skews the economic indicators for a sizeable portion of the population. For example, 51% of Latino households were below the self-sufficiency standard, compared to 24% for the county as a whole.[19]

[15] County Health Rankings. Mobilizing Action Toward Community Health. 2010 California. University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation.
[16] Ibid.
[17] Self Sufficiency Tables by County, All Family Types, 2008, http://www.selfsufficiencystandard.org/pubs.html (March 2010)
[18] Overlooked and Undercounted 2009: Struggling to make ends meet in California, 2009 Diana Pearce and United Way of the Bay Area, http://www.selfsufficiencystandard.org/pubs.html (March 2010)
[19] Ibid.

Measures of Poverty

While the recession technically ended in mid-2009, the impact on families and children is expected to linger on for years, according to economists. Poverty levels ("persons living in poverty") are generally higher for California than for Napa County. Up from 9.9% in 2005, 11.5% of Napa County children ages 0-17 in 2008 were estimated to live in families with incomes less than 200% of the official federal poverty level. The percentage of seniors living in poverty also rose during the 3-year period 2006-2008 from 2005 (Table 7).[20] Nine percent of the total county population was living below the poverty level, compared to 13.3% statewide.

Table 7. Persons Living Below Poverty Level, Napa County and California

Age Group	Napa County				CA
	2005	2006	2007	2008	2008
All ages	9,523 (7.5%)	13,324 (10.3%)	11,004 (8.6%)	11,511 (9.0%)	13.3%
All children under age 18	3,011 (9.9%)	3,200 (10.7%)	3,363 (11.4%)	3,411 (11.5%)	18.5%
Children ages 5-17	2,048 (9.3)	2,076 (9.6%)	2,141 (10.1%)	2,250 (10.7%)	17.3%
Persons age 65 and older*	7.6%	8.0%*			8.4%*

Source: U.S. Census Bureau. Small Area Income & Poverty Estimates. Estimates for California Counties;
*U.S. Census Bureau, 2006-2008 American Community Survey.

The percentage of Napa County children ages 0-17 living in families with incomes below the federal poverty level by race/ethnicity is shown in Table 8 below. In 2008, a family of two adults and two children was considered poor if their annual income fell below $21,834. Although the numbers of African American children in the county are too small for statistical reliability, it is worth noting that in 2008 more than one quarter (27.5%) of African American children ages 0-17 in California lived in poor families.[21]

Table 8. Napa County Children in Poverty, by Race/Ethnicity

Race/Ethnicity	2005-2007	2006-2008
African American/Black	*	*
Asian American	*	*
Caucasian/White	6.0%	9.8%
Hispanic/Latino	17.5%	17.1%
Multiracial	*	*

Source: Cited on kidsdata.org, U.S. Census Bureau, American Community Survey. Accessed at http://factfinder.census.gov/home/saff/main.html?_lang=en.
*Sample size too small for statistical reliability.

[20] U.S. Census Bureau, *Small Area Income and Poverty Estimates*. Accessed online at http://www.census.gov/did/www/saipe/county.html (March 2010)
[21] As cited on kidsdata.org, U.S. Census Bureau, American Community Survey. Accessed online at http://factfinder.census.gov/home/saff/main.html?_lang=en.

Another indicator of low-income status is the number of school children eligible for free or reduced-cost school meals.[22] The percentage of children enrolled in the program in Napa County, 41% in 2008-09, has remained fairly steady since 2005 and is lower than the state rate (Table 9).[23] Calistoga Joint Unified, Howell Mountain Elementary, and Napa County Office of Education school districts have higher proportions of children enrolled in the lunch program than the county average.

Table 9. Percent of Students Enrolled in the Free-Reduced Price Meals Program, Selected Years

	2005	*2006*	*2007*	*2008*	*2009*
Calistoga Joint Unified	60%	67%	74%	70%	68%
Howell Mountain Elementary	49%	44%	54%	48%	57%
Napa Co. Office of Education	34%	69%	75%	45%	LNE*
Napa Valley Unified	39%	38%	39%	40%	39%
Pope Valley Union Elementary	LNE*	LNE*	LNE*	LNE*	LNE*
St. Helena Unified	41%	40%	38%	39%	40%
Napa County Total	40%	39%	41%	41%	41%
California State Total	50%	51%	51%	51%	53%

*LNE (Low Number Event) refers to data that have been suppressed because fewer than 20 students were enrolled in the program.
Source: California Department of Education. http://dq.cde.ca.gov/dataquest/county&subject.

Although the need for affordable housing was not included within the scope of this assessment, Table 10 is provided to show an example of the difference in housing values in Napa County and the statewide average relative to affordability. Many even moderate-income households cannot afford to pay the median sales price (or rental price) for homes sold in Napa County, and most very low- and smaller low-income households' needs are unmet by local market rate housing.[24]

Table 10. Housing Values, 2008

Estimated median house/condo value in 2008: (it was $235,500 in 2000)

Napa County $565,800
California: $467,000

Source: http://www.city-data.com/county/Napa_County-CA.html. Accessed 5/21/10.

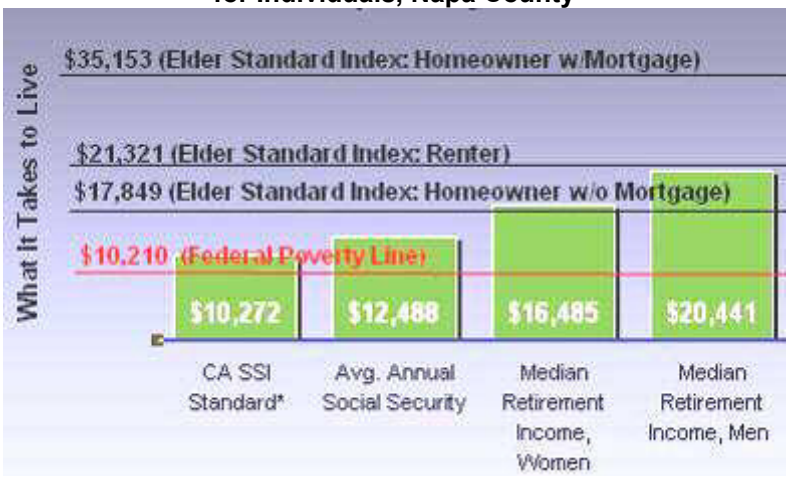
[22] Eligibility for free or reduced-price meals is set at 185% of the federal poverty level.
[23] Kidsdata.org. Lucile Packard Foundation for Children's Health. http://www.kidsdata.org/data/topic/dashboard.aspx?cat=39 (April 2010)
[24] Napa County General Plan, Housing Element. June 23, 2009.

Seniors and Poverty

The Napa Valley Older Adult Policy Platform (Healthy Aging Population Initiative) describes the new Elder Economic Security Standard™ Index (Elder Index) for California and its counties. The Elder Index measures how much income is needed for a retired adult age 65 and older to adequately meet his or her basic needs including housing, food, out-of-pocket medical expenses, transportation, and other necessary spending. [25] It documents that the federal poverty guideline covers less than half of the basic costs experienced by adults age 65 and older in the state, and demonstrates that elders require an income of at least 200% of then FPL to age in place with dignity and autonomy without relying on public programs.[26]

The bar graph below (Figure 3) compares the basic cost of living as quantified by the Elder Standard Index to three common sources of income for seniors. The gap between elders' basic living expenses, as shown by the lines in black, and their income, as shown by the green bar charts, illustrates the degree of economic instability that far too many Napa County elders experience. For example, even elders who own their home outright in Napa County are struggling to survive on incomes below the Elder Index and cannot make ends meet. The average Social Security payment of $12,488 is not enough to live on, and yet, many seniors rely exclusively on Social Security to cover their basic costs.

Figure 3. California Elder Economic Security Standard Index for Individuals, Napa County

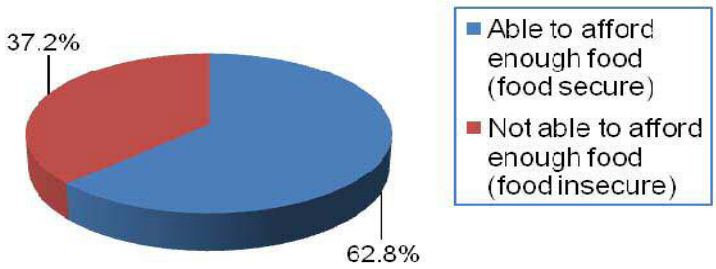


*Median elder retirement income includes Social Security, pensions, and all other non-earned income for seniors 65+. The Elder Standard Index assumes that elders are retired.
Source: http://www.insightcced.org/communities/cfess/elder-napa.html

[25] *Napa Valley Older Adult Policy Platform*. Healthy Aging Population Initiative. March 17, 2010. Index can be found at Insight/Center for Community Economic Development, accessed at http://www.insightcced.org/.
[26] Wallace SP, Molina LC. Federal Poverty Guideline Underestimates Costs of Living for Older Persons in California, Los Angeles: UCLA Center for Health Policy Research, 2008.

Not being able to afford enough food and dependence on public assistance for adequate nutrition are other important socioeconomic indicators of community health. Limited resources for purchasing food has a direct impact on health, for example increasing the risk of developing chronic diseases such as diabetes.[27] Based on the results of the 2007 California Health Information Survey in Napa County, in which adults whose income is less than 200% of the Federal Poverty Level were asked about the ability to afford enough food, only six of 10 (62.8%) respondents were considered "food secure" (Figure 4), virtually unchanged from 2005. It was estimated that about 10% of the county's population was currently receiving food stamps.

Figure 4. Food Security of Adults <200% of Poverty, 2005



Source: California Health Interview Survey, 2007. UCLA Center for Health Policy Research

Employment

Work for most people is at the core for providing financial security, personal identity, and an opportunity to make a meaningful contribution to community life. Although it is difficult to quantify the impact of work alone on personal identity, self-esteem and social contact and recognition, the ability to have employment—and the workplace environment—can have a significant impact on an individual's well-being. As of August 2010, 90.6% of Napa County's population was in the labor force. According to current labor market data, 69,600 of the 75,700 in Napa County's labor force were employed, a higher proportion than statewide, but lower than the U.S.[28]

[27] *The Inextricable Connection Between Food Insecurity and Diabetes*. California Pan-Ethnic Health Network. May 2010.
[28] California Labor Market Review. July 2010. http://www.labormarketinfo.edd.ca.gov/ (September 2010)

Unemployment

Rises in unemployment and uninsured have had a significant influence on the region's manufacturing, leisure and hospitality industries.[29] The unemployment rate in the Napa County was estimated as 9.4% in August 2010, above the year-ago estimate of 8.6% and tripled from 3.6% in 2007.[30] This compares with an unadjusted unemployment rate of 12.4% for California and 10.6% for the nation in the same period. Napa County's rate of unemployment was the 4th lowest of the 58 counties.

Educational Attainment

In addition to having implications for health, educational levels obtained by community residents can affect the local economy. In general, higher levels of education equate to the ability to earn higher wages, experience less unemployment, and enjoy increased job stability. "Persons aged 25 and older with less than a high school education" is the socioeconomic measurement typically used for this indicator. Napa County population has a similar level of educational attainment to the state as a whole. In 2008, about 1 in 10 (9.2%) persons aged 25+ in Napa County had not completed high school (for California, the figure is 9.1%).[31]

Napa County's high school dropout rate appears to have continued to rise since the time of the last needs assessment report. The four-year derived dropout rate in 2007-08 was 18.4% compared to 4.4% in 2003-04.[32] The statewide dropout rate rose by 6 percentage points in the same time period to 18.9% in 2007-08. In general, dropout rates among Hispanic, African American and Native American students in Napa County are higher than the county rate (Table 11). The rate for Hispanic students almost tripled from 9.3% in 2003-04 to 25.1% in 2007-08.[33]

Table 11. High School Dropouts and Rates for Students Enrolled in Grades 9-12

Ethnic Group	Total Enrolled			Total Drop (9-12)			4-Yr Derived Rate (9-12)		
	05/06	*06/07*	*07/08*	*05/06*	*06/07*	*07/08*	*05/06*	*06/07*	*07/08*
Amer Indian	102	95	87	0	5	7	0.0%	18.1%	31.8%
Asian	116	115	105	3	5	1	8.7%	16.2%	3.1%
Pacific Isld	21	21	27	0	0	1	0.0%	0.0%	12.5%
Filipino	172	203	224	1	5	3	2.5%	10.9%	5.7%
Hispanic	2243	2515	2603	67	151	154	14.1%	22.9%	25.1%
African Amer	127	132	142	1	8	19	4.3%	22.8%	44.9%
White	3239	3079	2938	29	109	110	3.5%	13.4%	13.9%
Multi-Rate/No Response	322	390	441	3	14	13	4.4%	14.4%	11.9%
Napa County Total	6342	6550	6567	104	297	308	6.9%	17.2%	18.4%
State Total							13.6%	21.1%	18.9%

Source: California Department of Education, DataQuest.

[29] QVMC Annual Market Assessment 2009. Internal document provided to the author.
[30] California Labor Market Review. July 2010. http://www.labormarketinfo.edd.ca.gov/ (September 2010)
[31] American Community Survey, 2008. http://factfinder.census.gov. (April 2010)
[32] California Department of Education, DataQuest. http://dq.cde.ca.gov/dataquest/ (April 2010)
[33] Ibid.

Because of Napa County's relatively small student subpopulations, there is considerable variation in some enrollment and dropout data, which makes it important to use caution when interpreting trends and comparisons across populations. Additionally, there is some disagreement over whether dropout rates accurately represent the number of students who leave high school without finishing, because there is no standardized method to track students who stop attending school.

Research has also shown that young people who drop out of high school are more likely to use drugs/alcohol, be involved in criminal activity, and become teen parents. High school dropouts also have higher unemployment rates and are more likely to receive public assistance.

Non-English Speaking

Of Napa County's total K-12 enrollment of 20,370 in 2008-09, 23% are reported to be English-Learners, close to the state average and down two percentage points since 2005-06.[34] The percentages are highest in the early grades—K-3 children account for about half of Napa County's 2008-09 English Learners.[35] The Calistoga Joint Unified and County Office of Education Districts have the highest percentage by a relatively wide margin (Table 12).

Table 12. Percent of English-Learners by Napa County School District

	2006-07	*2007-08*	*2008-09*
Calistoga Joint Unified	38.3%	45.4%	40.0%
St. Helena Unified	28.6%	28.2%	26.6%
Napa Co. Office of Education	39.6%	31.9%	40.3%
Napa Valley Unified	23.2%	23.1%	21.7%
Howell Mountain Elementary	17.9%	10.1%	22.9%
Pope Valley Union Elementary	19.4%	27.9%	24.6%
Napa County Total	24.4%	24.4%	23.0%
California State Total	25.0%	24.7%	24.2%

Source: California Department of Education at Ed-Data http://www.ed-data.k12.ca.us/welcome.asp March 2010.

Of the various languages spoken by Napa County's English Learners (Table 13 on the next page), by far the greatest proportion (95%) is Spanish.

[34] California Department of Education at Ed-Data http://www.ed-data.k12.ca.us/welcome.asp (March 2010)
[35] California Department of Education, DataQuest. http://dq.cde.ca.gov/dataquest/ (March 2010)

Table 13. Languages of Napa County English Learner Students, 2008/09

	Number of Students	Percent of Enrollment
Spanish	4,444	21.8%
Filipino (Pilipino or Tagalog)	94	0.5%
Punjabi	22	0.1%
Japanese	18	0.1%
Arabic	13	0.1%
All Other	102	0.5%
Total	4,693	23.0%

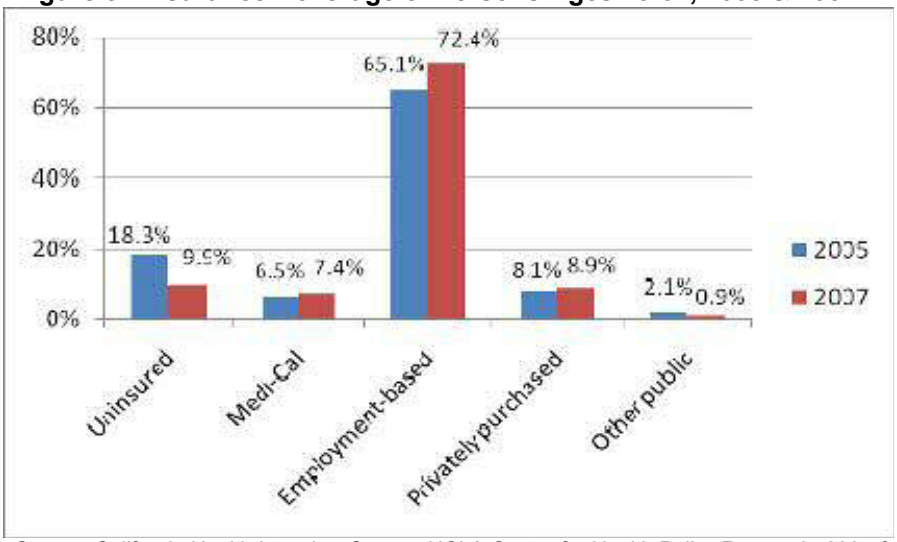
Source: California Department of Education, Educational Demographics Office, at Ed-Data http://www.ed-data.k12.ca.us/welcome.asp. March 2010.

Health Insurance Coverage

The cost of health services, including dental and mental health services, creates a barrier to care for people who are not covered by health insurance. Additionally, Napa County's growing senior populations, nearly all of whom are covered by Medicare, are expected to incur increasing out-of-pocket medical costs as they age.

According to the 2007 California Health Interview Survey (CHIS), 90% of Napa County adults age 18-64 had some form of health insurance, leaving 10% without medical coverage, down from 18% in 2005 (Figure 5). When all ages are included, 93% of Napa residents have coverage. *Having* coverage for care, however, does not guarantee *access* to care if there are an inadequate number of providers in the service area and/or providers are not willing to accept all forms of coverage, including Medi-Cal and Medicare. Approximately 7.4% of the non-senior adult population is covered by Medi-Cal.

Figure 5. Insurance Coverage of Persons Ages 18-64, 2005 & 2007



Source: California Health Interview Survey, UCLA Center for Health Policy Research, 2005 & 2007

About 72% of Napa County residents ages 18-64, according to CHIS, have health benefits through their employer, up from 65% in 2005. This is the third highest rate of the nine greater Bay Area counties. Of those who were eligible for employer-based coverage, 12.3% did not accept health benefits from their employer, giving the county the third highest refusal rate of the nine counties for employer-based benefits (Table 14). Nearly 14% worked for companies that did not offer health benefits, compared to 10.5% in 2003. Almost 9% purchased insurance privately.

Table 14. Percent of Napa County Residents Relative to Employer-Based Health Benefits in 2007

Accepted health benefits	Eligible for benefits, but did not accept	Not eligible for benefits offered by employer	Employer did not offer health benefits
63.4%	13.0%	9.9%	13.7%

Source: California Health Interview Survey, UCLA Center for Health Policy Research, 2007.

New analysis by the UCLA Center for Health Policy Research, based on projected estimates of 2009 insurance status from a predictive model using both CHIS and California Employment Development Department data, found that the number of Californians without health insurance grew in all counties.[36] In Napa County, however, rates of coverage were still more favorable than California statewide (Table 15).

Table 15. Insurance Status and Type During the Past 12 Months, Napa County and California, Ages 0-64, 2009

Area	Job-Based Coverage All Year	Medi-Cal/Healthy Families Coverage All Year	Other Coverage All Year*	Uninsured All or Part Year
California	50.1%	16.3%	9.3%	24.3%
Napa County	61.8%	10.5%	10.5%	17.2%

*"Other Coverage" includes: 1) individually purchased private coverage, 2) other public coverage, such as Medicare, and 3) any combination of insurance types during the past year without a period of uninsurance.
Source: UCLA Center for Health Policy Research. August 2010. Rates are predicted estimates from a simulation model based on the 2007 California Health Interview Survey and 2007/2009 California Employment Development Department data.

Seniors

Very few seniors in Napa County lack health insurance; most are covered by a combination of Medicare and a private supplemental plan or Medi-Cal (Table 16). Napa County seniors use a combination of Medicare and Medi-Cal much less frequently than seniors in the rest of the Bay Area counties, and are more likely to have private supplemental coverage in addition to their Medicare coverage.

[36] *California's Uninsured by County.* UCLA Center for Health Policy Research. August 2010.

Table 16. Type of Current Health Coverage for People Age 65+, 2003, 2005, 2007

Year	Medicare and Other	Medicare and Medi-Cal	Medicare Only
2003	78.3%	6.5%*	4.8%*
2005	74.0%	13.0%	10.2%
2007	86.3%	7.1%*	0.0%

Source: California Health Interview Survey, UCLA Center for Health Policy Research.
* Represents statistically unstable results due to small sample size.

Children

Although estimates range widely because of small sample sizes, data from the 2007 California Health Information Survey (CHIS) suggest 4.1% of children ages 0-18 in Napa County, were uninsured all or part of the year (Table 17). In 2007, Napa County's rate of children covered by employment-based insurance, 68%, was substantially higher than the state average of 54.9%, and its combined rate of Medi-Cal and Healthy Families enrollment, 21.1%, was lower.

Table 17. Health Insurance Coverage of Children Ages 0-18, Napa County, 2005 & 2007

	Napa County 2005		Napa County 2007		California 2007
	Estimate	Range of Estimate	Estimate	Range of Estimate	
Percent uninsured all or part year	4.6%*	(1.0-8.1)	4.1%*	(0.0-8.6)	6.4%
Percent insured all year, employment-based	73.4%	(64.8-82.1)	68.0%	(57.5-78.6)	54.9%
Percent insured all year, Medi-Cal	13.2%	(6.2-20.2)	12.5%	(5.6-19.4)	25.8%
Percent insured all year, Healthy Families/Child Health Insurance Program	3.1%*	(0.6-5.6)	8.6%*	(0-17.2)	6.7%
Percent insured all year, privately purchased and other	5.7%*	n/a	6.8%*	(2.5-11.1)	6.1%

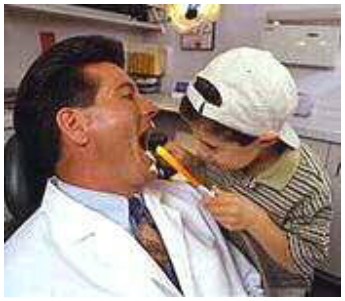
Source: California Health Interview Survey, UCLA Center for Health Policy Research.
* Represents statistically unstable results due to small sample size.

More Napa County children are eligible for programs than ever before due to the poor economy. In 2009, over one-third (13,187) of children age 0-18 were enrolled in a subsidized health insurance program for low-income families, distributed as follows: [37]

- Medi-Cal – 57%
- Healthy Families – 32%
- Kaiser Child Health Plan – 9%
- Children's Health Initiative (CHI) Healthy Kids – 2%

As a result of recent efforts by the CHI, approximately 96%-98% of children are now covered by some form of health insurance. Although closed to new enrollments for its own subsidized health insurance product, the CHI has been focusing on enrolling children in insurance programs regardless of which program they are eligible for. Its single point of entry software system allows the CHI to share client information between agencies and provide integrated case management.

[37] Personal a communication with Mark Diel, CHI Executive Director, May 19, 2010.



Section II. Selected Health Status Indicators

"People don't want to know what it [the diagnosis] is; if it's bad, they don't have the money to pay for it anyway."—Focus group participant

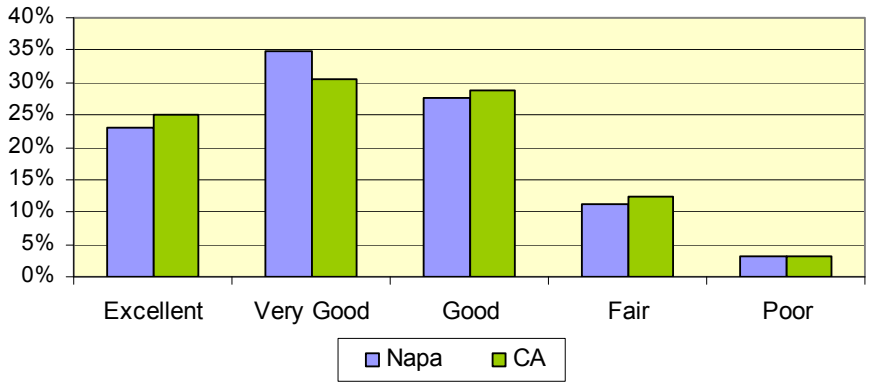
"Some people just swap one addiction for another. What will we learn later about the affects of those monster caffeine drinks on school kids?"– Key informant interviewee

Health and well-being are influenced by many factors. Health status indicators include the traditional vital statistics, such as birth and death rates, as well as factors such as safety and mental health, and health behaviors such as physical activity. Communities commonly measure their health against statewide averages and national standards or objectives such as Healthy People 2010, a federal health promotion and disease prevention agenda for improving the health of the nation's population.

SELF-RATED HEALTH STATUS

In population studies, self-rated health is generally regarded by researchers as a valid, commonly accepted measure of health status.[38] Understanding the correlates of self-rated health may help health care professionals prioritize health promotion and disease prevention interventions to the needs of the population.[39] One of five (23%) Napa County respondents to the 2007 California Health Information Survey rated their health status as "excellent" and 35% as "very good," percentages that collectively were slightly better than the statewide average.

Figure 6. Self-Rated Health Status, Napa County and California, 2007



Source: California Health Information Survey

[38] Franks P, Gold MR, Fiscella K. Sociodemographics, self-rated health, and mortality in the US. *Soc Sci Med.* 2003;56:2505–2514.
[39] Idler, EL., Benyamini, Y. (1997). Self-rated health and mortality: A review of twenty-seven community studies. *J Health Soc Behav,* 38, 21-37.

When the senior population (age 65+) is broken out of the county and statewide data, Napa County seniors rate their health slightly more favorably overall than other California seniors: 71.1% considered their health to be excellent, very good, or good in contrast to 69.4% of California seniors who gave themselves those high ratings.

Table 18. Percent of Population Self-Rated Health Status, Napa County and California, 2007

	Napa County		California	
	All Ages	*Seniors Age 65+*	*All Ages*	*Seniors Age 65+*
Excellent	21.6%	15.6%	25.0%	11.6%
Very good	27.0%	26.5%	30.4%	26.8%
Good	32.0%	29.0%	28.8%	31.0%
Fair	12.0%	19.1%	12.5%	21.9%
Poor	7.5%*	9.7%*	3.3%	8.7%

*Statistically unstable due to small sample size.
Source: 2007 California Health Interview Survey

MORBIDITY (DISEASE CONDITIONS AND ILLNESS)

Newly available county rankings reflect the overall health of counties in California, and provide a snapshot of how healthy residents are by comparing their overall health and the factors that influence their health with other counties in the state. Population health measures were based on scientific relevance, importance, and availability of data at the county level.[40]

Summary rankings for *Health Outcomes* show Napa County as 16th best of 58 counties in the state on mortality and 18th best for measures of morbidity (Table 19). Mortality is a life expectancy measure and morbidity is a combination of self-report fair or poor health; poor physical health days; poor mental health days; and the percent of births with low birth weight.

Table 19. Health Outcomes and Health Factors Summary Rankings, Napa County

		County Ranking (of 58 counties)
Health Outcomes	Mortality	16
	Morbidity	18
Health Factors	Health Behaviors	6
	Clinical Care	23
	Social/Economic Factors	10
	Physical Environment	50

Data are from the period 2000-2008.
Source: *County Health Rankings. Mobilizing Action Toward Community Health, 2010 California*.

[40] *County Health Rankings. Mobilizing Action Toward Community Health, 2010 California*. University of Wisconsin Population Health Institute.

Summary rankings for *Health Factors* for Napa County show a wide range. For health behaviors, the county is 6th best in the state, for clinical care 23rd best, on social and economic factors 10th best, and for measures of physical environment, 50th worst. Human behaviors include things like smoking and exercise; clinical care includes measures of access; social and economic factors include education, employment, and community safety; and physical environment is a combination of environmental quality and the built environment.

Napa County's low ranking in the area of physical environment (50 out of 56) appears to be driven primarily by the reported liquor store density in the county. The physical environment indicator uses particulate matter days, ozone days, access to healthy food, and liquor store density to assign county rank. While Napa County scores are better than the state average for the first 3 physical environment measures, the report indicates that Napa County has the highest density of liquor stores of any county (3.1 per 10,000). The liquor store density calculation is based on data from the U.S. Census Bureau County Business Patterns and uses North American Industrial Classification System (NAICS) codes to identify liquor stores. The NAICS appears to group wine shops within the same code as liquor stores and so it is likely that Napa County's status as a premier wine region negatively affects its physical environment score.[41]

Table 20 displays the incidence or cases of communicable diseases commonly reported for morbidity indicators in community health assessments.[42] The case rates shown in the table are per 100,000 population and show Napa County's rates are more favorable than state and national rates.

Table 20. Napa County Morbidity by Cause

County Rank Order	Health Status Indicator	2006-2008 Cases (Ave.)	Crude Case Rate		Crude Case Rate		Nat'l Obj
					Statewide	Nat'l	
37	AIDS Incidence (Age 13+)	6.3	5.6*		11.6	14.4	1.00
36	Tuberculosis incidence	5.7	4.1*		7.2	4.4	1.00
17	Chlamydia incidence	247.7	180.6		377.7	[a]	[b]
20	Gonorrhea incidence	24.0	17.5		79.7	119.0	19.00
N/A	Pertussis rate		**2009**	**2010**	**2009**	**2010**	
			4.97	9.94	1.28	9.2	

Source: County Health Status Profiles 2010. California Department of Public Health; CDPH Pertussis Report August 31, 2010.
* Rate or percent unstable; relative standard error greater than or equal to 23%.
[a] National rate is not comparable to California due to rate calculation methods.
[b] Prevalence data were not available in all California counties to evaluate National Objective of >3% testing positive in the population 15-24 years of age.

[41] Personal communication with Jennifer Henn, PhD, Epidemiologist, Napa County Public Health, July 27, 2010.
[42] Definitions are provided here for 2 terms frequently used in this section of the report. A crude rate (e.g., deaths) is the ratio of the number of deaths to the total population of an area. An age-adjusted rate is a weighted average of the age-specific (crude) rates, where the weights are the proportions of persons in the corresponding age groups of a standard population. Age-adjustment is a technique used to eliminate the effect of the age distribution of the population on mortality rates. Since the frequency of death varies with age, a measure free of the influences of population composition is needed to make comparisons between areas or over time.

Napa County's crude case rate of AIDS increased from 3.7 in 2003-2005 to 5.6 in 2006-2008 (both rates unstable). The latter rate was lower than the state rate of 11.6, but ranked 37th highest among California counties.[43] Between March 1983 and June 2010, the county had a cumulative total of 250 AIDS cases, slightly up from 245 in June 2009. Of those, 199 (60%) are now deceased. There have been 94 total HIV cases reported for Napa County between April 2006 and June 2010, up from 77 in September 2009.[44]

Table 21. Cumulative HIV/AIDS Cases Reported for Napa County as of June 2010

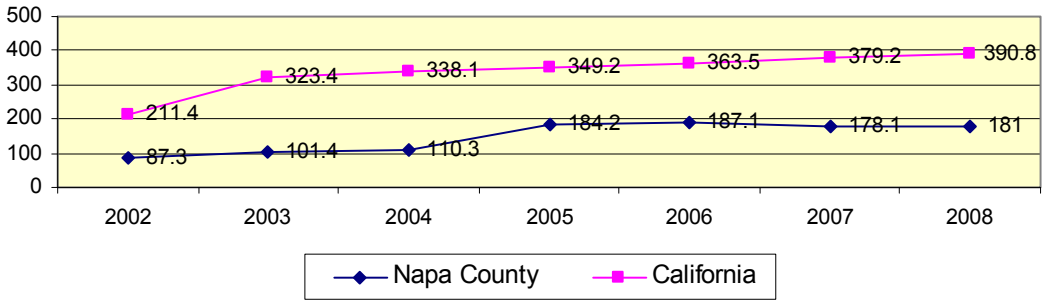
HIV				AIDS			
Total Cases	Living Cases	Deceased		Total Cases	Living Cases	Deceased	
		Number	%			Number	%
94	91	3	3	250	101	199	60

AIDS reporting began in March 1983. HIV reporting began in April 2006.
Counts exclude cases diagnosed, but not yet reported as of June 2010, and may understate the number of diagnoses and deaths in the most recent years.
Source: Napa County Public Health, June 2010.

Chlamydia, a bacterial disease, often has no symptoms, and people who are infected may unknowingly pass the disease to sexual partners. While treatable, Chlamydia can lead to infertility, and like gonorrhea and syphilis, can have long-lasting consequences for women. Newborns can also contract it from their infected mothers at the time of birth. Prior untreated Chlamydia infection is one of the most common causes of infertility.[45]

While Napa County's case rate of Chlamydia is lower than the statewide rate (Figure 7), it worsened between the 2003-2005 three-year average (131.8) and 2006-2008 (180.6). The county's ranking dropped from 15th best to 17th during that time.[46]

Figure 7. Chlamydia Case Rate Per 1,000 Population, 2002-2008



Source: California Department of Public Health, STD Control Branch, 2010.

[43] County Health Status Profiles 2010. California Department of Public Health. http://www.cdph.ca.gov/programs/ohir/Pages/CHSP.aspx (April 2010)
[44] California Department of Public Health. Office of AIDS. HIV/AIDS Quarterly Statistics. http://www.cdph.ca.gov/data/statistics/Pages/OA2009MonthlyStatistics.aspx (April 2010)
[45] Haggerty CL, et al. Risk of sequelae after Chlamydia trachomatis, genital infection in women. *J Infect Dis* 2010;201:134-155.
[46] County Health Status Profiles 2010. California Department of Public Health. http://www.cdph.ca.gov/programs/ohir/Pages/CHSP.aspx (April 2010)

Napa County's case rate (per 100,000 population) for tuberculosis is relatively low compared to California. Because the number of cases each year is small, it is difficult to detect trends over time. Napa County's case rate (per 100,000 population) for tuberculosis is lower than the state's rate, 4.1 (statistically unstable) in 2006-2008 compared to 7.2. Like California and the rest of the nation, Napa has seen an overall decrease in cases since the mid 1990's, though the decline has leveled off in recent years. The county's ranking went from 34th to 36th highest out of 58 counties between 2003-2005 and 2006-2008.[47]

Pertussis, a respiratory illness commonly known as whooping cough, is a very contagious disease caused by a type of bacteria. Although pertussis is a vaccine preventable disease, peaks in disease activity still occur every 2 to 5 years. The California Department of Public Health declared an epidemic of pertussis in June 2010. As of August 2010, there were 3,600 cases of pertussis reported in California for a state rate of 9.2 cases per 100,000 (the median case rate by county is 7.7). This is a 7-fold increase from the number of reported cases during the same time period in 2009, and the most cases reported in 52 years. Napa County's pertussis case rate (per 100,000 population) of 9.94 in 2010 (through 8/31/10) is slightly higher than the state's rate.[48]

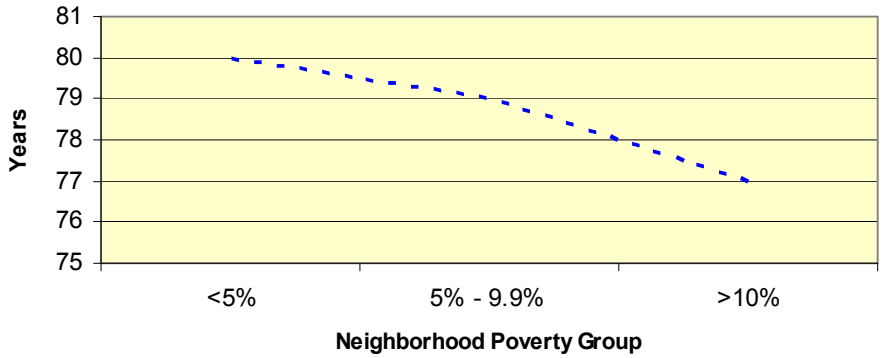
MORTALITY (DEATH)

Mortality statistics are the backbone of public health. Without knowing how the members of a population die, and at what ages, epidemiologists can only guess how many deaths are potentially preventable. Good mortality data can identify overlooked problems and help health organizations decide where to direct effort and money.[49]

Mortality indicators correlate with more than physical health conditions; social and environmental factors play important roles. A profile of Bay Area counties makes clear that being healthy and living long can depend very much on which community a person lives in.[50] The graph below (Figure 8 on the next page) of life expectancy by percent of poverty for Napa County shows how many years someone born today can expect to live if exposed to current death (mortality) rates throughout their life. People with less income and wealth can expect to live comparatively shorter lives.

[47] Ibid.
[48] http://www.cdph.ca.gov/programs/immunize/Documents/Pertussis%20report%208-31-2010%20-%20For%20Release.pdf. Accessed September 2, 2010.
[49] Brown, D. Health and Science. *Washington Post*. Reprinted September 18, 2010.
[50] *Health Inequities in the Bay Area.* Bay Area Regional Health Inequities Initiative. Public Health Institute. Data are from 1999-2001

Figure 8. Napa County Life Expectancy by Percent of Federal Poverty Level



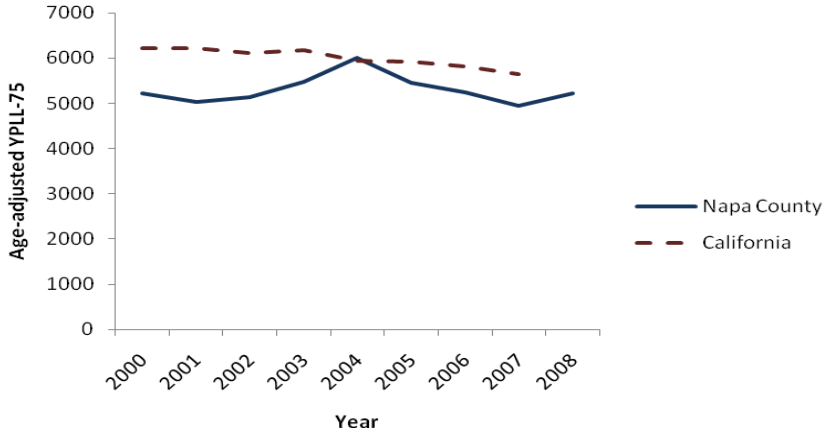
Source: Bay Area Regional Health Inequities Initiative. Public Health Institute. (Note: neighborhood poverty is derived from U.S. Census data and includes various measures of economic deprivation.)

Years of Potential Life Lost (YPLL)

YPLL is a measure of the number of years of potential life lost. It is used to reflect the impact of premature mortality (death) on a population's overall life expectancy. Seventy-five years is used as the standard life expectancy and YPLL-75 is obtained by subtracting the age at the time of death from 75. For example, a man who died from heart disease at age 60 would add 15 years of potential life lost, while a man who died at 80 would not contribute any years of life lost.

In 2008, the total age-adjusted YPLL-75 rate per 100,000 persons in Napa County was 5,213.9 years.[51] The age-adjusted YPLL-75 rate (or premature mortality rate) for Napa County was lower than the California rate between 2000 and 2007, except for 2004 when the rates were the same (Figure 9).

Figure 9. Age-adjusted YPLL-75 Rate, Napa County and California, 2000-2008.

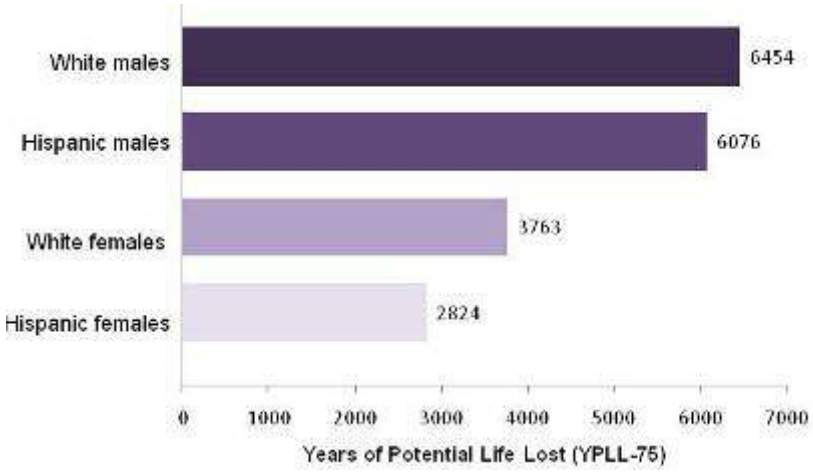


Rates are age-adjusted per 100,000 persons
Source: California Department of Public Health

[51] Henn J. *Years of Potential Life Lost (LPLL-75), Napa County.* Fact Sheet. Napa County Public Health. May 2010.

Figure 10 displays YPLL by gender and race/ethnicity and shows that male residents of Napa County had a premature mortality rate approximately 80% higher than females. Hispanic residents of Napa County had the lowest rate of premature mortality. Hispanic and white Napa County residents by gender suggest that Hispanic females have the lowest rate of years of potential life lost.

Figure 10. Age-adjusted YPLL-75 rate, All Causes of Death by Race/Ethnicity and Gender, Napa County 2005-2008.

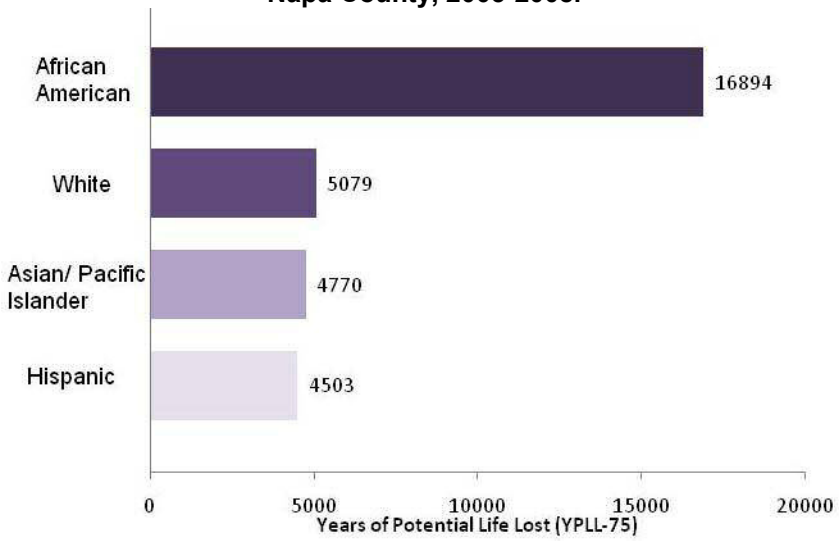


Rates are age-adjusted per 100,000 persons
*African American and Asian/Pacific Islander deaths by gender were not included due to small numbers.
Sources: California Department of Public Health, Center for Health Statistics Death Statistical Master files \2005, 2006, 2007 & 2008; State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.

When gender is removed from the Napa County YPLL data (to increase the sample size of populations with small numbers), as can be seen in Figure 11 on the next page the YPLL-75 (premature mortality) rate for African Americans from 2005-2008 was approximately 3 times higher than the rate for white residents of Napa County. There were 47 deaths in African Americans under the age of 75 during this time period (compared to 1,235 deaths in white residents under 75) but, because African American's make up only about 1.2% of the population, the resulting YPLL-75 rate is larger than rates for other race/ethnic groups.[52]

[52] Henn J. *Years of Potential Life Lost (LPLL-75), Napa County.* Fact Sheet. Napa County Public Health. May 2010.

Figure 11. Age-Adjusted YPLL-75 Rate, All Causes of Death by Race and Ethnicity, Napa County, 2005-2008.



Rates are age-adjusted per 100,000 persons
Sources: California Department of Public Health, Center for Health Statistics Death Statistical Master files 2005, 2006, 2007& 2008; State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.

Leading Causes of Death

The leading causes of mortality (Table 22 on the next page) display a broad picture of the causes of death in Napa County. The death rates shown are per 100,000 population. The crude death rate is the actual risk of dying. The age-adjusted rate is the hypothetical rate that the county would have if its population were distributed by age in the same proportions as the 2000 U.S. population. Death rates are adjusted in this way so that we can compare between populations that differ in their age distributions. The shaded rows in the table highlight the death rates where Napa County exceeds state, national, or National Health Objective rates.

Table 22. Napa County Deaths by Cause, 3-Year Average

Napa County Rank Order	Health Status Indicator	2006-2008 # of Deaths (3-yr avg)	Crude Death Rate	Age-Adjusted Death Rate	↓ better ↑ worse than 2003-05	Age-Adjusted Death Rate		National Health Objective
						Statewide	National[1]	
31	All causes	1,185	864	684	↓	666	760	[a]
42	All cancers	284	207	171	↓	156	178	158.6
16	Colorectal (colon) cancer	21	16	13	↓	15	17	13.7
36	Lung cancer	74	54	45	↓	38	51	43.3
39	Female breast cancer	21	31	23	=	21	23[2]	21.3
41	Prostate cancer	17	25	23	↓	22	24	28.2
34	Diabetes	32	23	19	↓	21	22	[b]
53	Alzheimer's disease	69	50	35	↓	26	23	[a]
10	Coronary heart disease	178	130	99	↓	137	191	162.0
35	Cerebrovascular disease (stroke)	79	57	43	↓	41	42	50.0
41	Influenza/pneumonia	38	28	20	↓	20	16	[a]
27	Chronic lower respiratory disease	73	53	42	=	38	41	[a]
28	Chronic liver disease and cirrhosis	18	13*	11*	↓*	11	9	3.2
13	Unintentional injuries	44	32	29	↓	30	38	17.1
16	Motor vehicle crashes	13	10*	10*	↓*	10	14	8.0
37	Suicide	17	12*	12*	↑*	9	11	4.8
12	Homicide	3	2*	2*	↓*	6	6	2.8
15	Firearms-related	9	7*	6*	=*	9	10	3.6
12	Drug-induced deaths	11	8*	8*	↑*	11	10	1.2

Source: County Health Status Profiles 2010. California Department of Public Health.
* Death rate unstable, relative standard error is greater than or equal to 23%.
[1] :Preliminary data for 2007. National vital statistics reports; vol. 58 no 1. Hyattsville, MD: National Center for Health Statistics. 2009.
[2] State Cancer Profiles. National Cancer Institute. http://statecancerprofiles.cancer.gov/cgi-bin/deathrates/deathrates.pl?00&055&00&2&001&1&1&1 (April 2010)
[a] Healthy People 2010 National Objective has not been established
[b] National Objective is based on both underlying and contributing cause of death which requires use of multiple cause of death data files. California's data exclude multiple/contributing causes of death.

While Napa County's overall death rate is higher than the state's, it and most cause-specific death rates have declined in the county since the 2003-2005 time period. The biggest declines were in deaths due to all cancers combined, colorectal cancer, and motor vehicle crashes. (See page 44 for a description of the county's 10 leading causes of *premature* death.)

Diseases of the circulatory system—coronary heart disease and stroke—are responsible for about 22% of Napa County's deaths, less than in 2003-2005. Death rates due to both causes are lower than the Healthy People (HP) 2010 objectives (substantially lower for coronary heart disease). Napa County's death rate from coronary heart disease is also substantially lower than the state rate and ranks 10th lowest out of 58 counties.

Cancer is the leading cause of death in Napa County—accounting for about 1 out of every 4 deaths. The county's death rate due to cancer ranks 42nd highest in the state and is higher than both the statewide rate and the HP 2010 national objective. Rates of death from breast and prostate cancer are slightly higher, but close to state rates (Table 23). The rate of death from lung cancer is higher by a greater margin.

Over 30% of cancer is estimated to be associated with diet and obesity; and another 30% with tobacco use.[53] Death from cancers of the trachea, bronchus and lung—often associated with tobacco use—lead all other types of cancer. Table 23 breaks out mortality data by type of cancer and shows that Napa County's rates are worse than national health objectives and statewide rates, except for colorectal cancer.

Table 23. Deaths Due to Cancer by Type of Cancer, 2006-2008

Type	Napa County				California	National Objective
	2006-2008 # of Deaths (3-yr avg)	Crude Death Rate	Age-Adjusted Death Rate	Rank Order	Age-Adjusted Death Rate	
All cancers	284	207	171	42	156	158.6
Lung	74	54	45	36	38	43.3
Colorectal (colon)	21	16	13	16	15	13.7
Female breast	21	31	23	39	21	21.3

Source: County Health Status Profiles 2010. California Department of Public Health.

The behaviors and conditions Napa residents reported in the California Health Interview Survey that increase the risk of cancer are displayed in Table 24 below. While these risk behaviors and conditions are similar to other California adults, the proportion among Napa County adults is higher for two of the conditions: overweight/obesity and binge drinking in the past year (both of which are discussed later in this report).

Table 24. Percent of Adults who Reported Risk Behaviors and Conditions for Cancer, 2007.

	Current Smoker	Former Smoker	No moderate or vigorous physical activity	Overweight or Obese	Binge drinking in past year
Napa County	14.6%	24.8%	57.5%	62.0%	34.6%
California	14.3%	23.6%	63.7%	57.1%	29.7%
Gender					
Male	20.8%	27.8%	57.7%	72.5%	45.9%
Female	8.7%	22.1%	57.3%	52.2%	23.9%

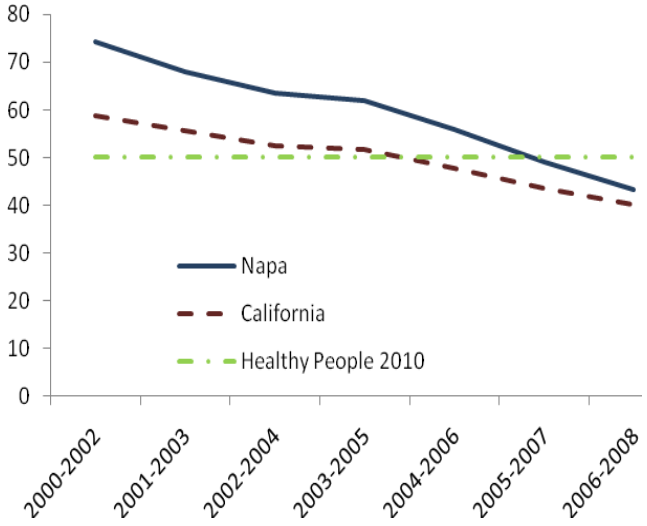
Source: California Health Interview Survey, 2007

[53] *California Cancer Facts and Figures, 2010.* California Cancer Registry, California Department of Health Services, and American Cancer Society. http://www.ccrcal.org/Publications.html (April 2010)

Stroke is currently the third leading cause of death for Napa County residents, behind cancer and diseases of the heart. Between 2005 and 2008 there were a total of 336 stroke deaths, an average of 84 deaths per year. The age-adjusted stroke death rate is 46.3 deaths per 100,000 persons. Napa County has a higher age-adjusted stroke death rate than the state of California but this difference was not statistically significant for the most recently available years (2006-2008).[54]

The stroke death rate in Napa County has been steadily declining (Figure 12) and currently meets the Healthy People 2010 objective of no more than 50 stroke deaths per 100,000 persons. The stroke death rate for Hispanic residents was 20% lower than the stroke death rate for white Napa County residents, but this difference was not statistically significant.[55]

Figure 12. Stroke death rates, Napa County and California, 3 year moving averages, 2000-2008.



Rates are age-adjusted per 100,000 persons
Source: County Health Status Profiles, California Department of Public Health, 2004-2010

The cause of death for which Napa County's death rate exceeds the HP 2010 objective by the largest margin is chronic liver disease and cirrhosis. Primarily attributable to excessive alcohol consumption, liver disease and cirrhosis was the 9th leading cause of death in California and the 10th in Napa County according to State data files for the 3-year period 2006-2008.[56] The county's age-adjusted death rate, 11 per 100,000, was almost four times higher than the HP 2010 objective for the nation, which is 3 per 100,000.[57] More detailed analysis by Napa County Public Health for the causes of

[54] Henn J. *Leading Causes of Death: Stroke Fact Sheet.* Napa County Public Health. May 2010.
[55] Ibid.
[56] County Health Status Profiles 2010. California Department of Public Health. http://www.cdph.ca.gov/programs/ohir/Pages/CHSP.aspx (April 2010)
[57] Ibid.

premature death—which separated alcoholic liver disease from other causes of liver disease/cirrhosis—shows alcoholic liver disease was the 6th leading cause of premature death. Between 2005 and 2008 there were 741 years of lost life (137 years per every 100,000 persons) attributable to this cause (Table 25).[58]

Table 25. Ten Leading Causes of Premature Death, Ages 1-74, Napa County, 2005-2008

Rank	Cause of Death	No. of Deaths	YPLL-75	Age-Adjusted YPLL-75
1	Coronary Heart Disease	180	2085.0	365.2
2	Motor Vehicle Accidents	53	1962.0	412.4
3	Suicide	54	1807.0	382.0
4	Lung Cancer	135	1339.0	230.5
5	Drug Overdose	29	774.0	154.9
6	Alcoholic Liver Disease	41	741.0	137.3
7	Stroke	58	716.0	135.7
8	Diabetes	50	666.0	118.1
9	Female Breast Cancer +	38	555.0	179.4
10	COPD**	61	503.0	80.7
	Total	699	11,148	
Key: ** Chronic Obstructive Pulmonary Disease, + only female population for rate				

Source: Napa County Public Health Division. August 2010.

Alzheimer's Disease

Dementia is characterized by the loss or decline in memory and one of at least a couple of other cognitive abilities. Alzheimer's disease is the most common cause of dementia,[59] and the 7th leading cause of death in the U.S. in 2006.[60] More women than men have dementia, primarily because women live longer, on average, than men. This longer life expectancy increases the time during which women could develop Alzheimer's or other dementia.[61] Similar to other health disparities, emerging research suggests prevalence rates of Alzheimer's are higher, on average, among African American and Latino adults than among whites, and among older than younger seniors in these racial/ethnic groups.[62,63]

[58] Napa County Mortality Report 2005-2008: Leading causes of death and premature death. Napa County Public Health Division. (Undated)
[59] *Alzheimer's Disease Facts and Figures 2010*. Alzheimer's Association. www.alz.org.
[60] Heron MP, Hoyert DL, Xu J, Scott C, Tejada-Vera B. "Deaths: Preliminary data for 2006," National Vital Statistics Reports Vol. 56, No. 16., Hyattsville, Md.: National Center for Health Statistics, 2008.
[61] Plassman BL, Langa KM, Fisher GG, Heeringa SG, Weir DR, Ofstedal MB, et al. "Prevalence of dementia in the United States: The Aging, Demographics and Memory Study." Neuroepidemiology 2007;29:125–132.
[62] Dilworth-Anderson P, Hendrie HC, Manly JJ, Khachaturian AS, Fazio S. "Diagnosis and assessment of Alzheimer's disease in diverse populations." *Alzheimer's & Dementia* 2008;4:305–309.
[63] Manly JJ, Mayeux R. "Ethnic differences in dementia and Alzheimer's disease." In Anderson NA, Bulatao RA, Cohen B. (eds.). Critical perspectives on racial and ethnic differentials in health in late life (pp. 95–141). Washington, D.C.: National Academies Press, 2004.

Estimates from different studies on the prevalence and characteristics of people with Alzheimer's and other dementias vary depending on how each study was conducted. Applying national prevalence estimates of 13% of people aged 65 and older with Alzheimer's disease,[64] approximately 2,538 residents in Napa County would be projected to have Alzheimer's.

For the years 2005-2008, Alzheimer's disease was the 5th leading rankable cause of death in Napa County. Over this 4-year period, there were 277 deaths from Alzheimer's disease. Napa County's high Alzheimer's disease mortality rank compared with other California counties may be at least partially explained by its older population: approximately 1.5% of the population in California is age 85 or above, while in Napa County 2.5% of the population is ≥ 85.[65]

The increased numbers of people with Alzheimer's will have a marked impact on local healthcare systems—they are high users of health care, long-term care, and hospice—as well as families and caregivers.

CHRONIC DISEASE AND OTHER CONDITIONS

Chronic diseases (e.g., cancer, diabetes, heart disease) cost the nation's economy more than $1 trillion a year in lost productivity and treatment costs and the amount could soar to $6 trillion by mid-century according to new figures on the cost burden of chronic disease. [66] The researchers—who conducted a state-by-state analysis of seven common chronic diseases—concluded that "investing in good health would add billions of dollars in economic growth in the coming decades." California was in the top quartile of states with the lowest rates of chronic diseases.

Heart Disease

"Heart disease" refers to a variety of conditions including coronary artery disease, heart attack, heart failure, and angina. Smoking, being overweight or physically inactive, and having high cholesterol, high blood pressure, or diabetes are risk factors that can increase the chances of having coronary heart disease. In addition, heart disease is a major cause of chronic illness.

Napa County's 2006-2008 three-year average, age-adjusted death rate from coronary heart disease was 99.0 per 100,000 population.[67] Lower than both the state rate of 137.1 and the Healthy People 2010 objective of 162, the County ranked 10th best of 58 counties.

While *death* due to heart disease is lower in Napa County than California as a whole, the County's prevalence of heart disease may be higher than the State's. According to

[64] *Alzheimer's Disease Facts and Figures 2010*. Alzheimer's Association. www.alz.org.
[65] Calculations by Napa County Public Health, July 2010, based on California Department of Finance population data.
[66] DeVol R, et al. An Unhealthy America: The Economic Burden of Chronic Disease. Milken Institute. October 2, 2007.
[67] County Health Status Profiles 2010. California Department of Public Health. http://www.cdph.ca.gov/programs/ohir/Pages/CHSP.aspx (April 2010)

the 2007 California Health Interview Survey, 9.9% of Napa County residents are estimated to have been diagnosed with heart disease, compared to 6.3% statewide (Table 26).[68] (Note: CHIS figures are not age adjusted so the higher percentage may be because Napa County has a higher proportion of older people compared to many other areas of the state.) In 2004, 2.2% of Napa County residents were hospitalized due to heart disease, compared to 1.7% statewide.[69]

Table 26. Percent of Adults Who Self-Reported Ever Being Diagnosed With Heart Disease

	Napa County	California
2003	9.5%	6.9%
2005	7.0%	6.2%
2007	9.9%	6.3%

Source: California Health Interview Survey, 2003, 3005, 2007.

Typically, heart disease develops in adulthood. But its risk factors, such as abnormal cholesterol levels and overweight/obesity often emerge during childhood and adolescence. According to a new study by the Centers for Disease Control and Prevention, 20% of young people aged 12-19 years in the U.S. have at least one abnormal lipid (blood fat) level, providing new evidence that underscores the health threat posed by the nation's obesity epidemic.[70]

Diabetes

The prevalence of diabetes continues to grow nationwide, and it poses a significant public health challenge. It increases the risk of cardiovascular disease, and the direct complications—blindness, lower limb amputation and end-stage kidney failure—increase as the prevalence of diabetes increases.[71]

More than one out of ten California adults has diabetes, a 38% increase in one decade, and one in three has pre-diabetes.[72] The prevalence of gestational diabetes has increased 60% in seven years, and research shows increasing diabetes in children and youth. Direct medical costs for the disease (e.g., hospitalizations, medical care, and treatment supplies) in California account for about $18.7 billion annually, with another $5.8 billion spent on indirect costs such as disability payments, time lost from work, and

[68] California Health Interview Survey, 2007. UCLA Center for Health Policy Research
[69] California Heart Disease and Stroke Prevention and Treatment Task Force. California's Master Plan for Heart Disease and Stroke Prevention and Treatment. California Department of Public Health. July 2007. http://www.cdph.ca.gov/search/results.aspx?k=prevalence%20heart%20disease (April 2010)
[70] Prevalence of Abnormal Lipid Levels Among Youths --United States, 1999-2006. Centers for Disease Control and Prevention. *MMWR* January 22, 2010. vol. 59, No. 2.
[71] National Diabetes Fact Sheet, United States Department of Health and Human Services, p. 7-8.
[72] Diabetes in California Counties 2009. California Diabetes Program. http://www.caldiabetes.org/content_display.cfm?contentID=1160 (April 2010)

premature death.[73] Similar to other chronic conditions, access to health care and disease management are key factors in reducing the burden of diabetes.

Obesity is a major risk factor for the development of diabetic complications, including cardiovascular disease and stroke. The prevalence of diabetes is more than twice as high among adults who are obese as it is among those who are overweight. Diabetes is also strongly related to social and economic factors. It is more than twice as common among adults who either did not attend or did not graduate from high school, compared to college graduates.[74]

In 2002, a national clinical trial demonstrated that type 2 diabetes can be delayed or prevented by healthy lifestyle changes, including moderate weight loss and regular, moderate-intensity physical activity.[75]

Napa has a total of 100,857 adults; among those, 8,371 self-reported as having diabetes.[76] The longer-term trends for diabetes are going the wrong way. In both Napa County and California, according to the California Health Interview Survey, the proportion of the adult population that has diabetes increased from 2005 to 2007 (Table 27).

Table 27. Diabetes, Adults Age 18 and Older

Area	Has Diabetes			Diagnosed Borderline or Pre-Diabetes		
	2003	2005	2007	2003	2005	2007
Napa County	5.1%	8.3%	9.2%	*	1.1%**	1.6%**
California	6.6%	7.0%	7.8%	0.8%	1.1%	1.5%

Source: California Health Interview Survey, 2003, 2005, 2007.
*Estimate is less than 500 people.
**Statistically unstable.

In 2007, Napa County's age-adjusted rate of diabetes, which was higher than the state rate, ranked 2nd worse among the 9 Greater Bay Area counties (only Solano County's rate was higher).[77] Neither the State nor Napa County achieved the Healthy People 2010 national objective of a diabetes prevalence rate of 2.5% (Table 28 on the next page).

[73] Ibid.
[74] California Health Interview Surveys, *Diabetes on the Rise in California*, Health Policy Brief, December 2005.
[75] Diabetes in California Counties 2009. California Diabetes Program. http://www.caldiabetes.org/content_display.cfm?contentID=1160 (April 2010)
[76] Ibid.
[77] *Obesity and Diabetes: Two Growing Epidemics in California*. UCLA Center for Health Policy Research. August 2010.

Table 28. Prevalence Rates[1] of Diabetes in Adults Age 18 and Older, 2007

	Age-Adjusted Rate
Healthy People 2010 Objective	2.5
Napa County*	8.4
California	7.5

Source: 2007 California Health Interview Survey.
[1]Rate is per 100 county or State population.
*Age-adjusted rate is significantly different from age-adjusted State rate.

Mirroring California, Napa County's prevalence and diabetes risk factors vary by race/ethnicity, age and gender (Table 29 on the next page). (Note that for risk factors, table results refer to the percentage of people with diabetes that have that risk factor.) In 2005, 7.9% of Latinos had diabetes compared to 7.1% of Whites.[78]

The following notable risk factor data concerning persons who are current smokers, overweight, obese, do not participate in regular physical activity, or consume less than five servings of fruits and vegetables a day among current diabetics in Napa County are highlighted by shaded cells in Table 29 with some of those findings listed below:

- 20% of female diabetics are current smokers compared to 5% of male diabetics
- Almost half of diabetics are obese:
  - 59% of female diabetics
  - 61% of white diabetics
  - 59% of diabetics ages 18-44
- 60% of diabetics eat less than 5 servings of fruits and vegetables a day:
  - 74% of Latino diabetics
  - 74% of diabetics ages 18-44
- Close to 30% of Latino diabetics are physically inactive

[78] Diabetes in California Counties 2009. California Diabetes Program. http://www.caldiabetes.org/content_display.cfm?contentID=1160 (April 2010)

Table 29. Napa County Diabetes Prevalence and Risk Factors among those with Diabetes, 2005

	Diabetes Prevalence	Current Smoking	Overweight	Obese	Physical Inactivity[1]	Less-than-5-A-Day[2]
	%	%	%	%	%	%
Countywide	8.3	12.2	38.6	45.6	16.3	59.9
Female	7.8	20.3	24.5	58.6	19.3	53.9
Male	9.0	4.8	51.4	33.7	13.7	65.4
Latino	7.9	*	60.0	28.8	28.8	74.4
Asian	*	*	*	*	*	*
African American	*	*	*	*	*	*
White	7.1	14.8	29.4	48.5	10.6	52.6
18-44	3.3	12.5	25.8	58.7	0.0	74.2
45-64	12.0	17.2	47.6	46.2	26.4	58.5
65+	13.5	3.1	30.4	36.4	8.5	53.8

Source: California Diabetes Program. (2009). Diabetes in California Counties. Sacramento, CA: California Diabetes Program, California Department of Public Health; University of California San Francisco, Institute for Health and Aging.
Based on the 2005 CHIS.
[1]Physical Inactivity is defined as less than 20 min. of vigorous exercise 3/week or 30 min. of moderate activity 5/week.
[2]Less-than-5-A-Day refers to the consumption of 4 or less fruits and vegetables per day.
*Insufficient number of observations to make a statistically reliable estimate.

Overweight and Obesity

Along with diabetes, the longer-term trends for obesity are also going the wrong way—nationally, statewide, and for Napa County. Overweight and obesity, which are often caused by an interdependence of dietary factors and physical inactivity, are becoming epidemic in the population and are associated with an increased risk for a number of serious health conditions. On average, higher body weights are associated with higher death rates. Rates of chronic disease and disability associated with poor diet and inactivity continue to rise each year. The public health impact of overweight and obesity is substantial, both in terms of disease burden and cost. It is estimated that obesity-related health expenditures accounted for more than a quarter of the growth in national health care spending between 1987 and 2001.[79] In California, the projected cost of physical inactivity, obesity and overweight in 2005 was $28 billion for health care and lost work productivity.[80]

Over half of all Californians are at increased risk for heart disease, type 2 diabetes, high blood pressure, stroke, arthritis-related disabilities, depression, sleep disorders, and some cancers.[81] And, there is considerable variation in the prevalence of overweight and obesity by race and ethnicity. While obesity affects nearly all age, income, educational, ethnic, and disability groups, rates are highest among Californians of Latino, American Indian, African American and Pacific Islander descent with lower

[79] California Obesity Prevention Plan: A Vision for Tomorrow, Strategic Actions for Today. Sacramento (CA): Department of Health Services; 2006. http://www.cdph.ca.gov/programs/Pages/CO-OP.aspx (April 2010)
[80] Ibid.
[81] California Obesity Prevention Plan: A Vision for Tomorrow, Strategic Actions for Today.

incomes and disabilities.[82] By the preschool years, racial/ethnic disparities in obesity prevalence are already present. While family income and cultural customs and beliefs are often factors, new studies show children of color and in poverty at higher risk than whites for early-life risk factors known to be associated with obesity: mothers smoking during pregnancy, starting solid food before 4 months; allowing very young children to have sugary drinks, fast food and/or TVs in their room.[83]

The proportion of obese adults in Napa County grew from 18% in 2001 to 29% in 2007 (Table 30). In 2001 the county had a lower prevalence of obesity than the state as a whole, but by 2007, it surpassed the statewide rate. Both the county and the state have moved further away from the Healthy People 2010 national objective of 15%. Rates of healthy weight mirror these trends; Napa County's rate fell from 45% in 2001 to 38% in 2007, moving further from the HP 2010 goal of 60%.

Table 30. Adult Prevalence of Healthy Weight and Obesity, 2001 & 2007

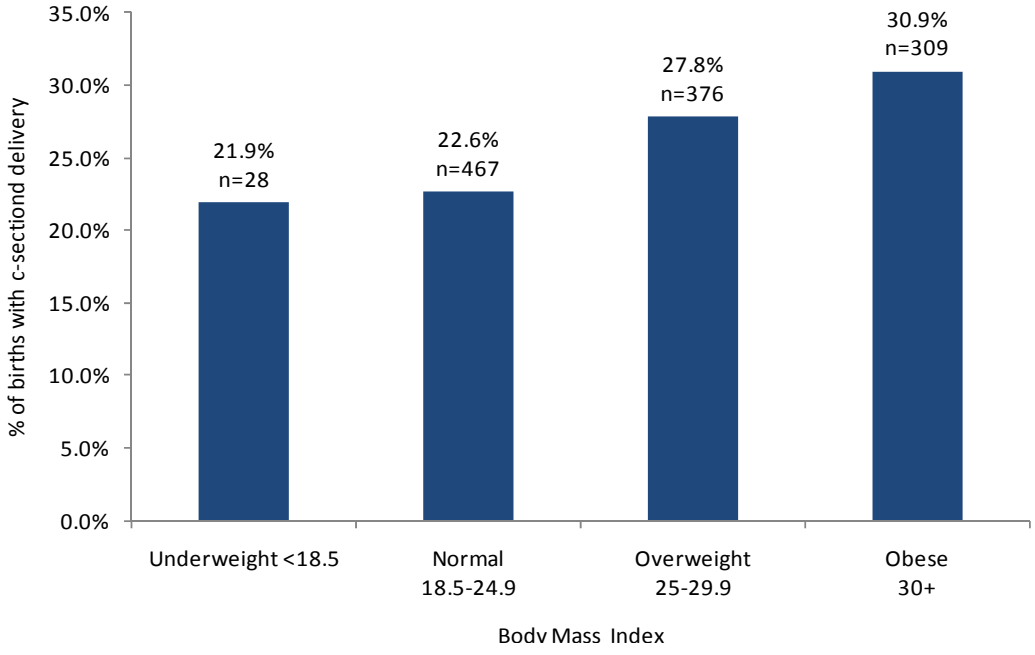
	Napa County		California		HP 2010
	2001	2007	2001	2007	
Healthy weight (BMI >18.5 and BMI <25.0)	45.2%	37.6%	43.0%	40.7%	60.0%
Obese (BMI>30.0)	17.7%	28.6%	19.3%	22.7%	15.0%

Source: California Health Interview Survey.

Overweight and obesity have long been known to complicate pregnancy and have an effect on birth outcomes. Babies born to obese women are nearly three times more likely to die within the first month of birth than those born to women of normal weight, and obese women are almost twice as likely to have a stillbirth.[84] Very obese women are also 3 to 4 times as likely to deliver their first baby by Caesarean section (which increases the risk for the mother) as first-time mothers of normal weight.[85] Although the associations are still not understood, infants born to obese mothers are one-third more likely to suffer significant birth defects, including spina bifida, limb reductions and heart defects according to recent research on maternal obesity.[86] Birth certificate data analyzed by Napa County Public Health showed 58.7% of the C-section births to Napa mothers in 2007-2009 were to women who were overweight or obese (Figure 13 on the next page).

[82] Ibid.
[83] Taveras EM, et al. Racial/ethnic differences in early-life risk factors for childhood obesity. *Pediatrics*. April 2010;125(4):686-695.
[84] Hollander D. The more obese a woman is, the greater her risk of having a stillbirth. *Perspectives on Sexual and Reproductive Health*. March 2008.
[85] Vahratian A, Siega-Riz AM, Savitz DA, Zhang J. Maternal pre-pregnancy overweight and obesity and the risk of cesarean delivery in nulliparous women. *Ann Epidemiol.* 2005;15(7):467-74.
[86] Waller DK, et. al. Pregnancy obesity as a risk factor for structural birth defects. *Archives of Pediatric and Adolescent Medicine.* 2007;161:745-750.

Figure 13. C-section Births by Maternal Body Mass Index, Napa County, 2007-2009



Source: Napa County Public Health

The rapid increase in overweight among children and adolescents is generating widespread concern. Over the past 20 years, the rate of overweight has doubled in children and tripled in teens nationally.[87] This rapid increase has generated widespread concern, as overweight and obesity are major risk factors for chronic diseases. Obese children are more than twice as likely to have type 2 diabetes, once seen only in adults, than children of normal weight. They are more likely to have risk factors for cardiovascular disease, including high cholesterol levels, high blood pressure, and abnormal glucose tolerance. The risk of new-onset asthma is also higher among children who are overweight.[88]

The 2008-09 California Physical Fitness Test data showed the percentage of children in Napa County in grades 5, 7, and 9 considered overweight (based on body composition factors) was 34.3%, 30.9%, and 30.6%, respectively.[89] The Napa County rates mirror the state rates for students tested in these grades except for the 5th graders, which in California was lower at 31.6%.

According to emerging research, one of the potential explanations for why puberty is starting earlier, particularly for Latina girls, is the increase in average body weight among children over the last 3 decades. Studies linking poor diet and childhood obesity

[87] California Obesity Prevention Plan: A Vision for Tomorrow, Strategic Actions for Today, Sacramento (CA): Department of Health Services; 2006. http://www.cdph.ca.gov/programs/Pages/CO-OP.aspx (April 2010)
[88] Gilliland FD, Berhane K, et al. Obesity and the risk of newly diagnosed asthma in school-age children. *Am J Epidemiol.* 2003;158:406-415.
[89] 2008-09 California Physical Fitness Report. http://data1.cde.ca.gov/dataquest/PhysFitness/PFTestCo2007.asp.

suggest the heavier girls are at about age 7 or 8, the earlier they enter puberty,[90,91] a change that puts them at higher risk for breast cancer and risky behaviors which can result in unplanned pregnancies.[92]

Breastfeeding Rate

Interventions aimed at childhood obesity typically target school-age children, but prevention should start much earlier, as early as the day the child is born according to pediatric experts. Breast milk not only provides infants with all the nutrients they need and elements that promote growth and a healthy immune system, but is also recognized as the first step in the battle against childhood overweight.[93] Studies have shown that breastfeeding is associated with lower rates of obesity. Mothers who breastfeed exclusively (breast milk is the infant's only food) are likely to breastfeed for a longer time—offering the best protection against overweight.

Statewide in 2007, about 87% of mothers chose to breastfeed their infants in the hospital; with 43% breastfeeding exclusively.[94] Napa County's rates are higher. In 2007, 94% of mothers did some breastfeeding in the hospital; 70.6% did so exclusively, for which the county is ranked 14th in the state (down from 9th in 2004). Among WIC participants who reported breastfeeding status in 2008, about one quarter (24.4%) were exclusively breastfeeding at the infant age of 2 months (Table 31).

Table 31. Breastfeeding Status Among WIC Participants, by Age of Child, 2008.

Age of Child	Exclusive Breastfeeding	Breastfeeding and Formula Feeding	Exclusive Formula Feeding	Solid Foods
2 Months Old	24.4%	40.9%	34.7%	N/A
4 Months Old	18.8%	37.6%	43.6%	N/A
6 Months Old	15.6%	31.3%	53.1%	N/A
11 Months Old	17.9%	25.4%	56.7%	N/A
12 Months Old	7.7%	11.3%	25.5%	55.5%

Source: Cited on kidsdata.org, California Department of Public Health, Women, Infants, and Children (WIC) Supplemental Nutrition Program.

As shown in Table 32 on the next page, rates vary by race/ethnicity, with 84% of Asian women breastfeeding exclusively, compared to 67% of Hispanic mothers (down from 70% in 2004). The Healthy People 2010 objective is for 75% of mothers to breastfeed

[90] Biro F, et al. Pubertal assessment method and baseline characteristics in a mixed longitudinal study of girls. *Pediatrics* August 2010.
[91] Davison KK, et al. Percent body fat at age 5 predicts earlier pubertal development among girls at age 9. *Pediatrics* April 2003;111(4):815-821.
[92] Kadlubar FF, et al. The CYP3A4*1B variant is related to the onset of puberty, a known risk factor for the development of breast cancer. *Cancer Epidemiology, Biomarkers & Prevention* April 2003;12:327-331.
[93] Owen CG, et al. Effect on infant feeding on the risk of obesity across the life course: A quantitative review of published evidence. *Pediatrics* 2005; 115:1367-1377.
[94] CA Hospital Breastfeeding Report 2008. County Fact Sheets. California WIC Association. http://calwic.org/bfreport_county_2008.aspx (March 2010)

in the early post-delivery period and 50% to still be breastfeeding when the baby is six months old.

Table 32. Percentage In-Hospital Exclusive Breastfeeding by Race/Ethnicity

Ethnicity	Napa County	State Average
Hispanic	67.1	32.4
Asian	83.9	43.8
White	75.9	63.6
Total	70.6	42.7

Source: CA Hospital Breastfeeding Report 2008. County Fact Sheets. California WIC Association.

Asthma

Asthma is a serious public health problem and is responsible for millions of outpatient visits and hundreds of thousands of hospitalizations nationally. Costs for asthma hospitalizations are very high: total charges in 2005 in California were $763 million.[95] A combination of factors work together to cause asthma to develop, most often early in life, and particular "triggers" such as exposure to allergens can make symptoms worse. Both family genes and certain environmental exposures increase the risk. For example, lower levels than previously thought of ozone and common particle pollutants (discussed later in this report) can trigger asthma attacks, and have been shown to increase the risk of emergency department (ED) visits and hospital admissions for asthma.[96]

While not negating the importance of avoiding allergen triggers, it is worth noting research that speaks to the protective effects of certain types of exposures when children are young, such as growing up on a farm.[97] According to some studies, the modern emphasis on cleanliness or "sanitizing the environment" may have reduced this natural immunotherapy over the past century and might be a factor in the global increase of these conditions.[98]

In Napa County, approximately 13,000 children and adults have been diagnosed with asthma.[99] According to the National Health Interview Survey, young people under age 18 have higher rates of asthma than any other age group.[100] In 2007, 15.4% of young

[95] Milet M, Tran S, Eatherton M, Flattery J, Kreutzer R. "The Burden of Asthma in California: A Surveillance Report." Richmond, CA: California Department of Health Services, Environmental Health Investigations Branch, June 2007.
[96] Meg Y-Y, Rull RP, Wilhelm M, et al. Outdoor air pollution and uncontrolled asthma in the San Joaquin Valley, California. *J Epidem & Comm Health.*2010; 64: 142-147.
[97] Von Essen S. The role of farm exposures in occupational asthma and allergy. *Curr Opin Allergy Clin Immunol* 2001;1(2):151–6.
[98] Liu AH, Murphy JR. Hygiene hypothesis: fact or fiction? *J Allergy Clin Immunol 2003;*111(3):471–8.
[99] California Breathing.org. Napa County Asthma Profile, July 2008 http://www.californiabreathing.org/index.php?option=com_content&task=view&id=34&Itemid=44 (March 2010)
[100]National Center for Health Statistics. "Asthma Prevalence, Health Care Use and Mortality." URL: http://www.cdc.gov/nchs/products/pubs/pubd/hestats/asthma/asthma.htm

people under age 18 in California had ever been diagnosed with asthma. Napa County's rate was higher—21.3%, up from 15.4% in 2003.[101]

According to the 2007 California Health Interview Survey, almost 97% of Napa County children and adolescents with asthma experienced symptoms in the preceding year, compared to 89% in California (Table 33). This suggests that a larger proportion of the county's children and adolescents than the state average may be at risk for serious illness and other complications associated with asthma, such as activity limitations and missed days of school.

Table 33. Lifetime Asthma,[1] Children and Adolescents, 2003 & 2007

	Lifetime Asthma in California Children and Adolescents, 2003 & 2007		Children and Adolescents Experiencing Asthma Symptoms Within the Past Year, 2003 & 2007	
	2003	2007	2003	2007
Napa County	15.9%	21.3%	92.9%	96.8%
California	15.4%	15.4%	92.3%	89.4%

Source: California Health Interview Survey, 2003 & 2007
[1]Individuals with "lifetime asthma" have ever been told by a doctor that they have asthma.

Table 34 shows the percent of Napa County residents, by age group, which has ever been diagnosed with asthma and, of those, the percent that reported experiencing symptoms within the past 12 months. A larger proportion of young people under age 18 have ever being diagnosed with asthma than those 18 and older. In both children and adults, being overweight is associated with higher asthma prevalence.[102]

Table 34. Napa County Residents Ever Diagnosed with Asthma, 2007

Age Group	Percent Ever Diagnosed with Asthma	Percent with Asthma who had Asthma Symptoms in Previous 12 Months
0-17	21.3%	96.8%
18-64	19.0%	94.6%
65+	13.5%	96.4%

Source: California Health Interview Survey, 2007.

When people are able to manage their asthma properly and receive appropriate health care, they should not have to go to the emergency department (ED) for treatment. Nevertheless, in 2009, there were 457 asthma diagnosis-related ED visits to Napa

[101] California Health Interview Survey, 2007. UCLA Center for Health Policy Research
[102] Milet M, Tran S, Eatherton M, Flattery J, Kreutzer R. "The Burden of Asthma in California: A Surveillance Report." Richmond, CA: California Department of Health Services, Environmental Health Investigations Branch, June 2007.

County hospitals that did not result in inpatient hospitalization: 42 to St. Helena Hospital ED; 354 to Queen of the Valley Medical Center ED; and 61 to Kaiser Vallejo (Napa patients only). At QVMC, 27% of the visits were to children age 17 and under.[103] In 2006 (the year of most recent data), the rate of Napa County ED visits for children under age 18 was lower than the state rate—the 3rd lowest of 58 counties. For people over 18, the rate was the 15th lowest in the state, yet higher than the statewide average.[104]

Table 35. Asthma Related ED Visits, 2006

	Napa number	Napa rate (per 10,000)	CA rate
0-17	157	51.4	68.0
18+	432	42.2	35.8

Source: Napa County Asthma Profile, July 2008, California Breathing.

Napa County's overall rate of asthma *hospitalizations,* 6.5 per 10,000, is lower than the state rate of 9.1 and ranks in the middle of all California counties.

MATERNAL HEALTH

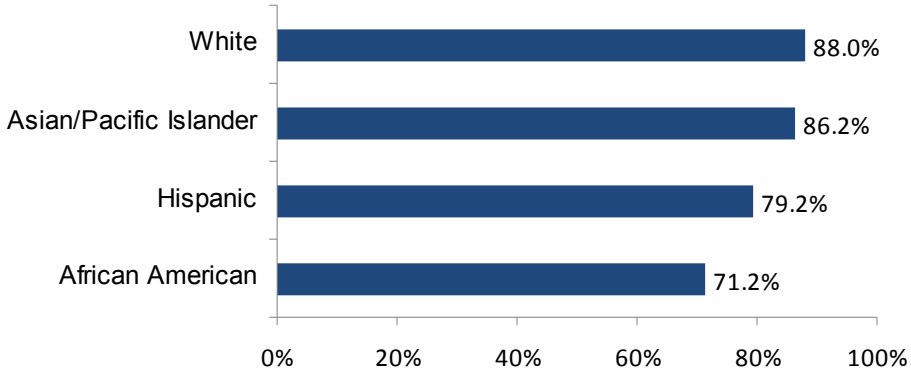
Prenatal Care

Early initiation of and adequate prenatal care are associated with improved birth outcomes. The national objective for births to mothers with "adequate/adequate plus" care (which includes timing of entry into prenatal care) is 90%. Only one California county (Marin) met this objective in the latest 3-year reporting period. In Napa County, 78.1% of women received adequate/adequate plus prenatal care during 2006-2008 (3-year average), up from 73.5% in 2003-2005 and from 69.8% in 2000-2002. Napa County's 2006-2008 rate fell just below the statewide rate of 78.7% and ranked 15th highest in the state.[105]

Entry into prenatal care varies by race/ethnicity. White women giving birth in Napa County were the group most likely to have received prenatal care in the first trimester (Figure 14 on the next page). The lower proportion for Hispanic women may partly reflect birth certificate data entry problems that have been identified at the largest hospital in the county; 66% of births at this hospital are to Hispanic women compared to 55% and 39% of births at the two other major hospitals serving the county.[106]

[103] Data provided to the author by hospital representatives. August 4, 2010.
[104] California Breathing.org. Napa County Asthma Profile, July 2008 http://www.californiabreathing.org/index.php?option=com_content&task=view&id=34&Itemid=44 (March 2010)
[105] County Health Status Profiles 2010. California Department of Public Health. http://www.cdph.ca.gov/programs/ohir/Pages/CHSP.aspx (April 2010)
[106] Napa County Maternal, Child and Adolescent Health Needs Assessment: 2010-2014, Napa County Health and Human Services Public Health Division, June 30, 2009.

Figure 14. Percent of Births With First Trimester Prenatal Care, by Race/Ethnicity, 2009

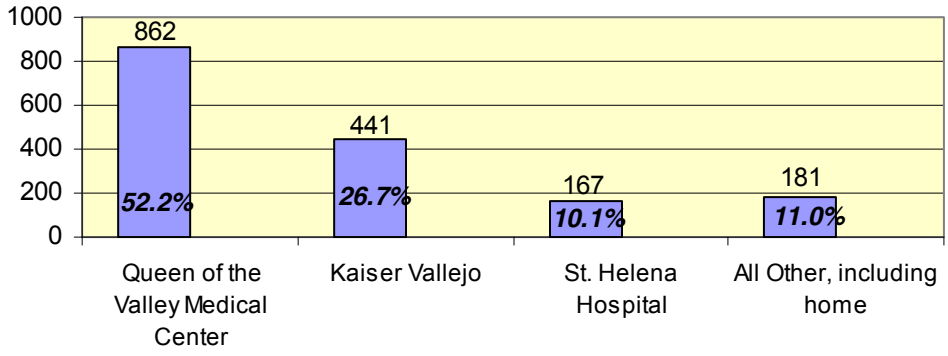


Data source: California Department of Public Health. Analysis: Napa County Public Health

Births*

Approximately 1,651 babies were born in 2009 to women living in Napa County.** The largest majority (52.2%) of births occurred at Queen of the Valley Medical Center (Figure15).

Figure 15. Number and Percent of Births to Napa Residents by Facility, 2009



Data source: California Department of Public Health. Analysis: Napa County Public Health

* See page 56 for birth data regarding C-sections and obesity. See page 53 for breastfeeding data.

** Births are reported by county of residence of mother not county of facility where the birth occurred.

Birth projections through 2015 show a slight but steady increase (Table 36), which is likely attributable to the county's overall population growth. Similar to the majority of the state, population growth is projected to be disproportionately higher among the Latino and certain Asian/Pacific Islander populations.

Table 36. Napa County Actual and Projected Births, 2005-2015

Actual	
2005	1,658
2006	1,754
2007	1,665
2008	1,671
2009	1,651
Projected	
2010	1,726
2011	1,743
2012	1,764
2013	1783
2014	1,806
2015	1,826

Source: Years 2005-2008: California Department of Public Health. County Birth Statistical Data Tables Years 2009-2015: California Department of Finance, County Birth Projections, 2009 Series.

Increasing by eight percentage points since 2003, 43% of births to mothers in Napa County in 2006 were paid by Medi-Cal, lower than the statewide rate of 47%.[107]

Adolescent Pregnancy

Data on teen pregnancy is notoriously poor as it is not reportable or recorded consistently anywhere. Teen birth data, on the other hand, is considerably more reliable because of the need for a birth certificate and the standardized data required for that. Nationally, the teen birth rate declined 2% in 2008, after increasing 5% between 20065 and 2007, according to the CDC's Center for Health Statistics.[108] With an age-specific birth rate of 27.3% in 2006-2008, Napa County ranks 21st best among California's 58 counties in births to adolescent mothers, an improvement from 29.5% in 2002-2004 (Table 37 on the next page).[109] The U.S. *pregnancy* rate among 15-19 year olds

[107] Improved Perinatal Outcome Data Reports, Napa County Profile, 2006. http://ipodr.org/055/vs/socioeconomics.html#tablenohs (April 2010)
[108] http://www.cdc.gov/reproductivehealth/adolescentreprohealth/AboutTP.htm#1. Accessed August 2010.
[109] County Health Status Profiles 2010. California Department of Public Health. http://www.cdph.ca.gov/programs/ohir/Pages/CHSP.aspx (April 2010)

increased 3% between 2005 and 2006—the first jump since 1990, according to an analysis of the most recent data collected.[110] While no national objective has been established for teen births, the national target for *pregnancies* (as opposed to births) among adolescent females is 43 pregnancies per 1,000.

Table 37. Births to Teen Mothers

Area	2007 Female Population 15-19 Yrs Old	2006-2008 Live Births (3 yr average)	Age-Specific Birth Rate
Napa County	4,725	129	27.3
California	1,438,740	52,622	36.6

Source: County Health Status Profiles 2010. California Department of Public Health.

Children of teen mothers are more likely to display poor health and social outcomes than those of older mothers, such as premature birth, low birth weight, higher rates of abuse and neglect, and greater likelihood of entering foster care or doing poorly in school.

Infant Mortality

Infant mortality rates are used to compare the health and well-being of populations across and within countries. The infant mortality rate—the number of deaths of children under 1 year of age per 1,000 live births—has continued to steadily decline in the U.S. and California over the past several decades. Nationally as well as statewide, however, African American infant death rates are significantly higher than both White non-Hispanic and Hispanic infants which are similar to one another. Because the number of infant deaths for most counties in California is too small to calculate reliable rates, the rate of infants born with low birth weight (less than 2500 grams at birth) is often used instead. In 2004-2006 in Napa County, the infant mortality rate was 5.0; in 2006-2008 it rose to 5.3.[111]

Low Infant Birth Weight

Low birth weight is a major public health problem, contributing substantially both to infant mortality and to childhood disabilities. The principal determinant of low birth weight is preterm (premature) delivery. Infant mortality rate and low birth weight correlate with poverty, unemployment and violent crime in the community, as well as poor nutrition and medical care.

Like the statewide rate, Napa County's 2006-2008 three-year average low birth weight rate, 6.2%, rose slightly from 5.7% in 2002-2004 (Table 38 on the next page). Neither

[110] U.S. Teenage Pregnancies, Births and Abortions: National and State Trends and Trends by Race and Ethnicity. Guttmacher Institute January 2010. www.guttmacher.org.
[111] Cited on kidsdata.org, California Department of Health Services, Center for Health Statistics, Vital Statistics Section, CD-Rom Public Use Birth and Death Files.

the county nor the state met the national Healthy People objective of 5%, and Napa County's statewide rank fell from 15th lowest to 31st among the 58 counties.[112]

Table 38. Low Birth Weight Infants

Area	2002-2004 (3 yr average)			2006-2008 (3 yr average)			Healthy People 2010 Goal
	Live Births	Low Birth Weight		Live Births	Low Birth Weight		
		Number	Percent		Number	Percent	Percent
Napa County	1,617	92	5.7	1,697	106	6.2	5.0
California	538,239	35,333	6.6	559,936	38,368	6.9	5.0

Source: County Health Status Profiles 2010. California Department of Public Health.

Adjusted for its overall number of births, St. Helena Hospital delivered a higher proportion of low birth weight babies than Queen of the Valley Medical Center in 2008 (Table 39).

Table 39. Low Birth Weight Infants by Napa County California, 2008

Queen of the Valley Medical Center		
Live Births by Weight	No. of Births	% of Total Births
Birth Weight <5 lbs.8 oz.	7	0.71%
Birth Weight <3 lbs.5 oz.	1	0.10%
St. Helena Hospital		
Live Births by Weight	No. of Births	% of Total Births
Birth Weight <5 lbs.8 oz.	5	1.81%
Birth Weight <3 lbs.5 oz.	0	0.00%
California		
Live Births by Weight	No. of Births	% of Total Births
Birth Weight <5 lbs.8 oz.	33,740	6.23%
Birth Weight <3 lbs.5 oz.	6,496	1.20%

Source: California Office of Statewide Health Planning and Development

SUBSTANCE USE AND ABUSE

Adult Alcohol and Drug Abuse

Alcohol abuse is a pattern of drinking that results in harm to one's health, interpersonal relationships or ability to work. Certain manifestations of alcohol abuse include failure to fulfill responsibilities at work, school or home; drinking in dangerous situations such

[112] County Health Status Profiles 2010. California Department of Public Health. http://www.cdph.ca.gov/programs/ohir/Pages/CHSP.aspx (April 2010)

as while driving; legal problems associated with alcohol use and continued drinking despite problems that are caused or worsened by drinking.[113]

Alcohol abuse is associated with a number of acute and chronic health effects. *Chronic* health consequences of excessive drinking[114] can include liver cirrhosis (damage to liver cells); pancreatitis (inflammation of the pancreas); various cancers, including cancer of the liver, mouth, throat, larynx (the voice box), and esophagus; high blood pressure; and psychological disorders. *Acute* health consequences of excessive drinking can include motor vehicle injuries, falls, domestic violence, rape, and child abuse.[115]

The State collects, monitors, and reports community-level indicators that serve as direct and indirect measures of the prevalence of alcohol and other drug use and related problems. Selected indicators for adults in Napa County are shown in Table 40. The county's rate for the indicator *Alcohol-involved motor vehicle accident fatalities* is higher than the state average.

Table 40. Community-Level Alcohol and Drug-Related Indicators, Adults

Indicator (rates per 100,000)	Report Period (3-yr avg. unless single year specified)	Napa	CA
Rate of arrests for drug-related offenses, ages 10-69	2002-2004	728.5	983.4
Rate of alcohol-involved motor vehicle accident fatalities	2001-2003	5.9	3.9
Rate of alcohol and drug use hospitalizations	2002-2004	173.1	214.8
Rate (per 1,000) of admissions to alcohol and other drug treatment , ages 10-69	2002-2004	586.4	856.8
Rate of deaths due to alcohol and drug use	2001-2003	21.4	20.1

Source: *Indicators of Alcohol and Other Drug Risk and Consequences for California Counties.* Napa County 2007. Center for Applied Research Solutions.
Note: These data are expected to be updated in late 2010.

Napa County's 3-year average rate of alcohol-involved motor vehicle fatalities in 2001-2003 was 1.5 times higher than the state rate.[116] Young adults between the ages of 18 and 24 have the highest rates of involvement in drinking and driving accidents, and in

[113] Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV), published by the American Psychiatric Association, Washington D.C., 1994. Reported at http://www.cdc.gov/alcohol/faqs.
[114] For men, heavy drinking is typically defined as consuming an average of more than 2 drinks per day. For women, heavy drinking is typically defined as consuming an average of more than 1 drink per day. Note: There is no one definition of moderate drinking, but generally the term is used to describe low-risk or responsible drinking. http://www.cdc.gov/alcohol/faqs.
[115] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. http://www.cdc.gov/alcohol/faqs.
[116] *Indicators of Alcohol and Other Drug Risk and Consequences for California Counties*, Napa County, 2007. Center for Applied Research Solutions. http://www.ca-cpi.org/Publications/community_indicators_2007.htm (June 2010).

Napa County, the rate of 18 to 24 year olds who were party to alcohol-involved accidents increased by more than 50% from 2000 to 2003.[117]

The California Health Interview Survey (CHIS) has found that alcohol use in Napa County varies by race/ethnicity. White residents have higher use rates, but Latinos have somewhat higher rates of binge drinking.[118] According to the National Institute on Alcohol Abuse and Alcoholism, binge drinking is defined as a pattern of alcohol consumption that brings the blood alcohol concentration level to 0.08% or above. This pattern of drinking usually corresponds to more than 4 drinks on a single occasion for men or more than 3 drinks on a single occasion for women, generally within about 2 hours.[119] According to the 2007 California Health Interview Survey (CHIS), the rate of binge drinking is higher in Napa County than statewide (Table 41). (Note that the CHIS question about binge drinking changed in 2007, from asking about binge drinking the past 30 days to the past year.)

Table 41. Adult Binge Drinking Rates

	Engaged in Binge Drinking[1]		
	2003 (in past month)	2005 (in past month)	2007 (in past year)[2]
Napa County	16.1%	19.4%	34.6%
California	15.1%	17.6%	29.7%

Source: California Health Interview Surveys, 2003, 2005, 2007. UCLA Center for Health Policy Research
[1] In this data source, for males, binge drinking is considered five or more drinks on one occasion; for females it is four or more.
[2] In 2007, the question changed to ask about binge drinking in the past year.

While these data are helpful for identifying risk and problem areas, there are some limitations that should be noted. For example, the prevalence of alcohol and drug use and related problems may underestimate actual occurrence due to under-reporting. Further, hospital admission rates do not include the utilization of services provided outside of the publicly-funded alcohol and drug treatment and recovery system. Additionally, hospital discharge rates only include discharges for diagnoses directly attributable to alcohol and drug use.

Methamphetamine is the leading illegal drug of abuse in Napa County, accounting for 40 to 50% of drug treatment admissions from 2000 to 2004.[120] While the county's overall rate of treatment admissions is substantially lower than the state average, the

[117] Ibid.
[118] *Indicators of Alcohol and Other Drug Risk and Consequences for California Counties*, Napa County, 2007. Center for Applied Research Solutions. http://www.ca-cpi.org/Publications/community_indicators_2007.htm (June 2010)
[119] National Institute of Alcohol Abuse and Alcoholism. *NIAAA council approves definition of binge drinking*. *NIAAA Newsletter* 2004;3:3.
[120] Ibid.

rate for youth under age 18 is more than double the state average and comprises 29% of all Napa County admissions, compared to only 9% statewide. The majority of youth receive treatment for marijuana use, accounting for two-thirds of all admissions in 2004.[121]

Adolescent Alcohol and Drug Use and Abuse

Underage drinking and underage binge drinking are associated with higher risks of motor vehicle crashes, suicide, and sexually transmitted infections.[122,123, 124] Underage alcohol use is more likely to kill young people than all illegal drugs combined. Youth who use alcohol are 1.5 times more likely to require emergency department care and 9.4 times more likely to drink and drive; they are also 2.5 times more likely to smoke.[125] An analysis of 2005 Youth Risk Behavior Survey data from 4 states found that liquor (e.g., bourbon, rum, scotch, vodka, or whiskey) was the most prevalent type of alcoholic beverage usually consumed by students in 9th-12th grade, followed by beer or malt liquor. Wine was the least popular drink by a wide margin. For the most part, the finding held true for both genders and across all racial groups.[126]

The community indicators the State collects, monitors, and reports for youth in Napa County are shown in Table 42. The county's rate for the following indicators is higher than the state average:

- Juvenile arrests for alcohol-related offenses
- Adolescent admissions to alcohol and drug treatment

Table 42. Community-Level Alcohol and Drug-Related Indicators, Youth

Indicator (rates per 100,000)	Report Period (3-yr avg. unless single year specified)	Napa	CA
Rate of juvenile arrests for alcohol-related offenses, ages 10-17	2004	***331.9***	219.9
Rate of juvenile arrests for drug-related offenses, ages 10-17	2004	451.3	482.3
Rate of juvenile admissions (per 1,000) to alcohol and other drug treatment, ages 10-17	2004	***1055.4***	462.8

Source: *Indicators of Alcohol and Other Drug Risk and Consequences for California Counties.* Napa County 2007. Center for Applied Research Solutions.
Note: These data are expected to be updated in late 2010.

[121] Ibid.
[122] Zador PL, Krawchuk SA, Voas RB. Alcohol-related relative risk of driver fatalities and driver involvement in fatal crashes in relation to driver age and gender: An update using 1996 data. *J Stud Alcohol*. 2000;61:387–395.
[123] U.S. Department of Health and Human Services. Centers for Disease Control and Prevention: Youth Risk Behavior Surveillance – United States, 2005. *Morb Mortal Wkly Rep*. 2006;55:.
[124] Bailey SL, Pollock NK, Martin CS, et al.. Risky sexual behaviors among adolescents with alcohol use disorders. *J Adolesc Health*. 1999;25:179–181.
[125] National Household Survey on Drug Use and Health
[126] CDC. Youth Risk Behavior Surveillance—United States, 2005. *MMWR* 2006;55(No. SS-5).

California Health Interview Survey data indicate that rates of binge drinking among California adolescents ages 12-17 have declined since 2005 (Table 43). Because of small population sizes, caution must be used in interpreting Napa County results. In 2007, no youth respondents reported binge drinking in the prior month, compared to 4.6% (statistically unstable) in 2005 and 20.7% (statistically unstable) in 2003. The national Healthy People objective for adolescent binge drinking is no more than 3.2%. The CHIS data do not distinguish type of alcoholic beverage.

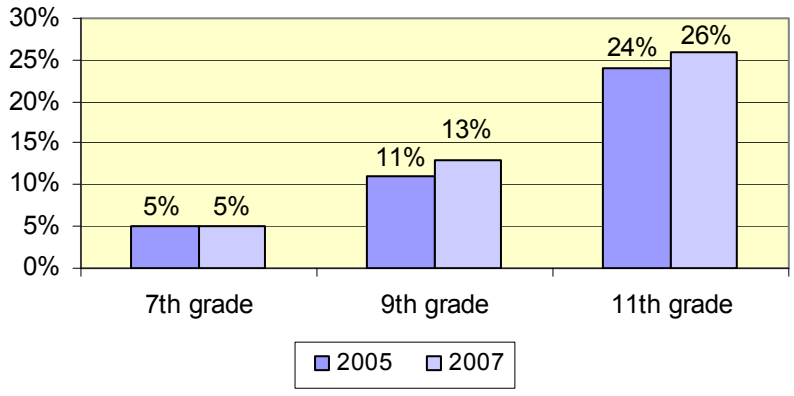
Table 43. Underage Binge Drinking Rates, ages 12-17

	Engaged in Binge Drinking in past month[1]		
	2003	2005	2007
Napa County	20.7%*	4.6%*	0%[+]
California	6.3%	7.0%	4.8%

Source: California Health Interview Surveys, 2003, 2005, 2007. UCLA Center for Health Policy Research
[1] For males, binge drinking is considered 5 or more drinks on one occasion; for females it is 4 or more drinks on one occasion.
*Estimate is statistically unstable.
[+]Telephone conversation with May Adan, PhD, CHIS staff, UCLA Health Policy Research, 8/5/10, confirmed this figure.

The California Healthy Kids Survey (CHKS), which collects data on students in grades 5, 7, 9 and 11, a minimum of every two years, offers another look at youth alcohol and drug use. Up slightly from 2006, 13% of Napa County 9th graders and 26% of 11th graders reported binge drinking in the last 30 days in 2007 (Figure 16).[127] The national objective is to reduce the proportion of high school seniors who report binge drinking to 11%.

Figure 16. Binge Drinking in Last 30 Days, Grades 7, 9, and 11, 2005 & 2007

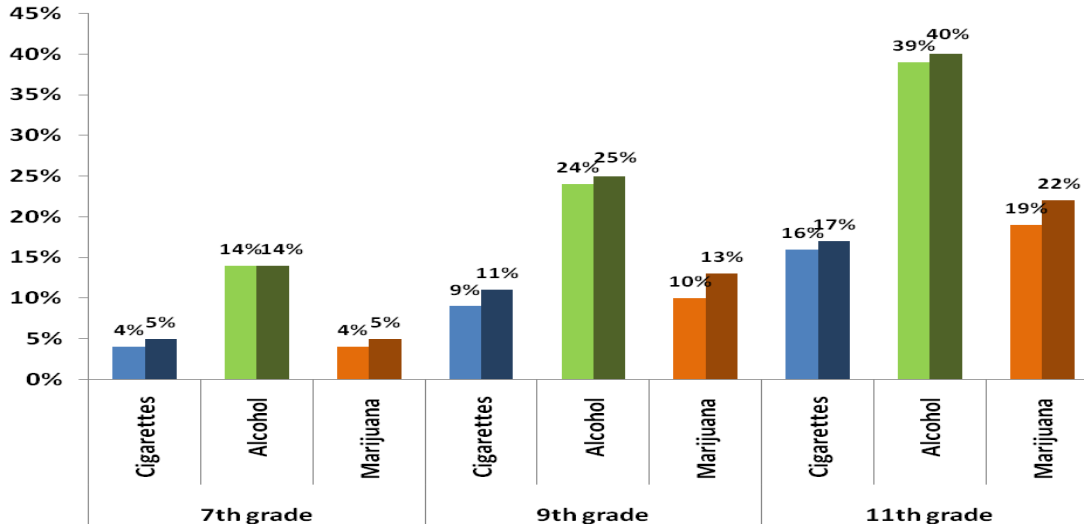


Source: California Healthy Kids Survey, Fall 2008.

[127] California Healthy Kids Survey, Fall 2008. http://www.wested.org/cs/chks/query/q/1298?district=aggregate (July 2010)

A summary of other CHKS findings for Napa County is displayed in Figure 17. Only 5% of 7th graders reported using cigarettes or marijuana in the last 30 days, although 14% said they had used alcohol. Among 9th graders, 11% reported smoking cigarettes, 13% using marijuana, and one-quarter using alcohol in the past 30 days. Use rates increase with grade level. Seventeen percent of 11th graders reported cigarette use in the last 30 days, 22% marijuana, and 40% alcohol.

Figure 17. Napa County Drug Use by School Children by Grade Level, 2005 & 2007



Source: California Healthy Kids Survey, Fall 2008.
Note: lighter color bars are 2005; darker color bars are 2007

The effect of alcohol advertising is important with regard to underage drinking and binge drinking. According to recent research, children as young as 11 and 12 years old who are exposed to alcohol marketing are more likely to use alcohol or plan to use it. Children with the highest levels of marketing exposure (e.g., at sporting events) were 50% more likely to drink and 36% more likely to intend to drink a year later compared to children with little exposure to alcohol ads.[128] Research has shown that delaying alcohol use decreases the likelihood that young people will drop out of school or participate in criminal activities.[129]

In 2004, about 10% of drug and alcohol-related arrests in Napa County were of youth under the age of 18.[130] The majority (68%) of these were male and White or Hispanic,

[128] Collins RL, Ellickson PL, McCaffrey D, Hambarsoomians K. Early Adolescent Exposure to Alcohol Advertising and its Relationship to Underage Drinking. *Journal of Adolescent Health*, April 2007;(40);6:527-534.
[129] Elliott DS. Health Enhancing and Health-Compromising Lifestyles. *Promoting the Health of Adolescents*. Oxford University Press, New York. http://www.oup-usa.org/toc/tc_0195091884.html.
[130] *Indicators of Alcohol and Other Drug Risk and Consequences for California Counties*, Napa County, 2007. Center for Applied Research Solutions. http://www.ca-cpi.org/Publications/community_indicators_2007.htm (June 2010)

with rates among Hispanic youth slightly exceeding those for White.[131] In the same year, the county's rate of juvenile arrests for alcohol-related offenses was 1.5 times higher than the state average.[132]

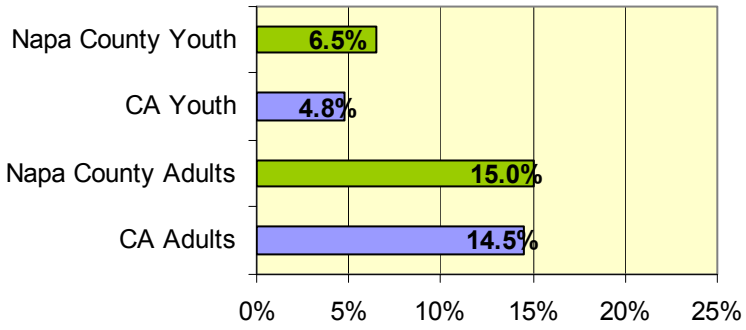
Adult and Youth Tobacco Use

Despite the effectiveness of comprehensive tobacco control programs in reducing smoking consumption, inequities remain. For example, smoking rates of college-educated individuals are now below Healthy People 2010 goals, but populations with lower income or lower education level, along with certain other groups, continue to smoke in higher number than the national average.[133]

Tobacco use is the single most preventable cause of death and disease in the United States. Smoking causes at least 80% of all deaths from lung cancer, about 80% of all deaths from bronchitis and emphysema and approximately 17% of all deaths from heart disease; 30% of all cancer deaths can be attributed to smoking. Across all states, the prevalence of cigarette smoking among adults ranges from 9.3% to 26.5%. California ranks 2nd among the states. Among youth ages 12-17, the range across all states is 6.5% to 15.9%. California ranks 3rd among the states.[134]

According to the 2007 California Health Interview Survey, 14.5% (down from 17.1% in 2005) of California adults smoked (Figure 18). A slightly higher proportion, 15.0% (down from 21.5% in 2005), of Napa County adults reported being a current smoker. Among youth ages 12-17, 6.5%* of Napa youth compared to 4.8% statewide reported being a current smoker.

Figure 18. Percent of Population Reporting Being a Current Smoker, 2007



Source: California Health Interview Survey.

[131] Ibid.
[132] Ibid.
[133] Centers for Disease Control and Prevention. Cigarette smoking among adults—United States, 2006. *MMWR Morb Mortal Wkly Rep*. 2007;56(44):1157-1161.
[134] http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2010.
* The small sample size and/or confidence interval (0-13.6%) make the rate statistically unreliable.

Neither the state nor county meet the Healthy People 2010 objective of no more than 12% of adults age 18+ who smoke cigarettes. Decreasing the rate of smoking would lead to a demonstrable decrease in mortality from cancer alone, not to mention the additional decreases in mortality from heart disease and stroke. Based on CDC estimates, a 1% decrease in smoking would lead to about a 1% decrease in all-cause mortality in Napa County.

Perinatal Substance Abuse

Alcohol, cigarette, and illicit drug use during pregnancy can cause poor pregnancy outcomes and early childhood behavioral and development problems. Although California is recognized as a national leader in developing alcohol and other drug services for women, many counties, including Napa County, do not have the benefit of an adequate spectrum of comprehensive gender-specific and culturally appropriate screening, treatment and support services to address the needs of pregnant women involved with substance abuse. Accurate statistics on substance use during pregnancy are difficult to obtain—for example, since alcohol is a legal drug, its negative impact is often overlooked—but several studies, including a regional effort, offer a sufficient picture of use to guide planning and intervention strategies.

The California Maternal and Infant Health Assessment (MIHA), an annual, statewide-representative telephone survey (English and Spanish) of women who recently gave birth to a live infant, also tracks tobacco and alcohol use during pregnancy. The data are linked to birth certificate information and weighted to reflect sampling design. Bay Area regional (Napa is 1 of 9 Bay Area counties) MIHA data for 2005-2006 showed 7.3% of pregnant women reported smoking during the 1st trimester and 2.3% during the 2nd trimester. And, approximately 16% reported drinking alcohol during the 1st trimester and 13% during the 3rd trimester.[135]

A 2008 report[136] by Ira Chasnoff, M.D., presents results of a study of outcomes of a comprehensive system of screening, assessment, and brief intervention in almost 79,000 pregnant women in 16 California counties from throughout the state. While the report does not attempt to present community-wide prevalence rates, it is based on a very large dataset and provides insights into perinatal substance use patterns statewide that have relevance for Napa County providers. In response to the *4P's Plus©* screening instrument[137] administered at the first prenatal visit, 12.8% of women in the study reported tobacco use in the month prior to knowledge of the pregnancy, 16.1% alcohol use, and 6.6% marijuana use.[138] Eliminating duplicate counts, the rate of positive screens, i.e. women *at risk* for substance use during pregnancy due to alcohol,

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[135] http://www.cdph.ca.gov/data/surveys/Pages/SanFranciscoBayAreaRegion.aspx. Accessed 8/4/10.

[136] Chasnoff, et al. Perinatal Substance Use Screening in California: Screening and Assessment with the *4P's Plus© Screen for Substance Use in Pregnancy. NTI Upstream, 2008.* http://www.cdph.ca.gov/programs/perinatalsubstanceuse/pages/default.aspx (July 2010)

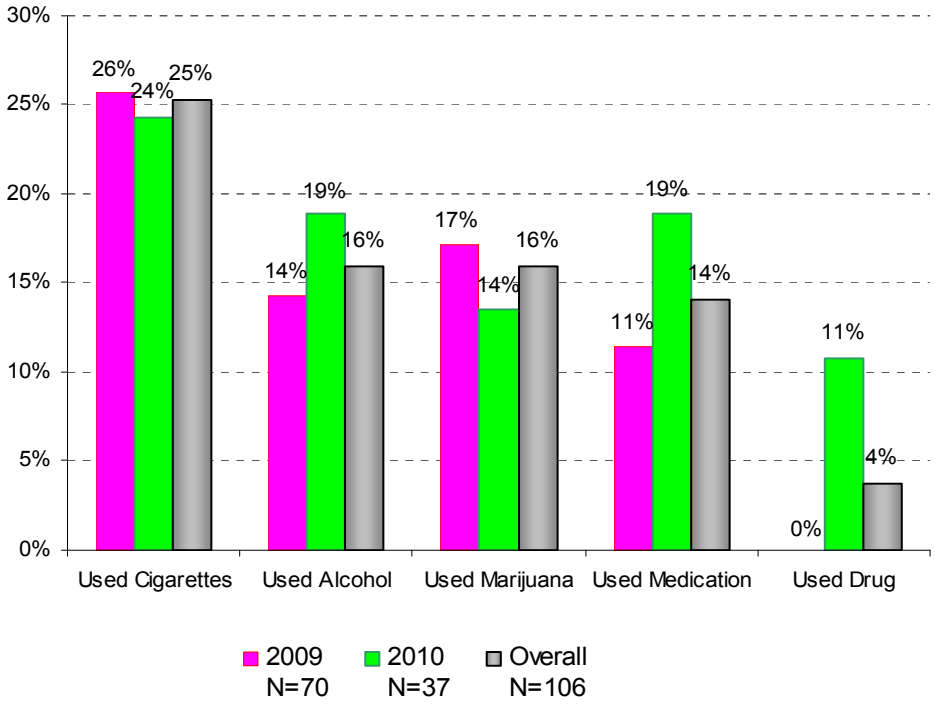
[137] *4P's Plus©* screening and intervention methodology is a time-conserving, user-friendly methodology easily incorporated into prenatal care, and is designed to obtain accurate information with follow-up intervention on positive screens.

[138] Chasnoff, et al. Perinatal Substance Use Screening in California: Screening and Assessment with the *4P's Plus© Screen for Substance Use in Pregnancy. NTI Upstream, 2008.* http://www.cdph.ca.gov/programs/perinatalsubstanceuse/pages/default.aspx (July 2010)

tobacco, or marijuana use in the month prior to knowledge of pregnancy, was 23.7%. Excluding women who reported using tobacco only, the rate was 19.2% and dropped to 8.6% after women learned of their pregnancy. Close to half (45%) of women continued to use alcohol and illicit drugs after learning they were pregnant.

Nearby Lake County is among the pilot counties utilizing the *4P's Plus©* screening and intervention methodology in all of its community clinics to deter drug use during pregnancy. Data available on 107 women who were screened and followed during their pregnancies in the period 4/15/09 - 06/03/10 might be of interest to Napa County. Of these 107 women, close to three quarters (73%) reported using some type of substance (including tobacco) *before* learning they were pregnant; *since* learning they were pregnant, 42.1% had used a substance, some more than one substance (Figure 19).

Figure 19. Substance Use During Pregnancy, 4PsPlus©, Lake County, 4/15/09 – 6/3/10



Applying conservative statewide estimates of prevalence from Vega and Chasnoff's earlier statewide work, approximately 190 infants would be projected to have been born substance-exposed in Napa County in 2008, or about 11.4% of all births that year.[139]

[139] Vega W et al. *Profile of Alcohol and Drug Use During Pregnancy in California, Perinatal Exposure*. UC Berkeley and the Western Consortium for Public Health. Study conducted for the California Department of Alcohol and Drug Programs, September 1993.

ORAL HEALTH

Early Childhood

Oral health is an important component of overall health. Pregnancy and early childhood are particularly important times to access oral health services because the consequences of poor oral health can have a lifelong impact.[140] Improving the oral health of pregnant women prevents complications of dental diseases during pregnancy (e.g., abscessed teeth), and has the potential to subsequently decrease Early Childhood Caries in their children. Yet many women do not seek—and are not advised to seek—dental care as part of their prenatal care, even though pregnancy provides a "teachable moment" as well as being the only time some woman are eligible for dental benefits.[141]

Dental disease affects more school-age children than any other chronic health condition—next to the common cold, tooth decay is the most prevalent human disorder. Dental disease among children in California is an epidemic, five times more common in children than asthma.[142] And it is an epidemic that is almost entirely (and inexpensively) preventable. In California, students miss an estimated 874,000 school days annually due to dental problems. These absences cost local school districts approximately $28.8 million.[143] Moreover, children from poor families suffer twice as much dental disease as middle-class children and their disease is more likely to remain untreated.

According to the 2006 statewide Dental Health Foundation needs assessment, about one-third of low income children have untreated decay compared to about one-fifth of higher income children. Nearly 40% of children with no insurance have untreated decay compared with 21% of children with private insurance.[144] Additional findings from the DHF assessment which have implications for Napa County children include:

- 54% of kindergartners and 71% of 3rd grade children screened have a history of tooth decay (which means that they had at least one tooth that was either decayed or had been filled because of tooth decay).

- 26% of children have a need for dental care–22% need non-urgent or early dental care, while an additional 4% need urgent dental care because of pain or infection.

- Latino and other minority children have more decay experience, more untreated tooth decay, and more urgent dental care needs than non-Latino white children. In

[140] U.S. Department of Health and Human Services. *Oral health in America: a report of the Surgeon General*. NIH Publication No. 00-4713, Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, National Institute of Dental and Craniofacial Research, May 2000.
[141] Oral Health During Pregnancy and Early Childhood: Evidence-Based Guidelines for Health Professionals. Aved BM, Weintraub JA, Stein E. *J CA Dent Assn*. June 2010.
[142] U.S. Department of Health and Human Services (HHS). *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: HHS, National Institutes of Health, National Institute of Dental and Craniofacial Research, 2000.
[143] Oral health: Integral to well-being. Expanding children's access to & use of oral health services. Children Now. Available at http://www.childrennow.org/index.php/learn/oral_health/.
[144] *Mommy it Hurts to Chew. The California Smile Survey An Oral Health Assessment of California's Kindergarten and 3rd Grade Children.* Dental Health Foundation, February 2006.

addition to having more tooth decay, Latino children are less likely to have private dental insurance.

Applying the statewide assessment data above to poverty-level children age 0-19 in Napa County, an estimated 6,680 children have decay requiring treatment, an estimate that is probably conservative.

While it is difficult to accurately determine the number of these children that are receiving care, according to the 2007 California Health Interview Survey (CHIS), three-quarters of children in Napa County are enrolled in some type of insurance program with dental coverage. And, 8 in 10 children reported visiting a dentist in the last year (Table 44), the same proportion as statewide. The proportion that used the oral health care system in the last year exceeds the national health target of 56%.

Table 44. Dental Health Indicators

Dental Health	Napa County	Statewide
Children with dental insurance	75.5%	80.4%
Children who visited a dentist in the last year	82.3%	80.4%

Source: California Health Interview Survey, 2007

The CHIS data represent Napa County children at all income levels, however. Medi-Cal data tell a different story. In 2008, only 18.5% of Napa County children age 0-20 with Medi-Cal dental benefits used a dental service—less than half the statewide average of 41.3%—ranking the county 44th among California's 58 counties. For Napa County children age 0-3 and 4-5, the utilization rate was 8.5% and 25.1%, respectively.[145] There are multiple reasons for low utilization of dental services by low-income children, even for those with some form of dental insurance. These range from lack of capacity and provider unwillingness to accept public-program coverage on the health system side, to lack of understanding the value of preventive care and fear of the dentist on the user side.

Community water fluoridation is the most effective way to prevent dental caries in all children, regardless of socioeconomic status, race, or ethnicity. Fluoride, which naturally occurs in all water sources, has been proven to slow the rate of tooth decay by as much as 49% in baby teeth and 59% in permanent or adult teeth.[146] Every dollar spent for community water fluoridation saves from $8 to $49 in treatment costs depending on the size of the community.[147] It is often considered cost prohibitive in smaller counties and cities, however. None of Napa County's cities are fluoridated.

[145] California Department of Health Care Services, Medi-Cal Dental Services Division. April 2010. Special report prepared for the author.
[146] Centers for Disease Control and Prevention. Public Health Service report on fluoride benefits and risks. *Journal of the American Medical Association* 1991; 266(8):1061–1067.
[147] Preventing Dental Caries with Community Programs. Centers for Disease Control and Prevention. Available at http://www.cdc.gov/oralhealth/publications/factsheets/dental_caries.htm.

Seniors and Oral Health

Oral health is often an overlooked component of seniors' general health and well-being and can affect general health and quality of life in very direct ways, such as pain and suffering and difficulty in speaking, chewing and swallowing. The loss of self-esteem, which can intensify isolation and possibly lead to depression, is associated with the loss of teeth.[148]

One of the most important predictors of dental care utilization is having dental insurance. According to the 2007 California Health Interview Survey, 59.3% of Napa County residents age 65+, compared to 47.2% statewide, reported having no dental insurance in the last year. In 2003 (more recent data are not available) 7.6% of seniors reported to CHIS not being able to afford needed dental care, compared to 10.9% statewide who reported this hardship. (Note: the small sample size for Napa County makes the figure statistically unstable.) Applying the national estimate to Napa County that 78% of adults age 65+ must pay dental care expenses out of pocket, approximately 17,262 of the county's seniors would be projected to have to cover the cost of their dental visits and treatment without the benefit of insurance coverage.

MENTAL HEALTH

Mental disorders are very important health problems and are just as disabling as serious chronic diseases like heart diseases and cancer in terms of premature death and lost productivity. There is ample research that indicates the majority of money spent on medical care goes to treating patients with interrelated health problems, that is, both physical and mental health problems. A key component of community health is "recognizing the relationship between mental and physical health and ensuring that services account for that relationship."[149]

Mental health problems are among the most important contributors to the burden of disease and disability nationwide. The effect of mental health disorders on health and productivity has long been underestimated. Devastating disorders such as schizophrenia, depression and bipolar disorder, Alzheimer's disease, the mental and behavioral disorders suffered by children, and a range of other mental disorders affect nearly one in five Americans in any year.[150] A similar proportion of California adults, 20%, said in the 2005 California Health Interview Survey (CHIS) they needed help for a mental or emotional health problem.[151] Projecting this estimate of need to Napa County's current population, up to 26,800 persons in the county could suffer from some level of mental health problem or disorder.

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[148] Davis DM et al. The emotional effects of tooth loss: a preliminary quantitative study. *British Dental Journal,* 188(9):503-506, May 2000.
[149] *Good Health Counts: A 21st Century Approach to Health and Community for California.* Prevention Institute. November 2007.
[150] *Mental Health: A Report of the Surgeon General. December 1999.* www.surgeongeneral.gov.
[151] Grant D, et al. Mental Health Status and Use of Mental Health Services by California Adults. *Health Policy Research Brief.* UCLA Health Policy Research. July 2010.

Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. While depression is under-detected at all ages, much more funding is available for treating younger people, for example. A key disparity often hinges on a person's financial status; formidable financial barriers block needed mental health care regardless of whether one has health insurance with inadequate mental health benefits or lack any insurance.

Approximately 20% of older adults, who face challenges coping constructively with the physical limitations, cognitive changes, and various losses, such as bereavement, that frequently are associated with late life, are estimated to experience specific mental disorders that are not part of "normal" aging. Many in the senior population have to contend with difficulties remaining in their homes due to health and financial reasons, a dearth of community-based affordable assisted living facilities, and difficulties accessing and retaining home health services. Although Napa County has a network of senior service providers and professionals, not all are available in every geographic area. Moreover, seniors frequently find that those services are hard to access, have different and sometimes confusing criteria for qualifying, have various cost structures, and are located in a variety of agencies and organizations. Family caregivers find it increasingly difficult to be aware of the range of services as well as to navigate the various programs needed to provide for the physical, mental health, and social needs of elder loved ones.

To understand how mental health concerns impact Napa County, several indicators were reviewed: psychological distress, teen depression, use of treatment resources, and suicide.

Psychological Distress

2007 California Health Interview Survey (CHI) results showed that 6.2% of Napa County residents reported they had experienced psychological distress in the past year. This proportion was lower than the statewide average of 8.5%.[152]

Teen Depression

Depression in teens was estimated to be 21% statewide and 16% in Napa County in 2005 (the most recent year data are available), according to CHIS.[153]

2007 data from the California Healthy Kids Survey showed that Napa County teens indicated symptoms of depression at approximately the same rate as teens in California when the data were examined by race/ethnicity (Table 45 on the next page). Teens who identified as Asian, Pacific Islander or multiethnic were slightly more likely than their peers statewide to report symptoms.[154]

[152] 2007 California Health Interview Survey, http://www.chis.ucla.edu/main/DQ3/geographic.asp, accessed 7/14/10.
[153] 2005 California Health Interview Survey, http://www.chis.ucla.edu/main/DQ3/geographic.asp, accessed 7/14/10.
[154] As cited on kidsdata.org, California Department of Education, California Healthy Kids Survey (WestEd). http://www.wested.org/chks, accessed 7/14/10. Teens reported "feeling so sad or hopeless every day for 2 weeks or more that they stopped doing some usual activities."

Table 45. Percentage of Youth reporting Depression Symptoms by Race/Ethnicity

Race/Ethnicity	California	Napa County	Difference
African American/Black	31.9%	30.4%	-1.5%
Asian	29.6%	33.0%	3.4%
Caucasian/White	29.1%	27.9%	-1.2%
Hispanic/Latino	33.3%	33.8%	0.5%
Native American	36.1%	36.6%	0.5%
Pacific Islander	36.8%	40.6%	3.8%
Multiethnic	34.9%	38.6%	3.7%
Other	33.9%	33.3%	-0.6%

Source: 2007 California Healthy Kids Survey.

When these same data were reviewed by gender and grade level, female teens in Napa County's non-traditional schools[155] were more likely than their peers statewide to report symptoms of depression (Table 46).[156]

Table 46. Percentage of Youth Reporting Depression Symptoms by Grade Level and Gender

Grade Level	Female			Male		
	California	Napa County	Difference	California	Napa County	Difference
7th Grade	32%	29%	-3%	25%	28%	3%
9th Grade	38%	39%	0%	25%	24%	-1%
11th Grade	39%	41%	2%	26%	28%	2%
Non-Traditional	49%	63%	14%	31%	31%	0%

Source: 2007 California Healthy Kids Survey.

Use of Treatment Resources

Napa County residents used mental health treatment resources at approximately the same rate as California residents. Female residents in Napa County were 5% more likely to see a professional, and male residents were 3% less likely (Table 47 on the next page).[157]

[155] Non traditional schools refer to the Napa County Office of Education schools that are for parenting teens and those who have been expelled repeatedly from regular schools.
[156] Ibid.
[157] 2005 and 2007 California Health Interview Survey, http://www.chis.ucla.edu. accessed 7/14/10.

Table 47. Use of Treatment Resources, California and Napa County residents

Treatment Resource	California			Napa County		
	Male	Female	Total	Male	Female	Total
Saw health professional for emotional/ mental problems	7%	10%	8%	4%	15%	9%
Has taken prescription medicine for emotional/ mental health issue in past year	7%	13%	10%	8%	13%	11%

Source: 2007 California Health Interview Survey

Suicide

Suicide exacts an enormous toll on its victims and the family and friends left behind. Suicide rates, which vary by age, gender and race/ethnicity, may underestimate the true rate of intentional self-harm. For example, the stigma attached to suicide may influence classification, and certain fatal events may arise from thoughts and actions similar to suicide (e.g., single-vehicle motor vehicle crashes, gang-related fights with weapons). For the three-year average 2006-2008, Napa County's rate was less favorable on deaths from suicide with an age-adjusted rate of 12.1* (up from 9.6 in 2003-2005) than California's rate of 9.4, and like the rest of the State did not achieve the Healthy People 2010 objective of no more than 4.8 for this indicator. [158] The county ranked 37th among the 58 counties on deaths from suicide.

The elderly are the highest-risk population for suicide according to the Centers for Disease Control and Prevention, but few suicide prevention programs target them—a result, advocates say, of scarce funding and lack of concern for older adults. Although they comprised only 12% of the U.S. population 2004, people age 65 and older accounted for 16% of all suicide deaths that year.[159] As the baby boomer population ages, the number of suicides among the elderly may be expected to climb. The California Department of Public Health, EPIC Branch identified that between 2000 and 2007 there were 25 suicide deaths reported among seniors ages 65+ in Napa County.[160]

SAFETY ISSUES

Falls Among Seniors

Among people 65 years and older, falls are the leading cause of injury deaths and the most common cause of nonfatal injuries and hospital admissions for trauma. Serious injuries from falls include hip and other fractures, and head, neck and back injuries that

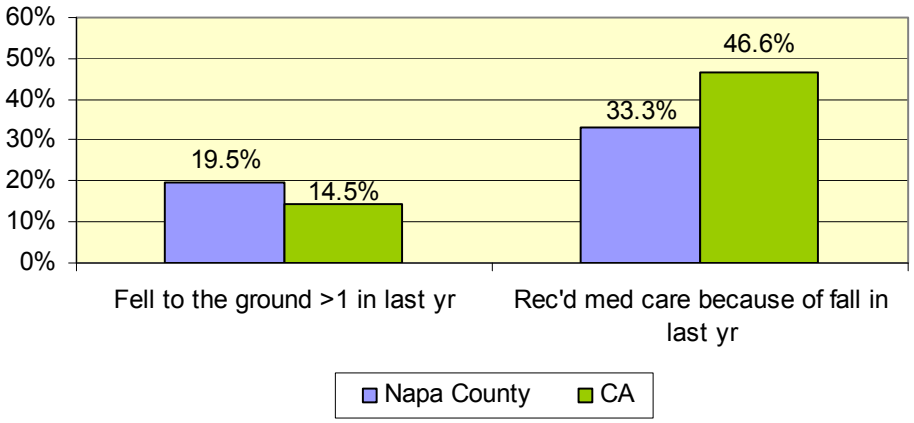
* The suicide rate is subject to a high degree of variability due to the small number of events used to calculate rates.
[158] California Department of Health Services, *County Health Status Profiles 2010.* Birth and Death Statistical Master Files. http://www.cdph.ca.gov/programs/ohir/Pages/CHSP.aspx, accessed 7/12/10.
[159] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (WISQARS) [www.cdc.gov/ncipc/wisqars.
[160] California Department of Public Health, Vital Statistics Death Statistical Master File. EPIC Branch. http://www.applications.dhs.ca.gov/epicdata/default.htm. Accessed July 6, 2010.

require significant care. Falls that result in hospitalization also are likely to cause placement in costly and restrictive long-term care facilities, significantly reduced post-fall activity, depression, anxiety and isolation. Full recovery is unlikely for a significant percentage of survivors.[161]

Hospital discharge information has traditionally been the best falls surveillance system in California (although the data are limited to only those falls that are serious enough to warrant a hospital admission). In 2006, there were 407 nonfatal hospitalized fall injuries among older (age 60+) Napa County residents; almost two-thirds of these falls were by women.[162] The average per-person cost of hospitalized stay in 2004 (the last time this figure was updated) for fall injuries among Napa County seniors was approximately $41,000.[163]

In 2007, the California Health Interview Survey (CHIS) began asking seniors, 65+, about falls. One in 5 in Napa County reported falling to the ground more than once in the past year, higher than the state average of 15% (Figure 20).[164] Of those who had fallen in the past year, a third had received medical care, compared to almost half statewide.

Figure 20. Falls by Seniors, Napa County and California



Source: California Health Interview Survey, 2007.
Note: Asked of those who had fallen in the past 12 months.

[161] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2006). www.cdc.gov/ncipc/wisqars.
[162] California Department of Public Health, Safe and Active Communities Branch, EPICenter. http://www.apps.cdph.ca.gov/epicdata/default.htm (July 2010)
[163] California Department of Health Services, Epidemiology, Prevention and Injury Control Branch, Hospital Discharge Data, some data reported in Fall Trends by County June 6, 2006, Fall Prevention Center of Excellence, USC.
[164] California Health Interview Survey, 2007. UCLA Center for Health Policy Research

Intimate Partner Violence

It is difficult to gauge the extent of domestic or intimate partner violence in a community, because it occurs most often behind closed doors, and it is estimated that a large number of occurrences go unreported. The primary indicator used for domestic violence is the number of law enforcement calls for assistance. Another is the percentage of calls that involve weapons.

In 2008 in Napa County, there were 396 calls for domestic violence assistance, 4% of which involved a firearm, knife, or other dangerous weapon (Table 48).[165] This is down from 537 calls in 2005, of which 11% involved a weapon.[166] The City of Napa accounts for approximately 3 out of 4 calls for assistance.

Table 48. Total Number of Total Domestic Violence Calls, Percent Calls Involving Weapons, Napa City's Percent of Total Calls

Category	2005	2006	2007	2008
Total calls	537	441	451	396
% of calls involving weapons[1]	11%	4%	5%	4%
Napa City, % of total	76%	77%	75%	70%

Source: California Department of Justice, Criminal Justice Statistics Center, Criminal Justice Profiles
[1] Firearm, knife or cutting instrument, or other dangerous weapon. Does not include personal weapons, defined as hands, feet, etc.

Child Abuse

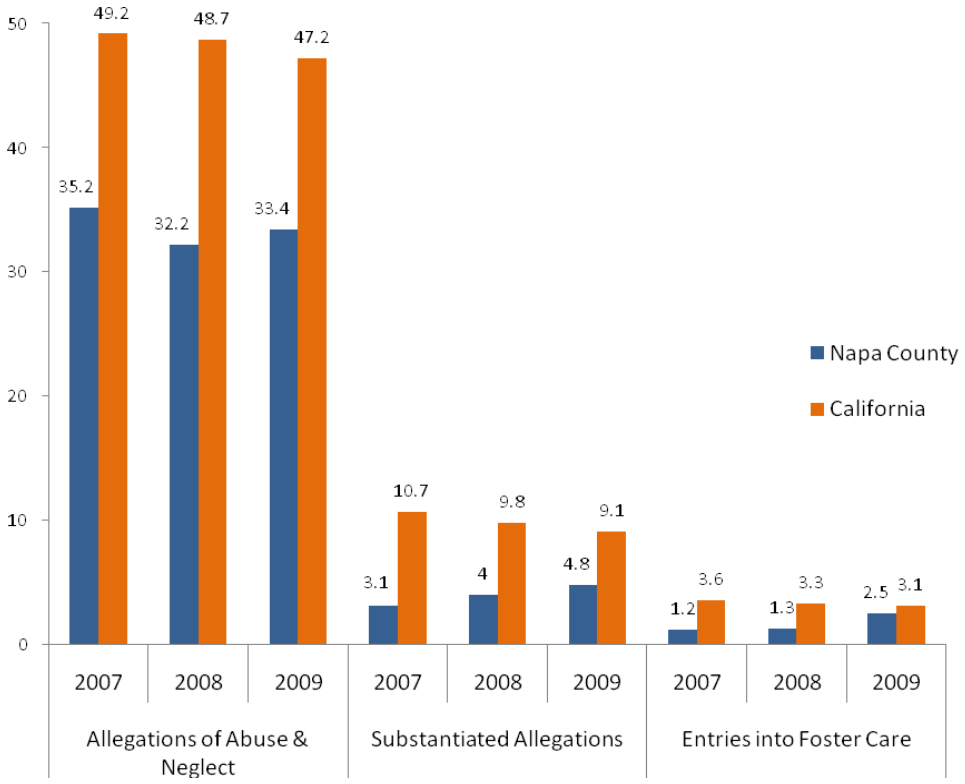
Child abuse is a serious problem with numerous long-term consequences. Children who experience maltreatment are at increased risk for adverse health effects and behaviors as adults—including smoking, alcoholism, drug abuse, eating disorders, severe obesity, depression, suicide, sexual promiscuity, and certain chronic diseases.[167] Napa County offers a full range of services for children who are or may be maltreated within their families.

The county's rates of child abuse allegations, substantiations and entries into foster care are generally much lower than rates for the entire state (Figure 21 on the next page). Over the last 3 years, the rate at which the Child Abuse Hotline has received child abuse allegations has remained fairly steady. However, the rate of substantiated

[165] California Department of Justice, Criminal Justice Statistics Center, Criminal Justice Profiles. http://ag.ca.gov/cjsc/pubs.php#profiles (July 2010)
[166] Ibid.
[167] Felitti V, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine* 1998;14(4):245–58.

allegations rose by 55%, and the rate of entry into foster care more than doubled between 2007 and 2009.[168]

Figure 21. Emergency Child Abuse-Related Response Dispositions, Incidence per 1,000 Children, Napa County vs. California, 2007-2009



Source: Child Abuse Allegation & Substantiation Rates, Child Welfare Dynamic Report System

Elder Abuse

Elder abuse is a serious problem that is said to live in the shadows of most communities and go largely unreported. California Department of Social Services Adult Protective Services (APS) data show that the number of active cases statewide has been steadily increasing in recent years.

Cases of self-neglect and neglect by caregivers are making up a larger proportion of total types of abuse and neglect than in the past. The majority (83%) of confirmed cases of self-neglect in the elder population are in three categories: physical care, health and safety standards, and medical care. It is not clear how much of the increase

[168] Child Abuse Allegation & Substantiation Rates, Child Welfare Dynamic Report System. http://cssr.berkeley.edu/ucb_childwelfare/RefRates.aspx (July 2010)

is due to the growth in the senior population, more awareness and reporting, and more actual occurrences.

The most common confirmed cases of abuse perpetrated by others are financial and psychological/mental. APS reports that most (78%) cases that are found to be inconclusive upon investigation receive services nevertheless.[169]

In FY 2009-2010, the Napa Long Term Care Ombudsman–which advocates for residents in Skilled Nursing Facilities (nursing homes) and Residential Care Facilities for the Elderly (RCFE: Assisted Living or Board & Care)–reported 32 cases of suspected abuse, neglect, or exploitation within its jurisdiction. Of those, 8 were resident-to-resident physical or sexual abuse; 4 were physical abuse, including corporal punishment; 2 were sexual abuse; 6 were verbal or psychological in nature, including punitive seclusion of a resident by staff; 8 involved financial exploitation; and 4 were cases of gross neglect. [170]

Between October 15, 2008 and August 3, 2010, law enforcement referred 82 cases of suspected criminal Elder Abuse to the Napa County District Attorney. Of those, the D.A. found 22 could not be proved beyond a reasonable doubt and declined to file charges; 4 are still being investigated; and, of the 56 referrals in which charges were filed, 4 are in warrant status, 5 are pending in the courts, 6 were dismissed, with alternate action taken in half of them, and 41 resulted in court sentences.[171]

Exposure from the Physical Environment

Air Quality

In the last several years, a growing body of scientific evidence has indicated that the air within homes and other buildings can be more seriously polluted than the outdoor air in even the largest and most industrialized cities. Other research indicates that people spend approximately 90 percent of their time indoors.[172] Thus, for many people, particularly children, the risks to health may be greater due to exposure to air pollution indoors than outdoors.

The air quality in many places in California has improved. But despite progress, many people still suffer pollution levels that are often dangerous to breathe, and unhealthy air remains a threat to health. Air pollution is especially harmful to children as their lungs and alveoli (air sacs) aren't fully grown until children become adults.[173] Poorer people

[169] California Department of Justice, Office of Criminal and Justice Planning, reported in RAND California Community Statistics http://ca.rand.org/cgi-bin/annual.
[170] Data provided by Michael Mautner, Deputy District Attorney, Napa County. 8/5/10.
[171] Ibid.
[172] http://www.epa.gov/iaq/pubs/insidest.html#Intro1.
[173] World Health Organization. The Effects of Air Pollution on Children's Health and Development: a review of the evidence E86575.2005. Accessed at http://www.euro.who.int/document/E86575.pdf .

and some racial and ethnic groups are among those who often face higher exposure to pollutants and who may experience greater responses to such pollution.[174]

The American Lung Association's *State of the Air 2010* report looked at levels of ozone and particle pollution found in monitoring sites across the U.S. in 2006-2008.[175] Napa County's grade and the estimated number of at-risk groups in the population are shown in Table 49.

Table 49. Napa County Air Quality Status

HIGH OZONE DAYS	
Ozone Grade	B
Orange Ozone Days[1]	2
Red Ozone Days	0
Purple Ozone Days	0
GROUPS AT RISK	
Total Population	133,433
Pediatric Asthma	2,828
Adult Asthma	8,750
Chronic Bronchitis	4,567
Emphysema	1,856
Cardiovascular Disease	38,965
Diabetes	9,720
Children Under 18	30,039
Adults 65 and Over	19,339
Poverty Estimate	11,511

Source: American Lung Association. Data from 2006-2008.
24-hour and annual particulate pollution not monitored in Napa County.
[1]Air quality index levels: orange=unhealthy for sensitive groups; red=unhealthy for all; purple=very unhealthy for all.
[2]Since no comparable Air Quality Index exists for year-round particle pollution, grading was based on the Environmental Protection Agency's determination of violations of the national ambient air quality standard. Counties that EPA listed as being in attainment of the standard were given grades of "Pass;" nonattainment counties were given grades of "Fail."

Pesticides

Contrary to the perceived illness risk from pesticides, the number of agriculture-related incidents in Napa County is relatively low. However, questions and concerns—along with anecdotal information, misperceptions, and misinformation—continue to be raised, including by focus group participants and community survey respondents in this assessment.

[174] O'Neill MS, Jerrett M, Kawachi I, et al.Health, Wealth, and Air Pollution: Advancing Theory and Methods. *Environ Health Perspect.*2003; 111: 1861-1870. Ostro B, Broadwin R, Green S, Feng W, Lipsett M.Fine Particulate Air Pollution and Mortality in Nine California Counties: Results from CALFINE. *Environ Health Perspect.* 2005; 114: 29-33. Zeka A, Zanobetti A, Schwartz J. Short term effects of particulate matter on cause specific mortality: effects of lags and modification by city characteristics. *Occup Environ Med.* 2006; 62: 718-725.
[175] State of the Air 2010. American Lung Association. Accessed at http://www.stateoftheair.org/2010/assets/SOTA2010.pdf.

All pesticides sold or used in the United States must be registered by the Environmental Protection Agency (EPA), based on scientific studies showing that they can be used without posing unreasonable risks to people or the environment. In California, the application of pesticides is highly regulated by the State of California Department of Pesticide Regulation through the County Agricultural Commissioners.

Agricultural pesticide use and inventory is tracked by the County Agricultural Commissioner. Prior to purchase, growers or contractors (vineyard managers) must obtain authorization from the Agricultural Commissioner in order to purchase agricultural pesticides, and then the amount used reported by the 10th of the month following treatment. At the end of the year, the balance on hand must equal the amount purchased less the amount used. Pesticides must be applied according to their label instructions. Acreage treated and the amount of pesticide used for the treatment must be reconciled with the application rate for the specific purpose. The most hazardous pesticides are designated as Restricted Materials in California and require a Restricted Material Permit issued by the County Agricultural Commissioner for purchase and/or use.

In the wine grape industry, the most common pesticide applied is sulfur. Sulfur provides protection against powdery mildew. Sulfur dust is organic and considered relatively safe to use. All of EPA's toxicology data requirements for sulfur have been satisfied for a number of years. Sulfur is known to be of low toxicity, and poses very little if any risk to human health. Short-term studies show that sulfur is of very low acute oral toxicity and does not irritate the skin. However, sulfur can cause some eye irritation, dermal toxicity and inhalation hazards (it has been placed in Toxicity Category III for these effects).[176]

People can be exposed to sulfur while mixing, loading or applying the pesticide, and while working among treated crops. Based on incidents of skin and eye irritation reported among field workers in California, EPA has determined that a hazard exists for workers reentering fields following foliar application of sulfur dust. Therefore, a 24-hour reentry interval and protective clothing requirements must be added to the labeling of all outdoor use sulfur products.[177]

Pesticide-related illnesses have been tracked within the state of California for more than 50 years. The California Department of Pesticide Regulation, Pesticide Illness Surveillance Program (PISP), maintains a database of pesticide-related illnesses and injuries. Case reports are received from physicians and via workers' compensation records. The local County Agricultural Commissioner investigates circumstances of exposure. Medical records and investigative findings are then evaluated by DPR technical experts and entered into an illness registry. These data help validate the effectiveness of exposure mitigations and identify areas where improvements are needed.

[176] Pesticides and Toxic Substances, *Sulfur, R.E.D. Facts*, U.S. Environmental Protection Agency. May 1991. www.epa.gov
[177] Ibid.

A total of 982 (down from 1,323 in 2005) cases were reported in California in 2007 as being potentially related to pesticide exposure.[178] Of these cases, 319 (32.5%) had an intended use related to agriculture of which 126 (39.5%) specifically involved *field workers*; 40% of the fieldworker cases concluded the health effects to be "possibly" and the other approximately 60% to be "probably" attributable to pesticide use.

A summary of pesticide illness/injury incidents due to all causes in Napa County in 2007 reported as potentially related to pesticide exposure is shown in Table 50. Of the 7 applicable cases with exposures (4 related to eye, and 1 each for skin, respiratory, and systemic), 2 were intended to be used for agricultural purposes; these cases involved workers who were cleaning and sanitizing winery equipment. No hospitalizations and no days lost to work occurred as a result of these exposures. For its size, the number of agriculture-related incidents in Napa County is relatively low.

Table 50. Pesticide Illnesses/Injuries Reported in Napa County, 2007

	Type of Exposure						Intended Use		
Relationship[1]	Direct Spray/Squirt	Spill/Other Direct	Drift	Ingestion	Not Applic.	Unknown	Agricult	Non-Agricult	Not Applic
Definite	1	0	0	0	0	0	0	1	0
Possible	0	1	1	0	0	2	2	2	0
Probable	0	1	0	1	0	0	0	2	0
Unrelated	0	0	0	0	4	0	0	0	4

Source: California Department of Pesticide Regulation, Pesticide Illness and Surveillance Program.
[1]*Definite*=both physical and medical evidence document exposure and consequent health effects; *Probable*=circumstantial evidence supports a relationship to pesticide exposure; *Possible*=evidence neither supports nor contradicts a relationship; *Unrelated*=sufficient evidence documents that pesticide exposure did not cause health effects.

PREVENTIVE HEALTH

Vaccination

Immunization is a measure of access to and utilization of preventive care. Vaccines can prevent the debilitating and in some cases fatal effects of infectious diseases. According to Healthy People 2010, vaccination coverage levels of 90% are sufficient to prevent the circulation of viruses and bacteria causing preventable disease.

In the fall, every licensed childcare facility in California must provide information on their total enrollment, the number of children who have or have not received the immunizations required, and the number of exemptions. In the spring, local and state

[178] Despite the decrease from 2005 to 2007, the Pesticide Illness Surveillance Program relies heavily on health care providers to recognize, manage, and report pesticide related illnesses and injury. Thus, the numbers predominantly reflect cases that are reported, which means that illnesses and injuries that are *not* reported (i.e. because the person did not seek medical care, because a physician did not recognize a pesticide related illness or injury, because a physician was not aware of reporting requirements and procedure, etc.) are not captured by the data. Data for 2008 still had not been verified at the time of this report. Personal communication with Nino Yanga, DVM, MPVM, MS, Pesticide Illness Surveillance Program, Department of Pesticide Regulation, June 24, 2010 and August 2, 2010.

public health personnel visit a sample of licensed childcare facilities, to collect the same information for comparison. The age group assessed by these surveys is 2 years through 4 years 11 months. On average, one-third of children in this age group attend licensed childcare centers. Hence, the data for children enrolled in licensed childcare centers may not be representative of the entire population of Napa County children in this age group. Data from the 2007-08 school year indicate that 93.5% of the children enrolled in reporting Napa County childcare centers received all required immunizations mandated by law (Table 51), a higher proportion than the statewide average.

Table 51. Immunization Coverage Among Children Ages 2-4 Years 11 Months in Licensed Childcare, 2007-08

Element	Napa	California
Admission status		
Entrants with all required immunizations	97.0%	93.5%
Conditional entrants	0.5%	4.9%
Entrants with permanent medical exemptions	0.11%	0.17%
Entrants with personal belief exemptions	2.43%	1.44%

Source: California Department of Public Health, Center for Infectious Disease Division, Department of Communicable Diseases, Immunization Division, Childhood Immunization Coverage 2006-2008.

The annual kindergarten assessment is conducted each fall to monitor compliance with the California School Immunization Law. Results from this assessment are used to measure immunization coverage among students entering kindergarten. In 2007-08, Napa County reported 95.8% of kindergarten entrants had all of their required immunizations at kindergarten entrance, a slightly higher percentage than the statewide average (Table 52).

Table 52. Immunization Coverage Among Children Ages 4-6 Years in Kindergarten, 2007-08

Element	Napa	California
Admission status		
Entrants with all required immunizations	95.8%	92.1%
Conditional entrants	2.5%	6.1%
Entrants with permanent medical exemptions	0.12%	0.18%
Entrants with personal belief exemptions	1.65%	1.56%

Source: California Department of Public Health, Center for Infectious Disease Division, Department of Communicable Diseases, Immunization Division, Childhood Immunization Coverage 2006-2008.

Health Screening for Cancer

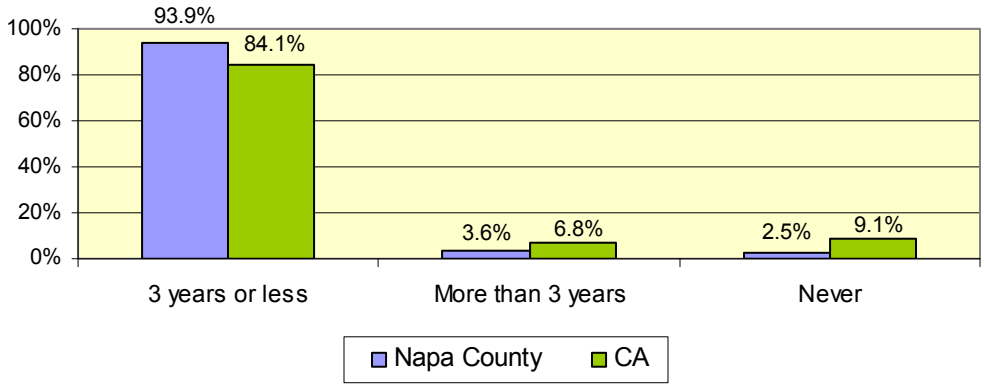
Cancer is the second leading cause of death in the nation, and is also one of the most common chronic diseases. Critical health indicators commonly monitored for community health include cancer screening for cervical, breast, prostate and colorectal cancers. While it has always been difficult to get some people to go for cancer

screening, it can be particularly challenging when financial barriers limit access or cultural beliefs influence utilization. In general, Napa County rates of cancer screening are more favorable than both state rates and national health objectives.

Cervical Cancer Screening

The Healthy People 2010 Objective is that at least 90% of women age 18 and older will have received a Pap test for cervical cancer during the past 3 years. The 2007 California Health Interview Survey (CHIS) asked about Pap test history. Close to 94% of women in Napa County reported having a Pap test within the last 3 years, 3.6% reported it had been more than 3 years since their last test, and 2.5% reported never* having had a Pap test. The county's rates—which are higher than in 2005—compare favorably with statewide averages (Figure 22), and meet the national health objective (Healthy People 2010) of 90% within the past 3 years and 97% ever having a Pap test.

Figure 22. Pap Test History



Source: California Health Interview Survey, 2007

Because cervical cancer is a preventable disease, incidence of this cancer can be reduced through public health interventions, such as education about cervical cancer risk factors, especially HPV infection. A vaccine is now available that prevents the types of genital human papillomavirus (HPV) that cause most cases of cervical cancer and genital warts. The vaccine is routinely recommended for 11 and 12 year old girls, and for females age 13 - 26 who have not yet been vaccinated or completed the vaccine series.[179] Mortality could be reduced and virtually eliminated through regular screening and early detection of the disease through a Pap smear.

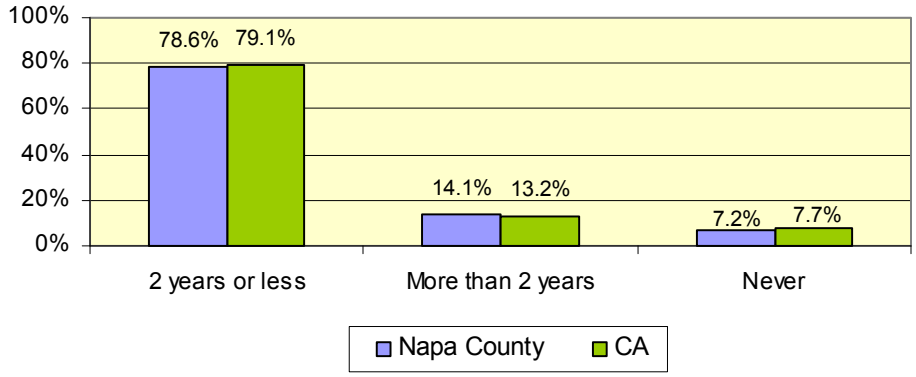
* The figure for the "Never" category is statistically unreliable due to small sample size.

[179] http://www.cdc.gov/std/hpv/STDFact-HPV-vaccine-young-women.htm.

Breast Cancer Screening

Earlier detection for breast cancer through regular screenings can greatly increase survival rates of breast cancer because it identifies cancer when it is most treatable.[180] At this time, mammography along with physical breast examination by a clinician is still the modality of choice for screening for early breast cancer. Napa County data from the 2007 CHIS show that 78.6% of women age 40-85 had a mammogram in the past 2 years (Figure 23), exceeding the national health objective (Healthy People 2010) of 70%. The county and statewide percentages for mammogram screening history are nearly the same.

Figure 23. Mammogram Screening History



Source: California Health Interview Survey, 2007

Colorectal Cancer Screening

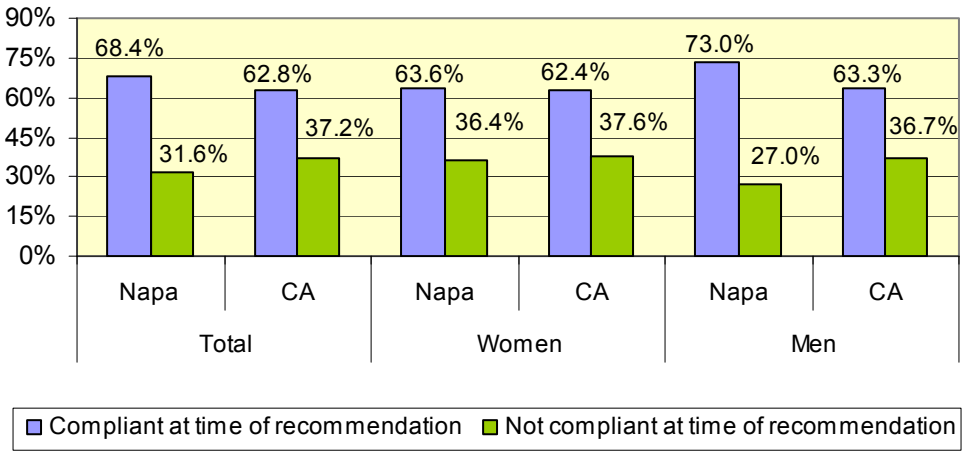
Colorectal cancer is the third most commonly diagnosed cancer and the third leading cause of cancer death in both men and women in the US. [181] Screening has been shown to have great effect on both cancer prevention and cancer survival rates,[182] but the challenge lies in making the test (colonoscopy/sigmoidoscopy) accessible to all adults at the appropriate age and schedule, and also in assuring that people actually follow through on recommendations to be screened. Survival from colon and rectal cancer is nearly 90% when the cancer is diagnosed before it has extended beyond the intestinal wall.

Respondents to the 2007 California Health Interview Survey (CHIS) were asked a series of questions about their cancer screening behaviors. When Napa County adults age 50 and older (based on American Cancer Society recommendations and the U.S.

[180] "Effects of chemotherapy and hormonal therapy for early breast cancer on recurrence and 15-year survival: an overview of the randomised trials," early breast cancer trials' collaborative group (EBCTCG), *The Lancet*, Vol 365, May 14, 2005, pp1687-1717
[181] *Colorectal Cancer Facts & Figures 2008-1010*. American Cancer Society. http://www.cancer.org/acs. Accessed July 2, 2010.
[182] Read TE, Kodner IJ. Colorectal cancer: risk factors and recommendations for early detection. *Amer Fam Physician* June 1999;59(11):3083-88.

Preventive Services Task Force guidelines for this age population) were asked about their compliance with a recommended colorectal screening, 68.4% said they were compliant *at the time of the recommendation,* a higher percentage than 62.8% statewide (Figure 24). In Napa County, males reported higher compliance levels than females (73% and 63.6%, respectively), whereas Californians of both genders had equivalent compliance levels.

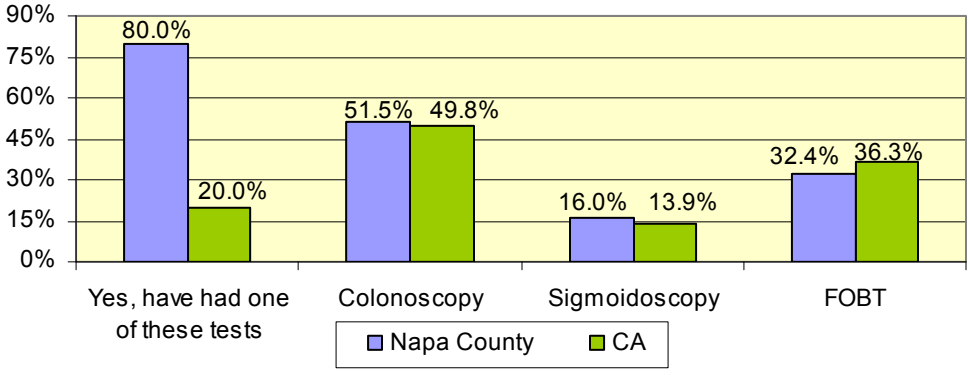
Figure 24. Colorectal Cancer Screening Compliance



Source: California Health Interview Survey, 2007

Eighty percent of Napa County adults age 50+ who responded to the 2007 CHIS reported they had had one of the types of tests (sigmoidoscopy, colonoscopy or FOBT) for this cancer (74.5% of Californians reported doing so). Of those respondents, most had had a colonoscopy (Figure 25). The national health target (Healthy People 2010) is to increase to 50% the proportion of adults age 50+ who have ever had a sigmoidoscopy; no Healthy People 2010 target has been set for the proportion of adults who should receive colonoscopy screenings.

Figure 25. Percent Reporting Having Ever Had a Colorectal Screening Test, and Type of Test



Source: California Health Interview Survey, 2007

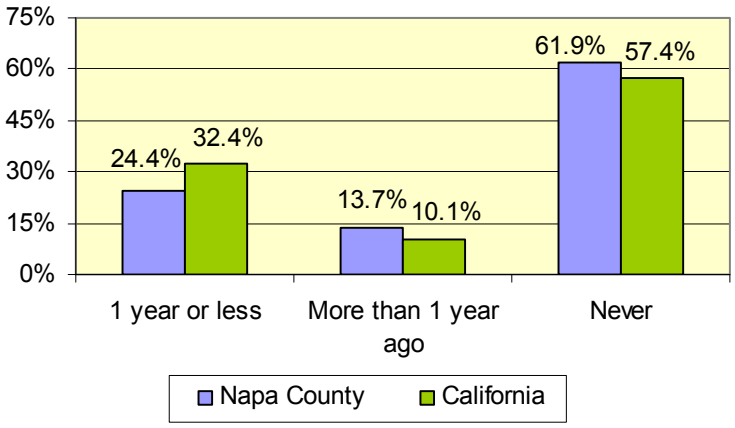
These apparently high colon cancer screening rates in Napa County belie a major disparity in screening, however. The CHIS findings cited above may not adequately represent low-income individuals who may be less likely to have access to or be able to pay for these tests. Unlike cervical and breast cancers, there is no state- or federally-funded program to subsidize or cover colorectal cancer screening. If Napa County is similar to the rest of California, Latino adults age 50+ are about one-third less likely than Non-Latino Whites to have had a sigmoidoscopy/colonoscopy in the last five years.[183]

Prostate Cancer Screening

Research has not yet proven that the potential benefits of testing outweigh the harms of testing and treatment. The American Cancer Society recommends that starting at age 50 (age 45 for African Americans and men with a father or brother who had prostate cancer before age 65), men talk with their doctor about the pros and cons of testing to make an informed choice about whether being tested for prostate cancer is the right choice for them. ACS guidelines recommend men who decide to be tested should have the PSA blood test, with or without a rectal exam. How often they are tested depends on their PSA level.[184]

Close to 62% of Napa County men age 40+ who responded to the 2005 CHIS reported they had never received a screening test for prostate cancer (Figure 26), a slightly higher proportion than men statewide.

Figure 26. Prostate Cancer Screening History



Source: California Health Interview Survey, 2007

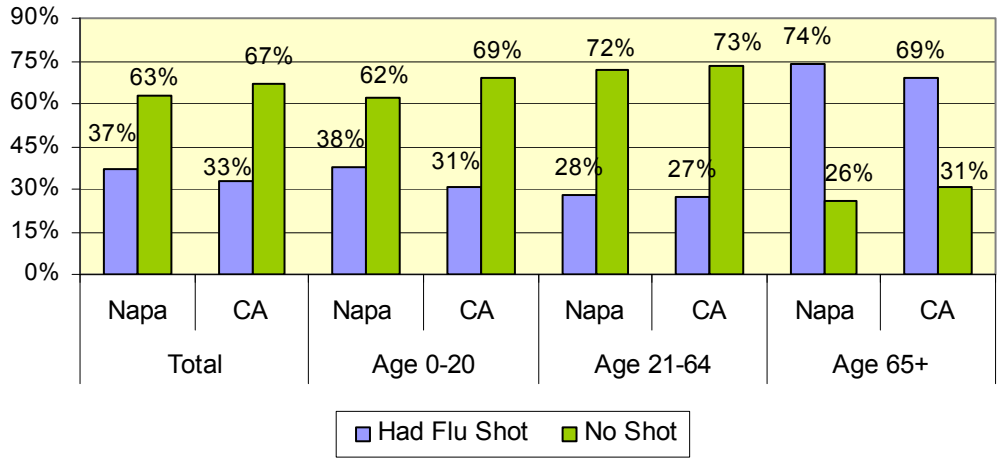
[183] Ibid.
[184] www.cancer.org/cancerscreeningguidlines. Accessed 8/4/10.

Flu Vaccination

The seasonal flu vaccine protects against three influenza viruses that research indicates will be most common during the upcoming season. The Centers for Disease Control and Prevention recommends that everyone 6 months and older should get a flu vaccine each year starting with the 2010-2011 influenza season. According to the CDC, it is especially important that certain groups get vaccinated either because they are at high risk of having serious flu-related complications or because they live with or care for people at high risk for developing flu-related complications. Examples of such groups include pregnant women, children younger than 5, but especially children younger than 2 years old, people 50 years of age and older, people of any age with certain chronic medical conditions, and health care workers.[185]

In 2007, more Napa County respondents to CHIS than Californian respondents on average, of all age groups, reported having had a flu shot within the last year (Figure 27). However, despite the CDC recommendations, only about 4 in 10 Napa County residents received a vaccination, although three-quarters of seniors received it.

Figure 27. Flu Shot Within Last Year



Source: California Health Interview Survey, 2007

[185] http://www.cdc.gov/flu/about/qa/flushot.htm. Accessed 8/5/10.

Section III. Health Resource Availability and Utilization

"I know someone who didn't know she should brush her teeth; she had never been taught." –Focus group participant

The principal health care providers serving low-income individuals in Napa County include two acute care hospitals, Queen of the Valley Medical Center and St. Helena Hospital, Clinic Ole, and Kaiser Permanente Medical Office which provides primary care, specialty services and pharmacy. Kaiser covers about one-third of the population in Napa County. Community and specialty clinics provide comprehensive primary care and dental services (Community Health Clinic Ole), reproductive and women's services (Planned Parenthood, St. Helena OB-GYN and The Women's Center of St. Helena Hospital), and certain specialty care services (Kaiser Permanente Medical Offices) located at various sites within the county. Other medical facilities include Napa State Hospital and the Veteran's Home of California. Emergency services are provided at Queen of the Valley Medical Center and St. Helena Hospital. Physicians, dentists and allied healthcare professionals practice in various facilities and private settings. In addition to these local resources, some Napa County residents also utilize services in nearby Santa Rosa (Sonoma County) and Vallejo (Solano County).

ACUTE CARE HOSPITALS[186]

Hospital Utilization

In 2008, there were a total of 372 licensed beds reported for Napa County's acute care hospitals: 191 beds at Queen of the Valley Medical Center and 181 beds (of which 37 were acute psychiatric beds) at St. Helena Hospital. The overall reported hospital occupancy rate in 2008 was 65.5% at QVMC and 29.5% at St. Helena (lower than the statewide average of 61.5%).

Emergency Department Visits

Queen of the Valley Medical Center and St. Helena Hospital

The State designates hospitals at 4 levels of trauma, with level I as the highest, and as the following licensed emergency medical services levels: "standby," "basic," and

[186] The source for the hospital utilization data reported in this section is California Office of Statewide Health Planning and Development. http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/Hospital_Utilization.html.

"comprehensive."[187] QVMC is designated "basic" and is a trauma level III facility. St. Helena Hospital is designated "standby" and is a non trauma center.

In 2008, QVMC reported 15,084 emergency department (ED) visits, St. Helena Hospital reported 6,687 visits, and Kaiser Hospital (Napa residents only) reported 3,421 visits. Approximately 27% of QVMC's and 11.7% of St. Helena's ED visits resulted in admission to the hospital. The statewide average admission rate in 2008 was 15.8%. All of these figures have remained relatively constant since 2000.

The most common problems that brought people to the ED in 2009 were somewhat similar for the 3 hospitals, although not always in the same order of reason for the visit (Table 53). *Injury/poisonings* was the most commonly-reported principle diagnosis group at the Napa-located hospitals, 34.8% at St. Helena and 26.0% at QVMC, followed by the general category "*symptoms*" (without a specified cause). Of note, about three-quarters of the *injury group* diagnoses were reported without specificity ("no principle cause reported") by the hospitals. The remaining one-quarter of the injury causes were mainly due to "other accidents" and "accidental falls." Kaiser's proportion of ED visits for *digestive system* problems was more than double the 2 Napa-based hospitals, and its visits for *respiratory system* problems about three times the proportion.

Table 53. Most Common Reason for ED Visits, 2008

St. Helena Hospital		Queen of the Valley Medical Center		Kaiser Hospital, Vallejo (Napa Residents Only)	
Principle Diagnosis Group	%	Principle Diagnosis Group	%	Principle Diagnosis Group	%
Injury/Poisonings	34.8	Injury/Poisonings	26.0	"Symptoms"	26.1
"Symptoms"*	21.5	"Symptoms"	22.8	Injury/Poisonings	17.2
Respiratory System	8.7	Respiratory System	10.6	Digestive System	10.6
Nervous System	5.9	Nervous System	8.8	Respiratory System	8.4
Musculoskeletal System	5.7	Musculoskeletal System	5.1	Circulatory System	8.2
Digestive System	4.0	Skin Disorders	4.5	Genitourinary System	6.1
Genitourinary System	3.9	Digestive System	3.8	Musculoskeletal System	4.2
Skin Disorders	3.5	Genitourinary System	3.8	Nervous System	4.1
Mental Disorders	3.5	Other Reasons	3.4	Other Reasons	3.6
Other Reasons	3.0	Mental Disorders	3.1	Mental Disorders	3.4
Circulatory System	1.9	Pregnancies/Perinatal	2.6	Skin Disorders	2.5
Infections	1.4	Circulatory System	2.2	Endocrine System	2.4
Endocrine System	1.3	Infections	2.1	Infections	2.3
Pregnancies/Perinatal	0.8	Endocrine System	1.2	Pregnancies/Perinatal	0.9

Source: California Office of Statewide Health Planning and Development.

*Symptoms, Signs and Ill-Defined Conditions.

[187] Licensed EMS levels: *Standby*—emergency medical care in a hospital where an EMS physician is at minimum, on-call. *Basic*— emergency medical care in a hospital where an EMS physician is on staff 24 hours a day, year-around. *Comprehensive* –emergency medical care in a hospital where an EMS physician is on staff 24 hours a day, year-around; other physician specialties required for this level.

Severity of ED Visits

ED visits were also examined for trends in severity according to the standard definitions used in hospital reporting.[188] Since 2005, on average across the 2 Napa-based hospitals, the percentage of visits for minor and low/moderate severity has reportedly decreased and the number of visits for moderate, severe without threat and severe with threat has reportedly increased (Figures 28 and 29). It is possible these changes are due to changes in hospital ED coding practices and not likely to any true change in severity. Kaiser's severity data are shown on the next page in Figure 30. ED visit severity appears not to have changed between 2007 and 2008. (Please refer to footnote at the bottom of this page.)

Figure 28. Severity of ED Visits, QVMC, 2005-2008

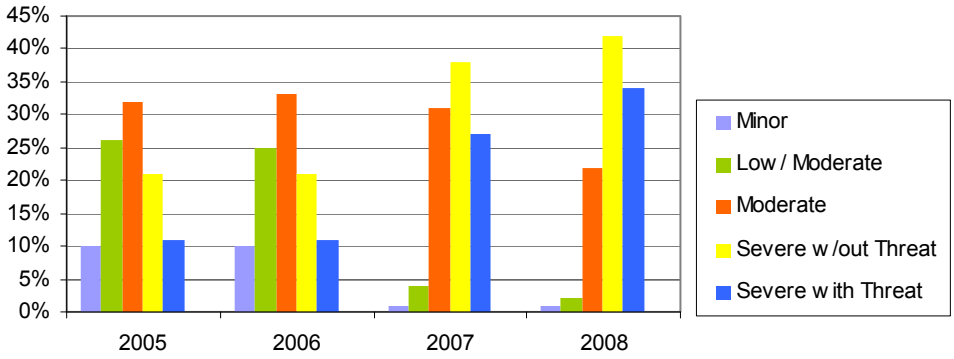
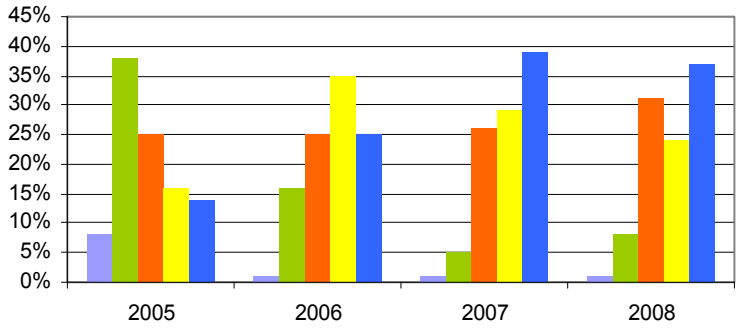
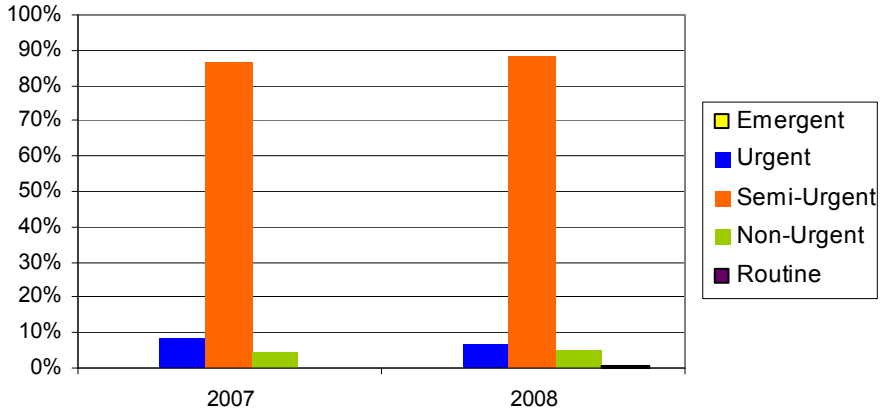


Figure 29. Severity of ED Visits, St. Helena Hospital, 2005-2008



[188] Kaiser provided data using different definitions of severity than what OSHPD reported for St. Helena Hospital and Queen of the Valley Medical Center for the years shown. Because Kaiser noted that in 2007 acuity classification criteria were modified from the criteria used in 2005 and 2006, only data for 2007 and 2008 are shown.

Figure 30. Severity of ED Visits, Kaiser Vallejo, Napa Residents Only, 2005-2008



Source: California Office of Statewide Health Planning and Development
(Provided by Kaiser Hospital, Vallejo)

COMMUNITY-BASED AND SPECIALTY CLINICS

Community Health Clinic Ole

Community Health Clinic Ole is the safety net provider for Napa County's underserved population, providing high-quality, affordable, and culturally sensitive health services. Clinic Ole is a Federally Qualified Health Center providing primary medical and dental care in various locations in the county (Table 54 on the next page). Days and hours of operation vary, and some sites offer services in the evening and on Saturdays. Clinic Ole also provides health screenings and education at various migrant farmworker housing camps and vineyards throughout Napa County. Services are provided on a sliding fee scale, based on family income. The organization is continuing to explore the option of opening a clinic in the rapidly-growing area of American Canyon.

Table 54. Clinic Ole Locations and Hours of Operation, April 2010

Location	Hours of Operation
Napa – 1141 Pear Tree Lane*	Mon. - Thur – 8:20 a.m. – 8:20 p.m. Fri. - 8:20 a.m. – 4:20 p.m.
Napa – 1141 Pear Tree Lane,* Walk-in Clinic Patients are seen on a first come, first served basis. Numbers are given out at 6:00 a.m. for both the morning and afternoon clinics.	As above and Sat. – 8:00 a.m. to 4:00 p.m.
St. Helena – 661 Main St.	Mon., Tues., Fri. – 8:20 a.m.-4:20 p.m. Thurs. – 12:20 p.m. – 8:20 p.m.
Calistoga – 911 Washington St.*	Mon. – 12:20 p.m. – 8:20 p.m. Thurs., Fri. – 8:20 a.m.-4:20 p.m.
Napa Valley College Student Health Services – 2277 Napa Vallejo Hwy Services available for Napa Valley College students only. Clinic is open September through June.	Mon., Tues., Thurs., Fri. – 9:00 a.m. – 3:00 p.m. Wed. – 9:00 a.m. – 7:00 p.m.
Napa, Hope Center – 1301 4th St.	Wed. – 2:00 p.m. – 5:00 p.m. Services available for the homeless on a walk-in basis
Napa, South Napa Shelter – 100 Hartel Ct.	Tues. – 6:00 p.m. – 9:00 p.m. Services available for the homeless on a walk-in basis

*Dental services are also available at this site.
Source: Community Health Clinic Ole.

While accommodation at all Clinic Ole sites is made for drop-in patients (and appointment no-shows are back-filled with drop-ins), according to staff the waiting time for a non-urgent service can be 2-4 weeks depending on the location.[189] Approximately 14 full-time equivalent licensed primary care providers, including dentists and licensed clinical social workers, are employed by the organization. Many of the staff is bilingual and bicultural. Adequate space is more of a problem than the supply of staff in limiting Clinic Ole's capacity to serve more clients.

In fiscal year (FY) 2008/09, Clinic Ole provided medical services to 18,980 clients; these services were provided at 65,446 visits (3.4 visits per client). Close to half (45%) of the patients are farmworkers and their family members. Nearly two-thirds (62%) are Latino and 55% prefer to speak Spanish. About 70% of the clients have incomes under 100% of the federal poverty level (this is equivalent to a family of 4 living on less than $24,255 a year).

[189] Some focus group participants reported the waiting time for a new patient appointment was 6 weeks.

Kaiser Permanente

Kaiser Permanente Medical Offices in Napa County provide services in the following departments: allergy, dermatology, eye care, internal medicine, optical sales, lab and radiology including mammography services, occupational health services, audiology, pediatrics, physical therapy, plastic surgery and women's health. Some services are by referral only. Health education services offer classes, lend books and videos and health-related pamphlets.

Planned Parenthood

Planned Parenthood (PP) Shasta Diablo, which has health centers in a number of northern California counties, operates two health centers in Napa County, in the City of Napa, where it offers comprehensive reproductive health services. In 2009, a total of 6,654 low-income women and men made 8,787 clinic visits to the Napa PP health centers. The majority (94%) of the clients served were women and half (49%) were clients age 24 and under. More than half (53%) of clients served were Latina.

In addition to clinic services, PP offers health education through presentations at community programs. In 2009, 6,300 Napa residents, including parents of adolescents, received community health education services.

St. Helena Obstetrics and Gynecology

St. Helena OB-GYN provides comprehensive, family-oriented care for women from adolescence to post-menopause, including the full spectrum of obstetrical care. It offers complete gynecologic services including Pap smears, contraceptive options, evaluation and treatment of infertility, menopausal conditions, incontinence problems and colposcopy for abnormal Pap smears, as well as a full range of gynecologic surgery services. Most types of insurance are accepted and several of the staff are bilingual in Spanish.

The Women's Center of St. Helena Hospital

The Women's Center provides mammography and bone density testing. The Center performed 2,994 procedures last year. The hours of operation are Monday through Thursday, 7:00 a.m. to 3:30 p.m., and Fridays from 6:30 a.m. to 2:30 p.m.

Queen of the Valley Medical Associates—OB-GYN

Queen of the Valley Medical Associates(QVMA)—OB-GYN (formerly called Napa Valley Women's HealthCare Center) provides a full range of obstetrical, including high-risk, and gynecological care that includes cancer prevention and detection, endocrinology evaluation, pre-pregnancy counseling, menstrual disorders, premenstrual syndrome (PMS) and menopause counseling and treatment. QVMA offers both surgical and medical approaches to women's health. A number of procedures are performed in the office setting, such as diagnostic hysteroscopy, sonography, colposcopy, and

cryosurgery. Additionally, the physicians specialize in minimally invasive surgery with many outpatient procedures and

short hospital stays. The minimally invasive robotic surgery program allows same-day or 1-day stays in the hospital. Office appointment hours are Monday through Thursday from 8:00 a.m. – noon and 1:30 p.m. – 4:45 p.m.

Dental Services

Children's Mobile Dental Clinic

In response to the overwhelming need for children's oral health services, in 2004 Queen of the Valley Medical Center developed a community collaborative involving schools, resource centers, faith-based organizations and Sister Ann's Dental Clinic to implement a Children's Mobile Dental Clinic. Currently owned and operated by Queen of the Valley, the clinic serves Napa County children age 6 months-21 years and sees an average of 212 patients per month. Services target low-income, uninsured or underinsured families. A variety of insurances are accepted, and a reduced sliding scale fee is available for uninsured patients.

Dental services include screening, fluoride varnish, digital x-ray, and sealants; and, uniquely for a community clinic, dental services also include white fillings, extractions, root canal treatment, and porcelain crowns. Hospital dentistry, when required, is provided on a case-by- case basis. In addition to dental services, the mobile clinic provides access to health resources including insurance enrollment and health promotion and education for the entire family.

The hours of operation are 9:00 a.m. -3:30 p.m. on a rotating schedule at the current sites:, Shearer elementary school, Napa Valley Language Academy, Puertas Abiertas Family Resource Center, Valley Oak High School at Menlo, St. Helena Catholic Church, Harvest Middle School, and Phillips elementary school. The mobile clinic also operates at Queen of the Valley Medical Center for endodontic clinic days.

Sister Ann Community Dental Clinic

Sister Ann Community Dental Clinic, part of Community Health Clinic Ole,[190] is the primary source of low fee and Medi-Cal subsidized dental care serving all age groups in Napa County. In FY 2008/09, the clinic provided dental services to 6,463 users at 16,390 visits (2.53 visits/ patient). Dental services include cleaning, examination/X-rays, fluoride treatments, sealants, fillings, oral hygiene instruction, minor oral surgery, emergency dental care and dentures for seniors.

There is a large demand for both routine and specialized dental services which Sister Ann is currently unable to meet. While low-income clients are charged on a sliding fee scale, the cost is still prohibitive for some patients and families according to focus group participants in the present needs assessment study.

[190] Sister Ann was originally established in 1989 as Queen of the Valley Hospital Children's Dental Clinic. In April 2007, Sister Ann Community Dental Clinic and Community Health Clinic Ole merged into one organization.

COMMUNITY PHYSICIANS AND DENTISTS[191]

Physicians

The local supply and ratios of private licensed primary care physicians and licensed dentists to the total population are core indicators for community health service availability. However, the supply of physicians and dentists is only one component of access to medical and dental care services. The ratios do not indicate which providers serve low-income persons or those without insurance, or indicate how much time providers spend in active practice; some only work part-time, for example. The data also do not address geographic distribution and provider willingness to accept Medi-Cal—or the presence of a community clinic providing dental services and medical services—factors that influence adequate and timely access to services within a county.

The adequacy of physician supply is generally evaluated based on the number of physicians per 100,000 civilian population, a useful benchmark for gauging adequacy. According to the Council on Graduate Medical Education (COGME), the national commission that publishes ranges for physician supply requirements, an appropriate range for *overall* physician supply is 145-185 patient-care physicians per 100,000 population.[192] With 321 non-federal, patient-care physicians active in Napa County in 2008, the county had 252 patient-care physicians per 100,000 population.[193] Napa thus ranks high relative to the physician requirements estimated by COGME (Table 55).

Table 55. Active Patient-Care Physicians and Ratio to Population, Napa and California, 2008

	Patient Care Physicians		Primary Care Physicians		Specialists	
	Total	*Per 100K Pop.*	*Total*	*Per 100K Pop.*	*Total*	*Per 100K Pop.*
Napa	321	231	103	74	218	157
California	66,480	174	22,528	59	43,951	115

Active patient care MDs practicing in California in 2008. Physicians with DO degrees are licensed by a different state board and so are not included in these data.
Primary Care Physicians= Family practice, general practice, internal medicine and pediatrics.
Specialists = Non-generalists, including unspecified specialty designations.
Source: AMA Masterfile, 2008; California Healthcare Foundation.

The COGME requirement estimates for *generalist* (primary care) physicians are 60-80 per 100,000 population, and for *specialists* it is 85-105 per 100,000 population. In 2008, Napa was in the upper ranges for the primary care supply estimates, with 74 generalists per 100,000 population. The county exceeds the upper bound of COGME's estimated requirements for specialists with 157 specialists per 100,000 population. For all 3 ratios

[191] The data in this section are for MDs only and do not include DOs (Doctors of Osteopathic Medicine) who are licensed by their own medical board. DOs represent 7.7% of all licensed physicians in California; they account for 5.6% of those licensed to practice in Napa County. There are 19 DOs listed for Napa County according to the Osteopathic Medical Board of California, April 4, 2010.
[192] Council on Graduate Medical Education, 1996; Council on Graduate Medical Education, 1995.
[193] American Medical Association, 2000; California Department of Finance, 2000.

shown in the table, Napa exceeds the California average in the upper range of estimated requirements. What these counts and ratios don't take into account, however, is that some specialists may come into the county part time, but it is not known exactly which specialists or how often.

The number and percentage distribution of the Napa patient care physicians are displayed by area of specialty in Table 56 below. Internal Medicine and Family Medicine—primary care physicians—account for 55.5% of the practice specialties, followed by Pediatrics and OB-GYN at 11.5% and 10.2%, respectively. Not surprisingly for Napa County because of Napa State Hospital, just over one-third (36%) of the specialists are psychiatrists.

Table 56. Active Patient Care Physicians by Specialty, Napa County

	Allergy/ Immunol	Anesthes	Cardiology	Colo-rectal	Cosmetic	Dermat	ER	Endocrine	Family Med	General Surg	Geriatric
#	2	12	9	0	1	7	9	1	34	5	3
%	1.5	8.6	6.5	0.0	.7	5.1	6.5	.7	24.5	3.6	2.2
	Gastro-enterol	GP	Hematol	Infectious	Internal Med	Neonatal	Nephrol	Neurol	Neuro-Surg	OB-GYN	Occup
#	3	6	1	1	43	0	3	3	1	14	5
%	2.2	4.3	.7	.7	31.0	0.0	2.2	2.2	.7	10.2	3.6
	Oncol	Opthalm	Orthoped Surg	Other Med	Otololaryn	Pain Med	Pathol	Peds	Phys Rehab	Plastic Surg	Psych
#	6	1	6	4	3	2	4	16	4	4	50
%	4.3	.7	4.3	2.9	2.2	1.5	2.9	11.5	2.9	2.9	36.0
	Pulmon	Radiol	Radiat Oncol	Rheumat	Sleep Med	Sports Med	Surg Oncol	Thoracic Surg	Urology	Vascular	Missing Data
#	2	10	4	1	1	0	2	4	5	4	26
%	1.5	7.2	2.9	.7	.7	0.0	1.5	2.9	3.6	2.9	18.7

MDs per 1,000 population, based on California Medical Board counts, 2008.
Source: California Healthcare Foundation.

According to workforce studies and projections, the physician workforce is aging, and a large number of physicians are nearing retirement, at the same time that a large proportion of the population is aging, contributing to a growing demand for physician services.[194] The age distribution of Napa County physicians is shown in Table 57 on the next page. Over 43% are older than 55 compared to one-third of physicians in that age group in the state as a whole.[195]

[194] *The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand.* U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. December 2008.
[195] Grumbach K, Chattopadhyay A, BIndman AB. *Fewer and More Specialized: A New Assessment of Physician Supply in California*, California Healthcare Foundation. June 2009.

Table 57. Active Patient Care Physicians by Age, Napa and California

	All ages	<30 yrs	30-35 yrs	36-45 yrs	46-55 yrs	56-65 yrs	66-75 yrs	75+ yrs
Napa								
No. of Physicians	321	0	16	63	103	104	26	9
% Distribution		0.0%	5.0%	19.5%	32.0%	32.3%	8.2%	2.8%
California								
% Distribution		0.4%	9.2%	28.6%	28.0%	24.3%	7.9%	1.5%

Source: California Healthcare Foundation.

Dentists

According to available data, 97 licensed dentists are in active practice in Napa County, the greatest majority (78%) located in the City of Napa (Table 58). (Of note, in 2007, 113 dentists were listed for Napa County.) Of these 97 dentists, 80% are considered general or primary care dentists, a proportion consistent with most other counties. At 3.3 primary care dentists per 5,000 population, Napa County is considered to have a "medium" supply of general dentists according to the dentist-to-population ratios established by the American Dental Association.[196] It is not known how many of the Napa County dentists take any Denti-Cal patients (which, now, is limited to primarily children), though the number is believed to be very low. The referral list of *dentists* taking new Denti-Cal patients published by the State Denti-Cal program (as of August 21, 2010) listed only Queen of the Valley Hospital for this resource,[197] although it is known that Sister Ann takes Denti-Cal. It is not known how many of the community dentists may practice only part time, which has implications for access as well.

Table 58. Number of Dentists in Active Practice in Napa County by Type and Location

Type of Dentistry	City							*Total*
	Napa	Calistoga	St Hel	Yntvlle	Amer Canyon	Ruthfrd	Angwin	
General	59	1	7	1	7	1	2	78
Endodontics	4	0	0	0	0	0	0	4
Oral Surgery	2	0	0	0	0	0	0	2
Orthodontics	4	0	1	0	0	0	0	5
Pediatric	3	0	0	0	0	0	0	3
Periodontics	2	0	0	0	0	0	0	2
Prosthodontics	1	0	1	0	0	0	0	2
Public Health	1	0	0	0	0	0	0	1
Total	76	1	9	1	7	1	2	97

Source: California Dental Association Masterfile, accessed 4/12/10.

[196] While there is no "ideal" population-to-provider ratio for dental health care, the basic ratio is ≥5,000:1 according to the California Office of Statewide Health Planning and Development. The ratios are estimates based on American Dental Association 1998 data and 1998 population projections. The primary care dentist-to-population range for a "medium" supply of dentists is 3:5,000 – 5:5,000. Napa County's supply of general dentists is at the low end of this range.

[197] http://www.denti-cal.ca.gov/provreferral/Napa.pdf, accessed 4/20/10.

PUBLIC HEALTH SERVICES

The provision of community health services is a partnership between the public and private sector. The Napa County Health and Human Services Agency Public Health Division provides basic public health services such as communicable disease surveillance and control; a strong maternal and child health program; Women, Infants and Children (WIC) program; public health emergency preparedness. Public Health also provides some clinical services, including immunizations and HIV counseling and testing. The Division provides little in the way of chronic disease programs or campaigns because of a lack of resources. Napa Public Health works closely with its local partners, however, by having representation on local health committees and coalitions.

MENTAL HEALTH SERVICES[198]

This section focuses on mental health services available in Napa County that provide screening and referral, crisis intervention, treatment as well as wellness and recovery services. A table is provided at the end of this section to show the distribution of services.

Mental health services in Napa County are defined broadly and include prevention and early intervention efforts such as mentoring and youth development programs as well as cross disciplinary programs that address substance abuse or other factors in mental health treatment. The California Department of Mental Health compiles local and statewide data about the number of clients served by public mental health clinics. A comparison of the data from 2006-2009 (Table 59) shows a decline in clients served in Napa County, but a less severe decrease from the statewide average. In 2008-2009, Napa County was able to serve 19% fewer clients seeking mental health services than were served in 2006-2007.

Table 59. Number of Public Mental Health Clients Served by Fiscal Year, Napa County and California (Unduplicated)

	Napa County		California	
Fiscal Year	Number of Clients Served	Percent Change	Number of Clients Served	Percent Change
2006-2007	1,604		590,864	
2007-2008	1,339	-17%	528,677	-11%
2008-2009	1,310	-2%	442,691	-16%
Total		-19%		-27%

Source: Statistics and Data Analysis: County Mental Health Client & Service Information (CSI) accessed at http://www.dmh.ca.gov/Statistics_and_Data_Analysis/CSI.asp, 5/19/10.

[198] Additional information about mental health services in Napa County are available online at www.napahelp.info and at the www.napa.networkofcare.org.

Napa County Health and Human Services Mental Health Division

Napa County Mental Health Division, under contract with the California Department of Mental Health, arranges for or provides specialty mental health services to Medi-Cal beneficiaries. However, initial emergency services are available to anyone in crisis regardless of Medi-Cal status. The Mental Health Division offers the following services:[199]

- **ACCESS.** Community-based mental health services including outpatient therapy and psychiatric medication, primarily through referrals to community mental health providers.
- **Psychiatric Emergency Response.** Comprehensive crisis mental health services, crisis intervention, suicide evaluation, and evaluation for hospitalization for both children and adults. Services are available 24 hours a day.
- **Children's Crisis Services.** Comprehensive crisis mental health services, crisis intervention, suicide evaluation, and evaluation for hospitalization for children with a mental health emergency.
- **Therapeutic Behavioral Services.** For individuals under the age of 21 with full scope Medi-cal, this program provides short term therapeutic support to resolve behaviors and keep youth in their residential placement.
- **Children's Medication Clinic.** Psychiatric medications and appointments for medication evaluation for children.
- **Adult Medication Clinic**. Psychiatric medications and appointments for medication evaluation.
- **Outpatient Psychotherapy Services**. Therapy to Napa County residents who have full scope Medi-Cal.
- **Adult Case Management**. Supportive services for mentally ill clients in need of assistance with daily living skills. Services include: crisis intervention, assistance locating and maintaining appropriate housing, medical and dental treatment, psychiatric medication referrals, representative-payee services and conservatorship services.
- **Comprehensive Services for Older Adults**. Supportive services for mentally ill clients, 60 years of age and older, in need of assistance with daily living skills. Services include: crisis intervention, assistance in locating and maintaining appropriate housing, medical and dental treatment, psychiatric medication referrals, and representative-payee services.
- **System Navigators**. Helps individuals and families with a focus on the needs of the Latino community to connect with mainstream resources such as mental health care, physical health care, Medi-Cal, food stamps, housing services and more.

[199] Unless otherwise noted, all items in this section accessed at www.napa.networkofcare.org 5/17/10.

- **Child and Family Behavioral Health.** Case management for Medi-Cal and Healthy Families eligible children who have a serious emotional disturbance and special education children who are referred by their Individual Education Program team and require mental health services in order to benefit from their education. Program also provides outpatient mental health services, including screening, crisis intervention, counseling and continuing care services for minors housed in the juvenile hall.
- **Therapeutic Child Care Center.** The Therapeutic Child Care Center is operated on county property in partnership with Child Start, Inc., the Napa County Head Start provider. The center focuses on the "emotional and physical development of infants and young children, parent-child relationships, and family support." There is capacity for 8 infants, 8 toddlers and 12 preschool aged children.

St Helena Hospital Center for Behavioral Health

St Helena Hospital Center for Behavioral Health is a 61 bed facility available 7 days a week to children and adults. Services include screenings, inpatient and outpatient programs. The center accepts most major managed care and health insurance plans, including Medi-Cal and Medicare. [200]

- **Child and Adolescent Inpatient Services.** There are two separate units to address the needs of children age 3 to 12 (18 beds) and adolescents age 13 to 18 (19 beds). Patients receive comprehensive assessment including psychiatric evaluation, psychological testing, medical history and physical evaluation, family assessment and educational evaluation.
- **Adult Inpatient Services.** The adult inpatient program provides short-term evaluation and treatment for adults who are experiencing acute symptoms of major mental illness. There are 24 beds for adults. The services listed in above for children and adolescents are also available for adults.
- **Transitions Partial Hospitalization.** Intensive outpatient mental health treatment to adults 18 years and older. It allows individuals to remain in their own community and living situation. The facility is located in Vallejo.
- **Outpatient Program.** A hospital-base psychiatric service for patients leaving the Transitions Partial Hospitalization program. Admission to the program is based on a need for evaluation, observation and control of psychiatric symptoms.

Napa State Hospital

The Napa State Hospital is a managed by the state Department of Mental Health and has 1,362 beds. The hospital's goal is to increase individual's capacity for independence and for safe and effective community treatment placement.[201]

[200] Accessed at www.sthelenahospital.org/Behavioral/, 5/17/10
[201] Accessed at www.dmh.cahwnet.gov/Services_and_Programs/State_Hosptitals/Napa/default.asp., 5/17/10.

Dreamcatchers

Dreamcatchers provides support to recovering mental health clients as they transition to leading independent lives within their communities. Services also include community outreach to reduce the stigma associated with mental illness.

Circle of Friends

The Circle of Friends operates the People Empowering People program, a consumer directed and operated drop-in center for Napa County residents with serious mental illness.[202] The program is located on the campus of Napa County Health and Human Services Agency in Napa.

Buckelew Programs

Buckelew Programs offers supportive subsidized housing in the community for previously homeless mentally ill adults. Staff provide rehabilitation counseling.

Crestwood Center at Napa Valley

Located in Angwin, the Crestwood Center at Napa Valley is a 54 bed mental health rehabilitation center. The program aims to stabilize mental health consumers, initiate a physician-directed and personalized medication routine, and begin working to change certain behaviors with the goal of transitioning the consumer to a lower level of mental health care.

Progress Place

Progress Place receives referrals from Napa County's Psychiatric Emergency Response program. There are seven beds available for adults and suicidal adolescents. The focus of the program is on reduction of the crisis, stabilization and diagnostic assessment.[203] Adolescents stay for a maximum of 3 days; the average adult stay is nine days.

Family Service of the Napa Valley

Family Service of the Napa Valley offers free and low-cost counseling to individuals of all ages in Napa County. Services include Animal Assisted Therapy, housing services and support services for seniors.

Alternatives for Better Living

Alternatives for Better Living offers general anger management classes for youth and adults as well as groups focused on anger issues for women or men who have been affected by domestic violence.[204]

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[202] Accessed at www.napahelp.info, 5/19/10.
[203] Accessed at www.napa.networkofcare.org 5/17/10.
[204] Accessed at http://www.a4bl.org/sitepages/about_us.html, 5/17/10.

Queen of the Valley Medical Center

The Queen of the Valley Medical Center provides support groups, stress management screenings and treatment, and counseling services for pregnant and post-partum women regarding depression, stress and anxiety.[205] The organization also provides spiritual care for patients, their loved ones and care givers. Services include support through prayer, compassionate listening, presence and counseling.[206]

Aldea Children and Family Services

Aldea provides individual, group and family mental health therapy for individuals of all ages. Services are provided in clinics and at schools and include an art therapy program for children. The agency also operated ADAPT, a program focused on emotionally disturbed teenagers who have not been able to function successfully in public school and are in danger of being placed in group homes. A high school curriculum is supplemented by individual, group and family therapy, plus round-the-clock on-call support aimed at keeping families together.[207]

Table 60 that begins on the next page shows the distribution of mental health services in Napa County.

[205] Accessed at http://www.thequeen.org/view/CommunityOutreach/, 5/17/10
[206] Accessed at http://www.thequeen.org/view/OurServices/spiritual_care. 5/17/10.
[207] Accessed at http://www.aldeainc.com/MentalHealth.htm, accessed 5/17/10.

Table_60. Mental Health Services Availability in Napa County, 2010

Organization	Services	Screening and Referrals	Crisis Services	Treatment, Wellness and Recovery
Family Resource Centers	Resources and Referrals.	X		
Community Clinic Ole	Assessments and Referrals	X		
Progress Place	Crisis treatment facility		X	
Napa Valley Hospice and Adult Day Services	End of life support Adult Day Program			X
Family Services of Napa Valley	Counseling and support services			X
Alternatives for Better Living	Anger management classes and support			X
Queen of the Valley Medical Center	Screenings, support groups and counseling; Spiritual Care	X		X
Aldea Children and Family Services	Mental Health therapy ADAPT			X
Napa County Health and Human Services	ACCESS	X		X
Napa County Health and Human Services	Psychiatric Emergency Response		X	
Napa County Health and Human Services	Children's Crisis Unit		X	
Napa County Health and Human Services	Therapeutic Behavioral Services			X
Napa County Health and Human Services	Children's Medication Clinic			X
Napa County Health and Human Services	Adult Medication Clinic			X
Napa County Health and Human Services	Outpatient Psychotherapy Services			X
Napa County Health and Human Services	Adult Case Management		X	X
Napa County Health and Human Services	Comprehensive Services for Older Adults		X	X
Napa County Health and Human Services	System Navigators			X
Napa County Health and Human Services	Child and Family Behavioral Health		X	X
Napa County Health and Human Services	Therapeutic Child Care Center			X
St. Helena Hospital Center for Behavioral Health	Child and Adolescent Inpatient Services	X		X
St. Helena Hospital Center for Behavioral Health	Adult Inpatient Services	X		X
St. Helena Hospital Center for Behavioral Health	Transitions Partial Hospitalization Program (Vallejo)			X
St. Helena Hospital Center for Behavioral Health	Outpatient Program			X
Napa State Hospital	Treatment facility			X
Dreamcatchers	Independent living support			X
Circle of Friends	Consumer directed and operated drop-in center			X
Buckelew Programs	Supportive Housing for mentally ill adults; Counseling			X
Crestwood Center, Napa Valley	Mental Health rehabilitation			X

SUBSTANCE ABUSE SERVICES

Substance abuse services are available through Napa County Health and Human Services Alcohol and Drug Services Division and several non-profit organizations.

Napa County Health and Human Services, Alcohol and Drug Services Division

The County program offers treatment for adults at the Napa campus.[208] Services include:

- **Prevention, Early Intervention and Youth Treatment**. Substance abuse prevention and youth treatment services. Youth treatment services are contracted to the Wolfe Center.
- **Access, Treatment Authorization**. Intake, assessment and referral services for adults seeking substance abuse and addiction treatment services.
- **Adult Outpatient Treatment and Recovery.** Outpatient substance abuse treatment for adults.
- **Court Treatment and Recovery.** Case management and referral services for individuals participating in Prop 36 or Drug court programs.

St Helena Recovery Center

A residential drug and alcohol treatment program for adults located at St Helena Hospital. Services include Drug and Alcohol Detoxification, Residential drug and Alcohol Program, Partial Hospitalization, Day Treatment, a Family Program and After care.[209] The program incorporates art therapy, acupuncture and massage and yoga among other components to enhance recovery.

Project 90

This is a residential drug and alcohol treatment program for adults that include detoxification and a social model program of recovery. This program offers treatment for adults with the co-occurring disorders of addiction and mental health issues.[210]

The Wolfe Center

This is the only adolescent treatment program in Napa County. Serving youth 12-18, the program serves youth in schools, community settings and at its facility located in Napa. Services include: prevention education, early intervention, and treatment. The Napa facility includes a co-located school campus to accommodate youth who are in need of more intensive day treatment. The Wolfe Center does not provide residential youth treatment services, and youth in need of detoxification or residential treatment are sent outside of Napa County. Art, music and recreation therapy are used to support the

[208] Accessed at www.napahelp.info, 5/19/10.
[209] Accessed at http://www.sthelenarecoverycenter.org/programs.php, 5/19/10.
[210] Accessed at www.napahelp.info, and www.project90.org/treatment, 5/19/10.

treatment process and mental health services are available at the Wolfe Center facility for youth with co-occurring disorders.[211]

Alternatives for Better Living

This agency provides confidential drug testing services, substance abuse training and counseling and education for adults as well as case management services for individuals on drug diversion (Penal Code 90).[212]

Community Action of Napa Valley

This program offers tobacco cessation classes free of charge to Napa County residents through the Napa County Tobacco Control Program. The program also provides tobacco prevention and education services.[213]

[211] Accessed at www.wolfecenter.org/programs.html, accessed 5/19/10.
[212] See www.a4bl.org/sitepages/about_us.html and www.napahelp.info, accessed 5/19/10.
[213] See www.napahelp.info, accessed 5/19/10.

Section IV. Other Related Assessments

"We need information about relationships and that they're more than sex. Helluva' lot of people were doing things before 9th grade—I had a kid in 9th grade—but that's when sex education classes started."
–Focus group participant

"We have the best of the best [food] here; but on the flip side every day we have people lining up for the free food."– Key informant interviewee

Napa County organizations are continually working to learn about residents' needs. The needs assessments summarized in this section were completed by others in the past 5 years. They address a variety of health concerns and populations and helped to inform the present community health needs assessment. The table below provides a guide to this section.

Table 61. Others' Health Related Needs Assessments for Napa County Populations

Organization/ Assessment (Year)	Primary Health Focus	Population Focus	Methods	Contact
First 5 Napa County (2010)	Early childhood health, including dental and mental health	Children 0-5 and their caregivers	Provider online survey	Sally Sheehan-Brown, First 5 Napa County
Safe Kids Napa Valley-California (2002-2007)	Safety, injuries	Children 0-14	Review of data	Sue Carrington, Queen of the Valley Medical Center
Napa County Bi-National Health (2009)	Access, outreach, insurance status, future plans	Latino adults living in Napa County	Participant surveys at various events	Maria Ruiz, Queen of the Valley Medical Center, Community Outreach
Napa County Maternal, Child and Adolescent Health Needs Assessment (2009)	Perinatal status indicators and system needs	Women, children, youth and families	Review of data, provider committee review	Laura Keller Napa County Health and Human Services, Public Health Division

Table continues on next page

Organization/ Assessment (Year)	Primary Health Focus	Population Focus	Methods	Contact
Napa County Health and Human Services Agency, Alcohol and Drug Services Strategic Plan for Substance Abuse Prevention (2009)	Alcohol and drug use	Youth and adults	Review of data	Shirin Vakharia, Napa County Health and Human Services Alcohol and Drug Division.
Napa County Health and Human Services Agency Alcohol and Drug Division and the Wolfe Center: Youth and Young Adult Substance Abuse Treatment Strategic Plan (2008)	Substance abuse	Youth and young adults		Shirin Vakharia, Napa County Health and Human Services Alcohol and Drug Division.
Napa County Office of Education and Napa County Health and Human Services, School Based Mental Health Services and Supports (2007)	Mental health	School-aged children and youth	Interviews, data review and teacher surveys	Terry Longoria, Napa County Office of Education Shirin Vakharia, Napa County Health and Human Services Alcohol and Drug Division. Jeanne Title, Napa Valley Unified School District
Mental Health Services Act, Various Needs Assessments	Mental health	Napa County residents	Interviews, focus groups, community forums, surveys and data review	Felix Bedolla, Mental Health Services Act
Area Agency on Aging, Plan Update	Wellness, advocacy, safety	Seniors	Planning process	Terri Restelli-Diets or Leanne Martinsen
Napa Valley Older Adult Policy Platform (2010)	Support and other health care services	Seniors	Policy platform to inform and guide policy advocacy efforts	Kathleen Tabor, Tabor Consulting
Child and Family Services Review Napa County Self-Assessment 2007-09	Mental health	Children and youth	Self-assessment	Napa County Health and Human Services, Linda Canan, Child Welfare Services Director

Table continues on next page

Organization/ Assessment (Year)	Primary Health Focus	Population Focus	Methods	Contact
Child Care Planning Council	Child Care	Employers, Child Care Providers and Families with Young Children	Data Review	Becky Billing, Napa County Child Care Planning Council
Child Start, Inc. Child and Family Services (Head Start),	General	Families with children age 3-5	Surveys, Focus Groups and Data Review	Deb Peralez, Child Start Inc
Clinic Ole Market Survey (2009)	Primary care	American Canyon residents	Household surveys by students	Dr. Robert Moore, Medical Director

FIRST 5 NAPA COUNTY[214]

First 5 Napa County funds services and supports for children age 0-5 and their caregivers. Current strategic areas include: Early Childhood Health, Early Childhood Learning and Education and Parent and Community Education. In March 2010 the commission reviewed input from 90 community partners who responded to an online survey. Key findings relating to Early Childhood Health include:

- Of the commission's three funding areas, partners indicated that First 5 Napa County had been most effective in impacting Early Childhood Health strategies (36%, n=62).
- When asked which of the current strategies addressing Early Childhood Health were the most critical and effective, respondents prioritized them as follows: (1) improve access to affordable health insurance and health care linkages for uninsured families (56%); (2) provide parent education focusing on parent's role in providing and accessing preventive care for their children 0-5 (49%); and (3) develop initiative to address children's needs in the areas of oral health, nutrition and safety (34%).
- Partners recommended expansion in the area of Early Childhood Health to address the issues of Early Childhood Mental Health, Obesity, Nutrition and Activity and Oral Health.

SAFE KIDS NAPA VALLEY-CALIFORNIA[215]

The Safe Kids Napa Valley-California Needs Assessment is a review of the injury data for children age 0-14 living in Napa County. The report includes data from 2002 through 2007 and offers numerous figures and tables to detail the frequency and causes of injuries in children.

[214] First 5 Napa County 2010 Community Survey PowerPoint Presentation, March 2010, prepared by First 5 staff.
[215] Safe Kids Napa Valley-California: Needs Assessment 2002-2007. Prepared by Susan Carrington, RN, BSN and Andrea Pogue, MPH student for Safe Kids Napa Valley, California. April 2009.

NAPA COUNTY BI-NATIONAL HEALTH[216]

The Napa County Bi-National Health group conducted several surveys with Latino residents in Napa County during 2009. Four separate surveys were distributed at four events: 2009 Health and Wellness Fair, 2009 Latina Women's Conference, 2009 Noche Mexicana, and the Latina Women's Tea 2009. Key findings from each of the surveys are noted below:

Health and Wellness Fair (n=176)

- 87 of 176 (49%) respondents indicated they did not know where to receive healthcare in the US.
- 115 of 177 (65%) respondents reported they did not have health insurance.
- When asked to rate their current health, 5% rated their health Excellent, 39% said Good and 49% stated Average. 7% rated their health Poor or Very Poor.

Latina Women's Tea (n=19)

- 10 of the 19 (52%) respondents indicated they had difficulty accessing services in Napa County. Of those who had difficulty, the most common services mentioned were Mental Health Counselors (60%), Housing (60%), Finding a Doctor or Dentist (50%), and Health Insurance (40%).
- The frequently cited "Immediate needs facing you as a Latina in Napa County," were Housing (21%), Lack of Health Insurance (16%) and Lack of Jobs (10%).
- When asked, "What are the best ways to connect with you", respondents indicated Family and Friends (21%), Community and Family Centers (21%) and Flyers (16%).
- When ill, respondents indicated they go to a doctor, hospital or clinic (78%). Other responses included home remedies (11%) and Friends (6%) and Puertas Abiertas (6%).

Noche Mexicana (n=28)

- Very few participants knew the symptoms of a stroke (1%) or where to find resources for alcohol/drug addiction (21%).
- At the pre-test, participants were uniformly in agreement that it is important to have frequent health screenings (100% agreed).
- At the pre-test, 86% reported they knew it was important to have personal goals/activities aside from those of their family. This improved to 100% at the post test.

Latina Women's Conference (n=87)

- 46% indicated they knew the symptoms of a stroke (40 of 87 respondents--pretest).
- The majority (94%) indicated they knew it was important to have personal activities and goals outside of their family (82 of 87 respondents--pretest).

[216] Napa County Bi-National Health, Prepared by Maria Ruiz Community Organizer, Queen of the Valley Medical Center, Community Outreach. Reports include: "2009 Health and Wellness Fair Survey Data Analysis", October 11, 2009; " 2009 Latina Women's Conference Pre/Post Survey Data Analysis", July 2009; "2009 Noche Mexicana Survey Data Analysis", September 5, 2009; and "Latina Women's Tea 2009 Data Analysis."

- The majority of the participants were in agreement that they were motivated to improve their education (80%), that they have the confidence to "negotiate with my partner to satisfy my priorities and wants" (80%), and that it is important to "have frequent health screenings and visit the doctor regularly" (95%). (pretest)

NAPA COUNTY MATERNAL, CHILD AND ADOLESCENT HEALTH NEEDS ASSESSMENT[217]

The Napa County Maternal, Child and Adolescent Health (MCAH) program conducted a needs assessment to assess the capacity of the community MCAH system to carry out…services in relation to the systems and services that address the needs of women, children, youth and families.

Key findings (Perinatal Health Status Indicators)

- Significant decrease in the teen birth rate for both Hispanic and White females ages 15 to 19; Napa is currently meeting the Healthy People 2010 Objective.
- The trend for low birth weights is increasing at 6.2% of live births for 2004-2006. Although numbers are small, African American women have significantly higher rates of low or very low birth weight births.
- No significant change in preterm births at 9.1% of births but is still higher than Healthy People 2010 Objective. African American and Asian women have higher percentages of preterm births.
- 2004-2006 data indicates 24% of children 5 to 19 are overweight; this is significantly higher than the Healthy People 2010 Objective of no more than 5% overweight.
- At hospital discharge 70.6% of women report exclusive breastfeeding and this falls below the Healthy People 2010 Objective. Data is lacking at six-months.
- Local data from Welcome Every Baby and Queen of the Valley Community Outreach report estimates of postpartum depression at between 25.5% and 16 %.

Over the next five years, MCAH will be focusing on postpartum depression and breastfeeding. To address capacity needs, they will be developing shared data collection, evaluation and outcomes with other providers.

STRATEGIC PLAN FOR SUBSTANCE ABUSE PREVENTION[218]

The Napa County Health and Human Services Agency, Alcohol and Drug Services Division developed the Strategic Plan for Substance Abuse Prevention for 2007-2010 and revised the plan in July 2009. Key findings in the following areas are discussed:

- Underage drinking is prevalent across Napa County
- Adult drinking and driving is prevalent across Napa County
- Marijuana use is prevalent among high school students in Napa and Calistoga

[217] Napa County Maternal, Child and Adolescent Health Needs Assessment: 2010-2014, Napa County Health and Human Services Public Health Division, June 30, 2009. Prepared by Laura Keller, BSN, PHN, NP, MCAH Director and Jennifer Henn, PhD, MCAH Epidemiologist.

[218] Napa County Health and Human Services Agency, Alcohol and Drug Services Division, "Strategic Plan for Substance Abuse Prevention" 2007-2010, Revised July 2009.

YOUTH AND YOUNG ADULT SUBSTANCE ABUSE TREATMENT STRATEGIC PLAN[219]

Napa County Health and Human Services Agency Alcohol and Drug Division and the Wolfe Center developed a strategic plan for youth and young adult substance abuse treatment in January 2008. The strategic plan began with a needs assessment, and the key findings included:

Access issues:

- The services are located in Napa, and the youth in need are located throughout Napa County.
- Screening for alcohol and other drugs does not occur until youth enter the criminal justice system.
- There are no residential treatment providers in Napa County

Community Culture:

- Youth and young adults enter treatment at a higher rate than youth and young adults other California counties.

Systems and Information Management

- Youth and young adults using substance abuse services are often in need of services from other systems, including mental health public health, child welfare and criminal justice.
- There is a need to use an integrated information management system to create seamless transitions for consumers and the data tracking required for monitoring and management.

SCHOOL-BASED MENTAL HEALTH SERVICES AND SUPPORTS[220]

Napa County Office of Education, Napa County Health and Human Services Agency, and Napa Valley Unified School District developed a needs assessment for school-based mental health services and supports in December 2007. Key findings included:

Mental Health Needs of Children

- 20% or more of school-aged children experience a need for mental health services in a given year.
- Stakeholders identified anger management/conflict resolution, family relations, anxiety and trauma as prevalent mental health concerns for school-aged children.
- The changing demographics of Napa County and the underutilization of mental health services and supports by Latino children, transition-aged youth and youth in the justice system will continue to affect the mental health needs of children.

[219] Napa County Health and Human Services Agency, "Youth and Young Adult Substance Abuse Treatment Strategic Plan", January 2008. Prepared by Nolfo Consulting in collaboration with Children and Family Futures.
[220] "School-Based Mental Health Services and Supports, Needs Assessment and Recommendations, Napa County 2007", prepared by Allen, Shea and Associates. Accessed at http://www.allenshea.com/documents/SBMHFinalReport_December2007.pdf

- Mental health services and supports need to be available to families as well as children.

Identifying Mental Health Needs for School-Aged Children

- Schools' responses to how they identify students at risk were very uniform and providers' responses were more varied.
- Parents whose child was identified with a clear academic concern reported receiving academic support and mental health services quickly. Parents whose child was identified as having a behavioral concern reported more frustration and a longer process to enter into the system of services and supports.

School-Based Mental Health Services and Supports

- School administrators and counselors described the need to balance academic and mental health needs in light of ongoing pressure to raise students' test scores.
- Schools and providers agreed that there are not enough school-based mental health services and supports to address the needs of students.
- Only half of the school administrators and counselors reported that they are able to address anger management/conflict resolution at their school, though this was one of the most frequently reported needs.
- Schools, providers and parents agree that students need effective mental health services and supports. The way effectiveness is evaluated and reported shows a variety of definitions for change and impact.
- There is a need for long-term funding to improve the stability of mental health services and supports. School and providers indicated frustration with the restrictive and transitory nature of grant-funded programs and preferred long-term flexible funding sources to provide appropriate services effectively.

MENTAL HEALTH SERVICES ACT

Proposition 63, The Mental Health Services Act, includes community planning and needs assessments in several components. The key finding from each component are shown in the sections that follow.

Community Supports and Services[221]

The needs assessment for the Community Supports and Services plan was completed in 2005. Over 600 community members shared their views on the need for mental health services in community forums, focus groups or interviews. The key findings are outlined below:

- **Locate mental health services throughout the county**: Ideas included a mobile assessment team, a mobile crisis team, and locating mental health services alongside other health services.

[221] The information for this section was included in the last Napa County needs assessment report. However, because it is still the most current mental health needs assessment for treatment services, it is reproduced here but in a shorter version and focused only on the needs, not the programs.

- **Increase the number of bilingual/bicultural professionals and services** and supports that reflect cultural competence.
- **Serve underserved populations:** Outreach, education and mental health services and supports for the underserved Hispanic community, transitional aged youth and older adults.
- **Improve education about mental health needs and services**. Education and information regarding mental health services for both individuals and families seeking mental health services and community "anti-stigma" education.
- **Consider different approaches to providing treatment services:** For example, in-home for seniors and wraparound services for individuals with co-occurring disorders.
- **Services and supports for older adults.** More professionals who specialize in the psychiatric issues of older adults as well as expanded services and supports (for example, in-home).
- **Expand crisis services** and include follow-up services, medication monitoring and service coordination.
- **Places in the community for those with mental illness**. 'Some place to be, some place to belong' for adults with mental illness who want to be a part of their community (for example, life skills, vocational services).
- **Develop a 'navigation' system** for individuals and families who are new to the mental health system (for example, family-to-family mentors).
- **Residential services** for individuals with dual diagnoses.
- **Transportation** to mental health and related services and supports.
- **Support groups** for individuals with mental illness as well as their caregivers.

Prevention and Early Intervention[222]

The planning for the Prevention and Early Intervention forum involved provider surveys and community forums and took place over the two-year period 2007-2009. The focus of the needs assessment was to understand how well needs were currently met, what barriers individuals encountered when seeking services and what types of services and supports are important for people in Napa County.

Current Need for Mental Health Prevention and Early Intervention Services
Providers indicated that 39% of the current need for mental health prevention and early intervention services was met with the existing services. Populations and geographic areas with less than 39% of their needs met were considered unserved and underserved.

Unserved and Underserved Groups[223]
Targeted outreach to specific groups was successful, and many participated. It was also noted that some representatives expressed fatigue and frustration due to numerous requests to represent their community. The mental health prevention and early intervention needs for each of the groups is noted below:

[222] MHSA Prevention and Early Intervention (PEI) Guiding Principles, Stakeholder Advisory Committee Session One, February 26th, 2009. PowerPoint Presentation.
[223] Ibid, slides 39-52.

- **Lesbian, Gay, Bisexual and Transgendered individuals** reported they were not understood by police, therapists, schools and service providers.
- **Native American** representatives expressed concern about the high rates of substance abuse and suicide, and the low life expectancy" for Native Americans.
- **Asian/Pacific Islander (API)** residents noted isolation due to language and cultural barriers, the need to understand diversity within the API population, [and] stigma about mental health.
- **Veterans** indicated difficulty finding and keeping employment, delayed post-traumatic stress disorder (PTSD) and conflicts between getting mental health services, the culture of the military and finding employment.
- **Latinos** talked about isolation from family and culture and substance abuse issues that lead to involvement with law enforcement.
- **Seniors** discussed isolation, transportation and fear of scam artists and elder abuse.
- **Upvalley communities** talked about the lack of access to services and resources, transportation and a "culture of denial" (St Helena).
- **American Canyon** reported the cultural and linguistic diversity is increasing, a lack of services in American Canyon, and a lack of youth activities.
- **The Unincorporated Areas of Napa County** reported concerns about the lack of services.

Workforce Education and Training[224]

The Workforce Education and Training component of MHSA included a interviews and surveys with public mental health providers in Napa County and took place from 2009-2010. When asked to prioritize the challenges in the current public mental health workforce, the top three concerns were:

- The lack of psychiatrists.
- The lack of bilingual/bicultural professionals.
- Cultural competence.

Providers were also asked how the limited funds available from MHSA should be used to improve the current public mental health workforce. Strategies to address the number of psychiatrists were deemed too costly and providers indicate the limited funds were better used strengthening other portions of the workforce. The priorities are below:

- Financial incentives to recruit and retain public mental health staff.
- Training and technical assistance to improve the skills of the current workforce.
- Career pathway programs to recruit and prepare individuals for entry into the public mental health field.

[224]"Workforce Needs Assessment Narrative, Summary of Findings". Final Version, March 2009, page 1.

AREA AGENCY ON AGING, 2010 AREA PLAN UPDATE[225]

The Area Agency on Aging (AAA) for Napa and Solano Counties developed a three-year area plan to address the needs of seniors in both counties. The goals for the plan, discussed below, are supported with state and national data outlining the needs for each of the areas of focus.

- **Wellbeing: Health and Economic Wellness**: AAA will support a comprehensive and coordinated system of care that promotes the well being of older adults, persons with disabilities and caregivers in a safe and supportive community. This includes service coordination, information, assistance and referral as well as provision of services.
- **Advocacy, Awareness, Education and Coordination Activities**: Increase awareness of services for older adults, persons with disabilities and caregivers through education and advocacy. Strengthen information, assistance and service coordination.
- **Safe communities are healthy communities**: AAA supports applying a primary prevention framework to mental health [in order to] support the care and treatment of those in need while also reducing the stigma associated with mental health problems.

Further information submitted by the Area Agency on Aging noted the following Emerging Issues, Crisis Issues and Continuing Issues[226]

<u>Emerging Issues</u>
- Inadequate and fragmented health (including mental health) and long term care policy at state and national levels.
- Expanded efforts needed to reach isolated individuals through gatekeepers and system navigators.
- Increase in seniors using homeless shelters.
- Un-affordability of dental care and prescriptions.
- Housing resources diminishing, expensive, and non-elder friendly.

<u>Crisis Issues</u>
- Economy, state budget cuts and eliminations.
- Increase in elder abuse, particularly financial elder abuse.
- Injuries due to falls.
- Energy and utilities.
- Access to healthcare.

<u>Continuing Issues</u>
- Elder abuse.
- Fall related injuries.
- Lack of county and community based mental health services for older adults.
- Senior homeless.

[225] *2010 Area Plan Update, Area Agency on Aging Serving Napa and Solano*, accessed at http://www.aaans.org/frames.htm 5/13/10.
[226] Personal communication with Terri Restelli-Diets, Area Agency on Aging, Napa and Solano. August 2, 2010.

HEALTHY AGING POPULATION INITIATIVE

In March 2010, more than a dozen key organizations and groups serving and advocating for older adults in Napa County developed a collaborative policy platform to inform and guide policy advocacy efforts.[227] The policy platform identifies Napa-specific priority issues, details recommended strategies to improve conditions for older adults in Napa County, and builds a collaborative framework for advocacy among Napa Valley's senior advocates.

The Napa Healthy Aging Population Initiative, which includes the Area Agency on Aging, convened the policy development group. The Policy Platform identified 5 key goal areas representing desired outcomes for older adults in Napa Valley that directly (see Goal 5) and indirectly and impact health (Table 62). A number of strategies, such as medical guidelines that support chronic disease management, injury prevention education, and transportation to medical care resulted from the goals.

Table 62. Goals and Priorities of the Napa Healthy Aging Initiative, 2010

GOALS	PRIORITIES
Goal 1: Provide adequate economic stability for older adults to meet basic needs and maintain health and wellbeing as long as possible.	Priority 1: Adopt economic self-sufficiency standards for determining eligibility for social programs.
Goal 2: Assure Napa older adults the right to live in the least restrictive environment.	Priority 2: Provide comprehensive, flexible long-term care services for all older adults regardless of financial status.
	Priority 3: Promote affordable, accessible, adequate, appropriate housing.
Goal 3: Protect the quality of life and rights of elders.	Priority 4: Provide access to education, abuse protections, legal services, and improved coordination with law enforcement.
Goal 4: Create elder-friendly communities.	Priority 5: Assure access to affordable, accessible, acceptable, available, safe, friendly transportation for all older adults.
	Priority 6: Promote elder-friendly community planning.
Goal 5: Provide access to healthcare and preventive services for older adults to maintain health and wellness.	Priority 7: Assure access to available, appropriate, affordable, accessible comprehensive health care.

Source: Napa Older Adult Policy Platform.

CHILD AND FAMILY SERVICES REVIEW—NAPA COUNTY SELF-ASSESSMENT

As part of a continuous quality improvement process for child welfare services in California, all counties must develop a 3-year System Improvement Plan (SIP) on a triennial basis. Each county incorporates input from various child welfare constituents

[227] *Napa Valley Older Adult Policy Platform*. Healthy Aging Population Initiative. March 17, 2010.

and reviews the full scope of Child Welfare and Probation services within the county, examining strengths and needs from prevention through continuum of care. The process of doing this is referred to as the County Self Assessment (CSA). In Napa County, a focus group that included judges and attorneys and 4 stakeholder meetings were held in August-September 2009. Over 70 stakeholders participated in these meetings, representing services providers from across the county and a wide range of disciplines. The charge to the group was to review and analyze performance data, identify strengths and challenges and offer recommendations.

Six trends and themes that emerged from the self-assessment and identified across outcomes included:

1. Napa County Social Workers and Probation Officers have a high level of contact with their families and offer many resources, and supportive services.
2. The Napa County community values providing services to community members in times of stress. The county has many resources and provides quality services to children, youth and families.
3. The challenge in Napa County now is how do we maintain the high level of services that community expects and agencies currently provide in the context of the current fiscal crisis?
4. There is a very real need for more bi-lingual and bi-cultural services across the continuum of prevention, intervention, service provision and treatment in Napa County.
5. In the Napa County Child Welfare and Probation systems there is need for more placement resources that meet the unique needs of the children and youth in the county.
6. There is a need to continue to build collaboration and coordination with the providers of mental health and alcohol and drug services to assure optimum care for our children and families.

With these overarching themes and trends in mind, the Self Assessment team identified 5 areas to be focused on in the SIP.

1. How do we maintain the standards set regarding the small recurrence of maltreatment for families that have been touched by the child welfare system? (Safety outcome)?
2. What additional services can be put in place to safely reunify children and youth with their families within a twelve month period? (Permanency Outcome)?
3. How can we improve lifelong connections for children and youth who are in the child welfare and probation? (Permanency Outcome)?
4. How can we improve our processes and practices to shorten the length it takes for children and youth to be adopted if necessary? (Permanency Outcome)?

5. How can we continue to build collaboration and coordination with the providers of mental health and alcohol and other drug services to ensure optimum care for our children and families? (Well-being outcome)?

The final theme was to consider the cultural and language needs of the monolingual and bilingual families in all of the Department's strategic planning efforts.

CHILD CARE PLANNING COUNCIL

The agency's 2010 Needs Assessment[228] outlined the needs for childcare providers and families with children in Napa County. The health-related findings included:

- Additional capacity for infant child care is needed.
- Additional capacity for subsidized programs is needed for all age groups.
- The importance of program quality is becoming increasingly recognized at the state level, highlighting the importance of provider participation in addressing program quality.
- A variety of resources exist in Napa County to address the needs of specialized populations, especially children with disabilities.
- The demand for emergency child care has been growing, and additional resources are needed to address the increased demand.

CHILD START, INC.: CHILD AND FAMILY SERVICES (HEAD START)

Child Start, Inc. operates Head Start in Napa County and Solano County and conducts a needs assessment every 3 years to assist with program planning. The 2010-2013 Community Assessment[229] identified strengths and needs through local data review, focus groups, and surveys with families enrolled in Child Start, Inc. programs. Families served by Child Start, Inc. live in Napa or Solano County and have at least one child between the ages of 3 and 5 years old.

- Key health-related findings include:
    - Nearly all participating children have health insurance coverage.
    - Speech or language impairment was the most prevalent disability for enrolled children during 2008-09, affecting 12% of Head Start children.
    - Asthma prevalence for children in the service area is higher than the state average.
    - The prevalence of obese and/or overweight children is increasing.

- Child Start Inc. staff reported a need for more physical, mental and dental health resources for enrolled families, such as:

[228]Napa County Child Care Planning Council Needs Assessment 2010, DRAFT, Duerr Evaluation Resources, Accessed at http://www.napacoe.org/component/docman/cat_view/208-child-care-planning-council?orderby=dmdate_published&ascdesc=DESC, 8/18/10.
[229] Child Start, Inc. Community Assessment, 2010-2013, prepared by Duerr Evaluation Resources.

- Additional free physical and TB test clinics for families without insurance.
- Additional medical services/exams for parents of enrolled families.
- Scarcity of mental health resources, especially for adults, and long waiting lists.
- A need for additional services relating to behavior, schizophrenia, and bi-polar disorder, and more bilingual resources for dealing with stress.

- Parents who are participating in Child Start Inc. programs identified the need for health and dental care, support for families with disabled children, developmental assessments, assistance with social skills for their children and information about nutrition and exercise.

CLINIC OLE MARKET ASSESSMENT FOR AMERICAN CANYON[230]

In January-February 2010, students of Touro University School of Public Health, with support from Clinic Ole, conducted a household survey (n=56) in American Canyon to determine residents' familiarity with Clinic Ole and their likelihood of using its services if a satellite clinic were to be opened in the area. The following results were provided:

The sample:
- Houses randomly selected.
- Survey conducted only in the afternoon (not in evening or weekends).
- Students were required to get consent prior to the survey which resulted in some refusals, particularly among those with health insurance.
- The average age of respondents was 28 and the average number of family members was 4.
- No information about income level was provided.

Familiarity:
- 82% had heard of Clinic Ole; of these, 87% had used its services at some time in the past.
- 95% said they would use services if a clinic was opened in American Canyon.

Location:
- 40% favored the Safeway/plaza area as a location for the clinic site.
- 30% said "anywhere."
- 17% suggested the area near WalMart.

Barriers identified to health care:
- 40% inadequate/lack of health insurance coverage.
- 30% lack of transportation/distance to health care.
- 20% affordability.

[230] Personal communication with Dr. Robert Moore, Medical Director, Clinic Ole, April 29, 2010.

Section V. Local Perspectives about Needs and Solutions

"The phone translator isn't always telling the doctor what I say; they don't ask the right question. I don't like to use my kids to translate."—Focus group participant

Communities have much strength on which to build community health. These include strong family ties and social networks, trust and respect among community members, organizations with community roots, and health-promoting traditions such as high fruit and vegetable diets and exercise.[231] A number of these strengths, or assets, were recognized by the community members and other stakeholders who participated in this needs assessment. They also identified the health problems of greatest concern, and the community health needs of highest priority and most relevance to them.

INPUT FROM THE COMMUNITY SURVEY

Description of Respondents

The *Healthy Napa Survey* (Attachment 8) was distributed online and in hard copy in various community locations throughout Napa County in an attempt to gain a wider understanding of the health needs of those who live in the county. Examples of sites that hosted the questionnaire—which included placements intended to reach higher-risk populations—were branches of public libraries, Napa Senior Center, Boys and Girls Clubs in American Canyon and Napa, Child Start, and St. Helena and Calistoga Family Resource Centers. Overall, 798 surveys were completed, 38% online and 62% on paper. Of the 235 surveys returned in Spanish, all were completed in hard copy (Table 63 on the next page).

[231] *Good Health Counts: A 21st Century Approach to Health and Community for California.* Prevention Institute. November 2007.

Table 63. Type of Survey Completed, by Language

	Type of Survey				
Language	Paper		Online		Total
	n	Percent	*n*	Percent	
English	258	46%	300	54%	558
Spanish	235	100%	0	0%	235
Total	493	62%	300	38%	793

The characteristics of the respondents were compared to the 2007 community survey to examine the differences in the two samples.[232] While the demographics of the current sample to some degree mirror those of the overall County, [233] the sample is strictly a convenience sample and should not be interpreted as being representative of the County as a whole. There was intentional oversampling of the most vulnerable groups and those who tend to utilize more services. The comparison between the survey populations in 2007 versus the 2010 sample shows that females and individuals who identify as Latino are over-represented, and individuals who identify as White are slightly under-represented. In this latest survey, the current sample is representative of the county's demographics for seniors, Asian, African American, and Native American individuals as well as languages other than English.

The 2010 survey sample size is an increase of 117% from the 2007 sample (798 surveys compared to 366 surveys). There were a higher percentage of females, individuals who identified as White, and seniors responding to the present survey.

Table 64. Characteristics of the Community Survey Respondents, 2007 and 2010

Characteristic	2007 Respondents		2010 Respondents		Difference
Gender	*n*	Percent	*n*	Percent	Percent
Female	257	70%	600	76%	6%
Male	97	27%	151	19%	-8%
Missing	12	3%	42	5%	2%
Total	366	100%	793	100%	
Ethnicity	*n*	Percent	*n*	Percent	Percent
Hispanic/Latino	226	62%	318	40%	-22%
White	68	19%	380	48%	29%
Asian	48	13%	26	3%	-10%
African American	15	4%	6	1%	-3%
Native American	n/a	n/a	26	3%	3%
Mixed	7	2%	19	2%	0%

Table continues on next page

[232] While the comparison is of interest, it is important to note that one cannot assume trends over time, i.e., that community opinions have changed over time, as the survey respondents represent different samples.
[233] The 2010 sample was compared to the U.S. Census estimates for Napa County. Groups who were sampled within 5% of the U.S. Census estimates are considered appropriately reflected in the sample.

Characteristic	2007 Respondents		2010 Respondents		Difference
Ethnicity (cont.)	*n*	Percent	*n*	Percent	Percent
Other	n/a	n/a	26	3%	
Missing	2	1%	39	5%	4%
Total	366	100%	793	100%	
Age	*n*	Percent	*n*	Percent	Percent
Under 21	19	5%	22	3%	-2%
21-64	308	84%	639	81%	-4%
65+	29	8%	93	12%	4%
Missing	10	3%	39	5%	2%
Total	366	100%	793	100%	

The city location and language of the surveys also changed in 2010. There was an increase in the proportion of surveys from Napa and Upvalley and a significant decrease in the percentage of surveys from American Canyon (Table 65). Despite the countywide promotion and availability of the online survey, the latter likely is a reflection of where the hard copy surveys were placed. In the prior survey, 57% were returned in Spanish while in the 2010 survey 30% were returned were in Spanish, a decrease of 27%.

Table 65. City Location and Language of Community Survey Respondents

Characteristic	2007 Sample		2010 Sample		Difference
City	*n*	Percent	*n*	Percent	Percent
Napa	184	50%	516	65%	15%
American Canyon	155	42%	57	7%	-35%
Upvalley	27	7%	130	16%	9%
Other	0	0	42	5%	5%
Missing	0	0	48	6%	6%
Total	366	100%	793	100%	
Language	*n*	Percent	*n*	Percent	Percent
Spanish	207	57%	235	30%	-27%
English	157	43%	558	70%	27%
Missing	2	1%	0	0%	-1%
Total	366	100%	793	100%	

As commonly included in community health needs assessments, respondents were asked to rate their own health status; they also reported whether or not they had seen a dentist in the previous year. As shown in Table 66 below, the current sample was more likely to rate their health excellent or good (increase of 14% overall) and less likely to rate their health fair or poor (decrease of 15%). Sixty-eight percent of respondents reported seeing a dentist in the past year, an increase of 7% from the prior sample (2007 data not shown).

Table 66. Self-Reported Health Status, Community Survey

Health Characteristics	*n*	Percent
Excellent	171	22%
Good	388	49%
Fair	170	21%
Poor	31	4%
Missing	33	4%
Total	793	100%

Perceived Positive Health Effects of Living in Napa County

Survey respondents were asked "What about living in Napa County contributes to people's health and well-being in a positive way?" The most common response was "the beautiful, clean environment" (Table 67). The responses were analyzed to see if there were different benefits reported by those who completed the survey in English and those who completed it in Spanish. While both groups noted the environment and many opportunities to exercise, people who completed the survey in Spanish were more likely to cite the health care offered/good facilities as a benefit.

Table 67. Perceived Positive Health Attributes of Napa County, Community Survey

Health Attributes of Napa County	All Respondents		English Surveys		Spanish Surveys	
	n	%	*n*	%	*n*	%
Beautiful, clean environment	273	34%	211	38%	62	26%
Many opportunities to exercise	131	17%	101	18%	30	13%
Good community services	79	10%	51	9%	28	12%
Nice climate	74	9%	68	12%	6	3%
Health care offered/good facilities	68	9%	37	7%	31	13%
Peaceful/quiet/calm place	57	7%	33	6%	24	10%

Table continues on next page

Health Attributes of Napa County (cont.)	All Respondents		English Surveys		Spanish Surveys	
	n	%	*n*		*n*	%
Small town/country living/quality of life	48	6%	38	7%	10	4%
Sense of "community spirit"	40	5%	32	6%	8	3%
Access to healthy food	36	5%	29	5%	7	3%
Good law enforcement, safe environment	32	4%	21	4%	11	5%
Good job opportunities	11	1%	3	1%	8	3%
Everything about Napa is positive	10	1%	10	2%	0	0%
Other	53	7%	40	7%	13	6%
Missing	74	9%	45	8%	29	12%
Total Respondents	793		558		235	

Health Habits

Respondents were asked to choose 2 health habits that are most important to their own health. Many respondents checked only 2 responses and others checked up to 12. The ideas were prioritized in the same way regardless of the response method, and the responses from those who checked 2 responses were used for analysis. Exercise and eating fresh fruits and vegetables were viewed by approximately one-third of individuals as the most valuable health habit, followed by not smoking (Table 68).

Table 68. Health Habits that Contribute Most to Maintaining Personal Health, Community Survey

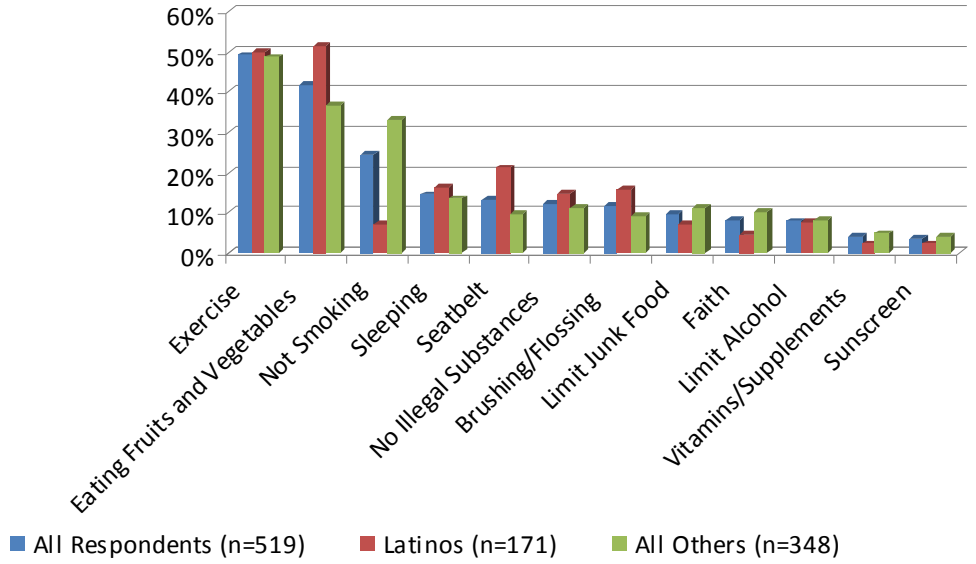
Health Habits	Respondents	
	n	Percent
Doing some form of exercise (e.g., walking)	255	32%
Eating fresh fruit and vegetables each day	216	27%
Not smoking	127	16%
Sleeping at least 7 hours each night	75	9%
Wearing seatbelt	69	9%
Not using illegal substances	64	8%
Brushing and Flossing Daily	60	8%
Rarely eating fast or “junk” food	51	6%
Practicing my faith/attending services	43	5%

Table continues on next page

Health Habits (cont.)	Respondents	
	n	Percent
Taking vitamin pills or supplements daily	21	3%
Wearing sunscreen	19	2%
Other	40	5%
Positive Relationships/ Positive Outlook	14	2%
Healthy food	7	1%
Leisure/Hobbies	7	1%
Access to Health Care/Preventive Care	3	0%
"Need all of these"	3	0%
Other (only one response)	6	1%
Respondents who marked more than two responses	274	35%
Missing	4	1%
Total Respondents	793	100%

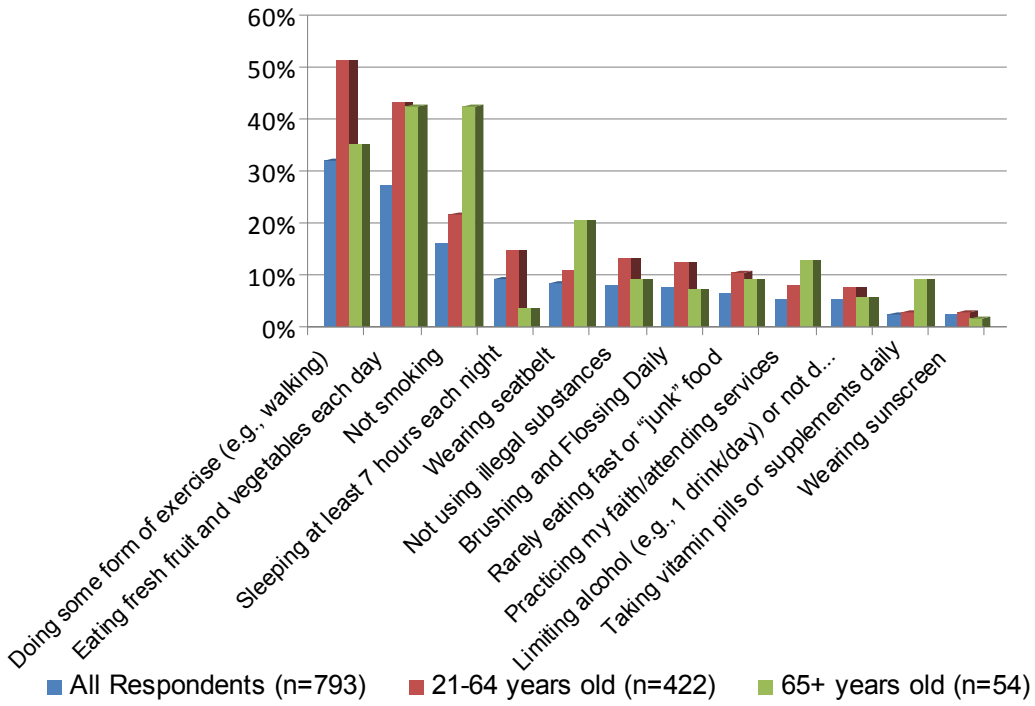
To understand how health habits varied across populations, the results were analyzed by ethnicity and age groups. For the respondents who identified as Latino, the top 2 most important habits remained exercise and eating fruits and vegetables (Figure 31). Wearing a seatbelt was the third most frequently noted habit with 21% of the responses from Latinos compared to 13% overall.

Figure 31. Health Habits by Ethnicity



When reported health habits for adults and seniors were compared,[234] both shared the same prioritized health habits: exercise, eating fresh fruits and vegetables and not smoking (Figure 32). Seniors were more likely than adults to indicate not smoking as most important and less likely to report exercise, however.

Figure 32. Health Habits by Age Group



Perceived Negative Health Effects of Living in Napa County

Respondents were also asked how living in Napa County might contribute in a negative way to residents' health, examining differences between Latino and non-Latino respondents. Overall, pesticides was the most frequent answer followed by traffic congestion and the high cost of living (Table 69 on the next page). The respondents who completed the surveys in Spanish noted more concern about allergies/asthma/ pollen/allergens, crime/safety/law enforcement, and perceived discrimination/racism. The respondents who completed the survey in English were more likely to cite traffic congestion and the high cost of living. Eight percent of the respondents replied that there was nothing negative about living in Napa County.

[234] Youth were not included in this comparison due to a low response rate (n=19).

Table 69. Perceived Health Detriments of Napa County, Community Survey

Health Detriments	All Respondents	English Survey	Spanish Survey
	n (%)	*n* (%)	*n* (%)
Pesticides	81 (10%)	57 (10%)	24 (10%)
Traffic congestion	74 (9%)	73 (13%)	1 (0%)
High-cost of living in the county	66 (8%)	56 (10%)	10 (4%)
"There's nothing negative about Napa County"	65 (8%)	35 (6%)	30 (13%)
Allergies/asthma/pollen/allergens	41 (5%)	25 (4%)	16 (7%)
Alcohol/drugs/smoking	39 (5%)	24 (4%)	15 (6%)
Crime/safety/law enforcement	37 (5%)	19 (3%)	18 (8%)
Access to health services/cost/lack of insurance	34 (4%)	22 (4%)	12 (5%)
Lack of alternatives to cars: lack of public transportation and bike access	34 (4%)	33 (6%)	1 (<1%)
Discrimination/racism	33 (4%)	16 (3%)	17 (7%)
Trash/not recycling/pollution (air, water, land, noise)	33 (4%)	26 (5%)	7 (3%)
Wine industry (negative attitudes toward alcohol and availability)	31 (4%)	29 (5%)	2 (1%)
Lack of access to activities/ exercise	30 (4%)	24 (4%)	6 (3%)
Inadequate number of social services/benefits	27 (3%)	17 (3%)	10 (4%)
Poor nutrition/too many junk food places/rich food in restaurants	27 (3%)	19 (3%)	8 (3%)
Development/population increase	19 (2%)	19 (3%)	0 (0%)
No jobs	17 (2%)	9 (2%)	8 (3%)
Car accidents/ dui/driving safety	15 (2%)	15 (3%)	0 (0%)
Narrow thinking (closed minded, negative attitudes, narrow view)	14 (2%)	14 (3%)	0 (0%)
Socioeconomic divide	14 (2%)	13 (2%)	1 (<1%)
Tourism and wine industry (too many wineries; tourist congestion)	16 (2%)	16 (2%)	0 (0%)
Lack of outreach and service coordination	9 (1%)	4 (1%)	5 (2%)
Lack of shopping options	8 (1%)	7 (1%)	1 (<1%)
Stress	7 (1%)	6 (1%)	1 (<1%)
Being away from family/loneliness/insecurity	7 (1%)	1 (<1%)	6 (3%)
Other	33 (4%)	24 (4%)	9 (4%)
Missing	130 (16%)	78 (14%)	52 (22%)
Total Respondents	793	558	235

Identified Health Needs/Problems

To determine the community's perspectives about health priorities, respondents were asked to identify the 3 most important health needs for people in Napa County. The identified needs were categorized into 8 main topics for analysis; the subcategories provide examples of the types of needs described. Although there is a certain amount of overlap among some of the categories, it was beneficial to segregate these items to show specificity and detail. Nearly half (47%) of the respondents noted a need for additional more access to affordable health services (which included the response "insurance") as the top issue, followed closely (42%) by needs related to food, from

affordability to dietary habits (Table 70). Slightly over one-third cited "lifestyle" needs such as exercise.

Table 70. Top Health Needs/Problems Identified in Napa County, Community Survey*

Health Need/Problem	n	Percent
Health Services/Health Care	**374**	**47%**
Affordable and available health services	223	28%
Health insurance	153	19%
Affordable and available dental care	91	11%
Mental health services	54	7%
Home-based services	11	1%
Vision services	6	1%
Food/Nutrition/Weight	**330**	**42%**
Better nutrition and nutrition education	195	25%
Weight management/weight loss/obesity	110	14%
Affordable and available healthy foods	47	6%
Lifestyle	**274**	**35%**
More physical activity/exercise	225	28%
Lower stress	52	7%
Better self-care (personal hygiene, personal needs)	40	5%
More sleep	19	2%
Other Needs	**182**	**23%**
Affordable/acceptable housing	33	4%
Employment	32	4%
Social support/cultural support	28	4%
Clean environment	24	3%
Transportation	24	3%
Basic needs (food, clothing, shelter/warmth)	15	2%
Spiritual support/more faith	10	1%
Other	51	6%
Alcohol, Drug and Tobacco Use, Abuse, and Treatment	**127**	**16%**
Alcohol	67	8%
Drugs	55	7%
Tobacco	48	6%
Addiction/not specified	5	1%

Table continues on next page

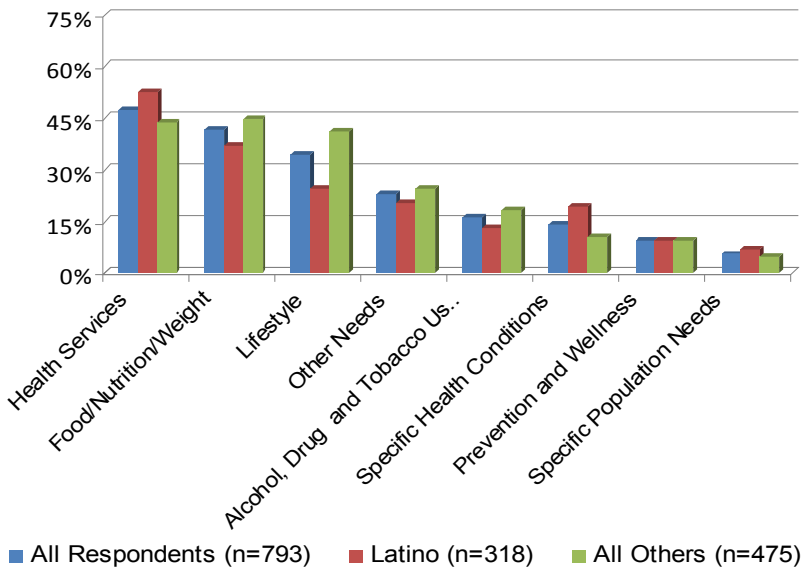
* Note: the sample size (n) for the bolded category headings is the number of respondents who had at least one response in the category. Respondents may have indicated more than one need in the category. The percentages of the subcategories are based on the total number of survey respondents (n=793), and do not add up to the main category percentage due to multiple responses with a category.

Specific Health Conditions	**111**	**14%**
Diabetes	53	7%
Cancer/cancer prevention	34	4%
High blood pressure/cardiac issues	18	2%
Allergies	17	2%
Depression	15	2%
Other health conditions (asthma, lupus, AIDS, autism, cholesterol)	42	5%
Prevention and Wellness	**75**	**9%**
Health education	42	5%
Prevention and wellness services (including preventive screenings)	38	5%
Information about services available/outreach	19	2%
Specific Population Needs	**44**	**6%**
Aging/support for seniors	18	2%
Programs for youth	16	2%
Information/services in Spanish, language barriers	13	2%
Missing	84	11%
Total respondents	793	100%

Identified Health Needs by Groups

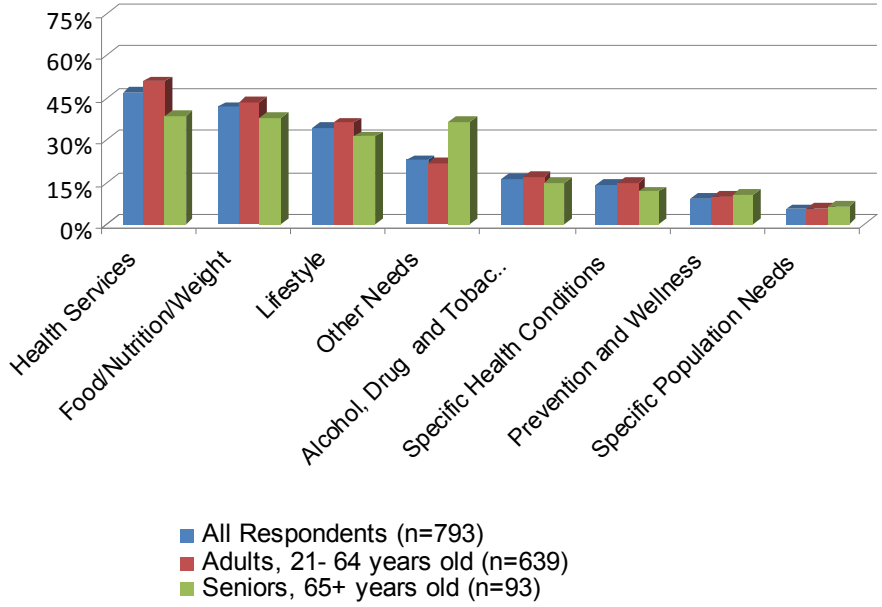
The data were analyzed to see how the identified top health needs varied by ethnic group, age group and self-reported health status. (See Tables A.1-3 in Appendices for detailed comparison data.) Respondents who identified as Latino were more likely to report a need for dental care, 17% vs. 8%, and health insurance, 25% vs. 15% (both shown under “health services” in the graph), and diabetes care (shown under “specific health conditions”), 14% vs. 2%, than non-Latinos. Latino respondents were less likely to report a need for better nutrition/ nutrition information, 18% vs. 29%, and exercise (lifestyle), 18% vs. 35% (Figure 33 on the next page).

Figure 33. Health Needs by Ethnicity



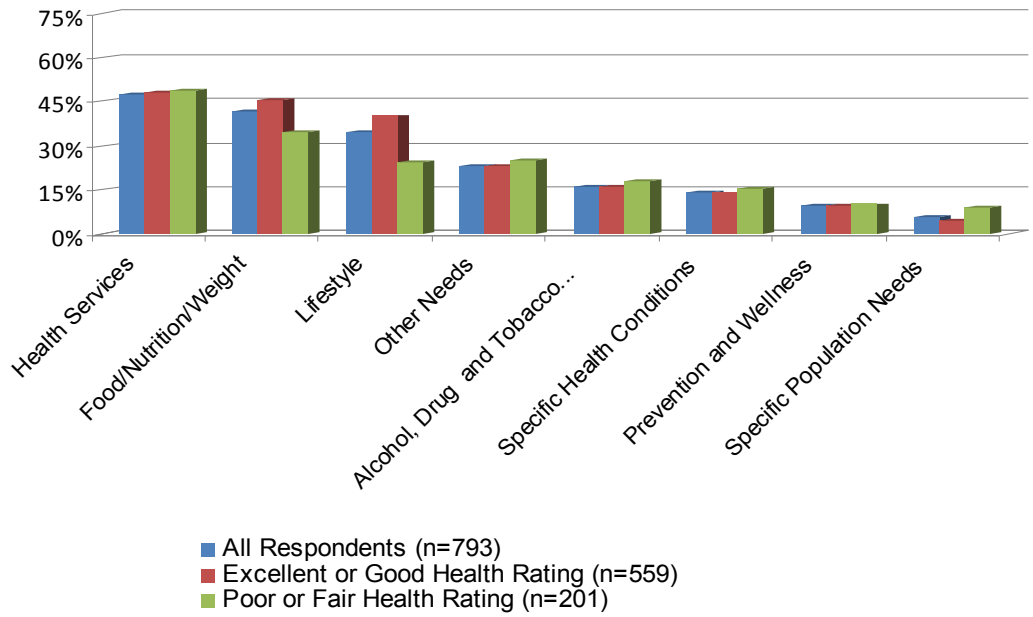
As shown in Figure 34, seniors were more likely than adults to report a need for transportation (shown as "other needs"), 10% vs. 2%, and less likely to report a need for dental care ("health services"), 4% vs. 13%, and health insurance ("health services"), 14% vs. 21%, and stress reduction ("lifestyle"), 0% vs. 8%.

Figure 34. Health Needs by Age Group



When identified priority health needs were analyzed by self-reported health status, generally those in “Fair” or “Poor” health were more likely to report a need for diabetes care, 11% vs. 5% (Figure 35), and less likely to report a need for better nutrition and nutrition education (“food/nutrition/weight”), 19% vs. 28%, and exercise (“lifestyle”), 18% vs. 34%.

Figure 35. Health Needs by Self-Reported Health Status



Access-Related Problems When in Need of Health Care

Respondents were asked to state whether any of a list of common barriers was “usually a problem” when they or their family needed medical/dental care. As shown in Table 71 on the next page, 44% reported it was usually a problem to find affordable health care. One-third or more also found it to be a frequent problem finding convenient office hours, taking time off work without the fear of losing pay, and locating a provider to accept their form of insurance. Overall, the other barriers were less often a problem, but reported by 15%-18% of respondents; 19% reported that none of the items was a usual problem.

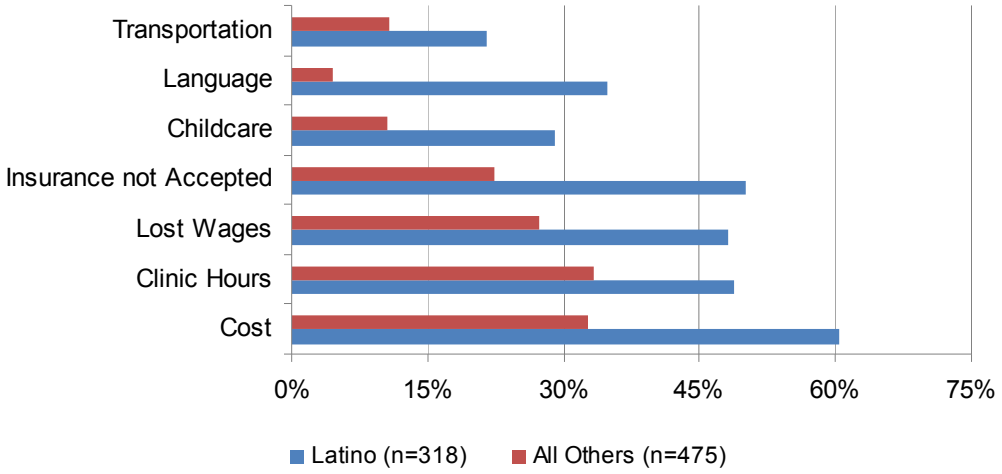
Table 71. Problems Usually Experienced When in Need of Health Care, Community Survey

Item	Usually a Barrier?	
	Yes	No
Finding somewhere that offers free or reduced-cost services	347 (44%)	297 (37%)
Finding an office or clinic that's open when I'm not working	313 (39%)	290 (37%)
The ability to take off work when I/my family is sick, without losing pay	283 (36%)	320 (40%)
Finding someone who takes my insurance (including Medi-Cal)	265 (33%)	356 (45%)
Childcare	142 (18%)	462 (58%)
Finding a place where they speak my language	132 (17%)	481 (61%)
Transportation	119 (15%)	484 (61%)
None of these are barriers	153 (19%)	
No Response	50 (6%)	
Total Respondents	793 (100%)	

Barriers and Ethnicity

When the data were analyzed by ethnicity, it was clear those respondents who identified as Latino experienced far more barriers overall than the rest of the respondents. Only 6% of the Latino respondents reported no barriers compared to 28% of the other respondents (Figure 36). Similar to all respondents, affordability and insurance coverage posed the greatest barriers to Latino respondents.

Figure 36. Access Barriers by Ethnicity



Analysis of Other Barriers

Because results for 2 of the barrier items raised particular interest for certain groups, childcare as a barrier was analyzed by age group, and transportation as a barrier was analyzed by city location to look for differences. (Of the total respondents, only 15% reported that transportation and 18% reported that childcare were usually barriers.)

When childcare was analyzed by age group, 14% of individuals less than 21 years of age, and 21% of those between 21-64 years of age, reported that childcare was usually a problem. Of interest, a small percentage (6%) of seniors (age 65+)—possibly those raising grandchildren—also indicated that childcare was a problem.

When transportation was analyzed by location, those who lived in American Canyon or Upvalley were most likely to note that transportation was usually a problem when seeking health care. Overall, 15% of respondents noted that transportation was a concern, compared to 25% of those who indicated they live in American Canyon, 22% of those who live Upvalley, and 13% who live in Napa/Yountville. (The total sample from American Canyon, as has been noted, is small and may not be representative.)

Ideas to Help Improve the Health of People in Napa County

Individuals were asked choose and rank 3 ideas from a list for improving the health of people who live in Napa County (a write-in for "other" was also provided). Although many of the respondents prioritized the ideas as requested, others put a check mark by the category but did not indicate a ranking. Consistent with the identified needs and reported barriers, respondents ranked the need for "more affordable health insurance" as a first priority (Table 72). When combined with the category "more medical care"—which the Collaborative believed was an important distinction from "affordable insurance"—one-third (32%) of respondents indicated those ideas as the top priority. (See Table A-4 in the Appendices for the full table of the 1st, 2nd, and 3rd priority rankings.)

Table 72. Prioritized Ideas to Improve Health in Napa County, Community Survey (n=793)

Ideas to Improve Health	First Priority	
	n	%
More affordable health insurance	173	22%
More access to affordable wellness type centers and services	119	15%
More affordable medical care	80	10%
More year-round activities for youth	46	6%
More efforts to have a cleaner environment (air, water….)	43	5%
More low-cost mental health/counseling services	41	5%
More support services for the homebound and frail elderly	32	4%
More affordable dental care	21	3%

Table continues on next page

Ideas to Improve Health	First Priority	
	n	%
More public transportation options	19	2%
Other	6	1%
Housing	*1*	*0%*
Alcohol, Drug And Smoking Services	*1*	*0%*
Activities/Exercise For All Ages	*1*	*0%*
Healthy Food/Nutrition	*0*	*0%*
Jobs	*0*	*0%*
"All Of The Above"	*0*	*0%*
Other (Only One Respondent)	*0*	*0%*
Missing		

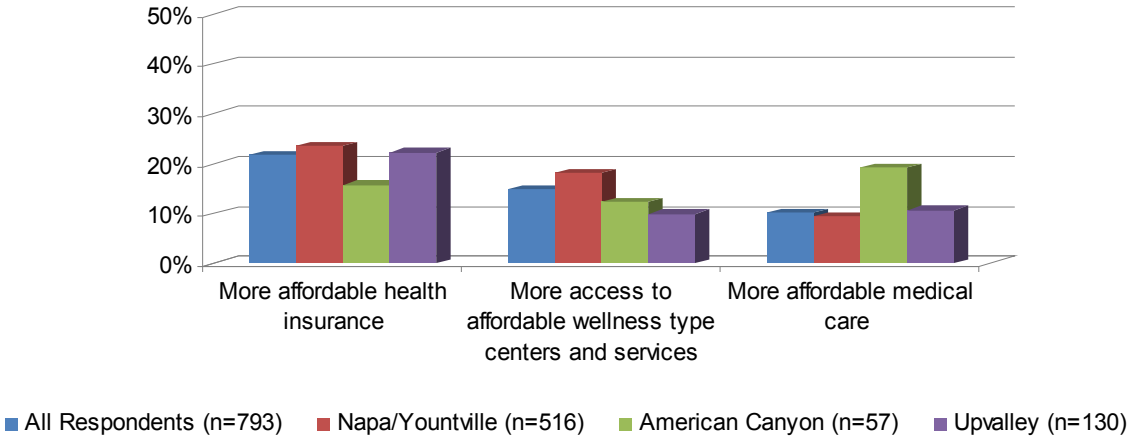
Note: Some respondents checked "Other" without writing in the idea for improving health.

To aid in local planning, ideas for improving residents' health were also analyzed by respondents' location to identify how priorities vary up and down the valley. For purpose of analysis, the locations were grouped into American Canyon; Napa/Yountville; and Upvalley (comprised of Angwin, St. Helena and Calistoga, Pope Valley, Deer Park, Rutherford and Oakville). It is important to remember that the population of survey respondents likely is not representative of the population of these areas. This is particularly true for those areas, such as American Canyon, from which the sample size was small.

Although the overall priorities for the geographic areas are the same, the order of the priorities changed. All 3 communities chose the same ideas: health insurance, medical care and wellness services. In American Canyon, more affordable medical care was the top priority.[235] In Napa/ Yountville and Upvalley, the need for health insurance was the first priority. Napa/Yountville respondents were also more likely to prioritize more access to affordable wellness center services and activities. The overall responses for "First Priority" items are compared in Figure 37 on the next page.

[235] As described earlier, the consumer survey used a convenience sample (i.e., people who volunteered to complete a questionnaire). Because relatively few people from American Canyon participated, these results may not be reflective of those who live in that area.

Figure. 37 Ideas to Improve Health In Napa County by Location



COMMUNITY FOCUS GROUPS

Characteristics of the Sample

A total of 113 individuals attended one the 9 community focus groups. (The numbering of the groups in Table 73 relates to the findings presented in subsequent tables.) While no one group is representative of Napa Valley residents, *in the aggregate* there was substantial diversity across the groups. With the exception of American Canyon—because attendance there was so low—the focus groups drew participants from throughout the county. The majority were Latino—some with limited English-speaking ability—with the remainder predominantly White, non-Latino. Women and men were generally represented in equal numbers, and while the participants were typically 30-60 years of age, two groups also had a mixture of seniors and two were comprised mostly of older adolescents and young adults. Four of the focus groups were held at Family Resource Centers. Two of the groups were conducted in Spanish with a bicultural/bilingual facilitator.

Table 73. Community Focus Group Characteristics

City/Site		Characteristics	Primary Language	Participants
1	VOICES	Mixed race/ethnicity; youth	English	10
2	QVMC Wellness Center Therapeutic Writing Group	Mostly White; mostly seniors	English	11
3	McPherson Family Resource Center	Mostly Latino; mostly adults	Spanish	14
4	St. Helena Family Resource Center	Mostly Latino; mostly adults	Spanish	11
5	New Beginnings	Mostly Latino; pregnant or parenting teens	English	19
6	Napa Senior Center	Mostly white; mixed adults and seniors	English	21
7	American Canyon Family Resource Center	Mixed race/ethnicity; adults	English	6
8	Calistoga Family Center	Mostly Latino; mostly adults	English	9
9	QVMC Latino Advisory Council	Mostly Latino and White; mostly adults	English	12
Total				113

Most-Commonly Identified Health Needs/Problems

The participants were asked to identify unmet/under-met health needs or problems "most important to people in Napa County." They were encouraged to think of needs from the perspective that not all health *problems* are associated with *unmet needs* and of health in broad terms and not as "medical" needs only. Participants were not asked to prioritize or rank the needs once they were identified. Table 74 displays the health needs or problems focus group participants identified.

It will be clear from these data that although the facilitator did not limit the participants in identifying needs, but attempted to draw them out and occasionally prompt them with additional questions, some groups chose to focus on fewer needs and issues than other groups. While the participants were asked to think broadly about all Napa County residents, it was common for people to focus predominantly on needs and issues most familiar to them or typical of their own neighborhoods and age groups.

Table 74. Health Needs/Problems Identified by Focus Group Participants

The need for….	Focus Group #								
	1	2	3	4	5	6	7	8	9
Dental services, especially for adults/seniors	X	X	X	X	X	X	X	X	X
Access to health services due to financial reasons (e.g., co-pay, no insurance)		X	X	X	X	X		X	X
Mental health issues (e.g., stress, depression)	X	X				X	X	X	X
Alcoholism and drug abuse services	X	X				X			X
Unawareness of type/location of available services/how to use		X		X		X		X	
Preventive health/wellness (e.g., affordable places to exercise)		X	X					X	
Healthy affordable food/need to "eat right"			X			X			X
Access to health care services (all reasons but financial, e.g., no specialists)				X					X
Vision and hearing services for seniors		X				X			
Jail services (primarily medical and mental health)	X					X			
Sex education ("start earlier")	X								
Transportation									X
In-home health care/adult day care									X
Inadequate # bilingual/bicultural health staff									X

X = the item was cited by the focus group. A blank space indicates the need or issue was not mentioned.

Focus Group Key:

1 VOICES
2 QVMC Wellness Center Therapeutic Writing Group
3 McPherson Family Resource Center
4 St. Helena Family Resource Center
5 New Beginnings
6 Napa Senior Center
7 American Canyon Family Resource Center
8 Calistoga Family Center
9 QVMC Latino Advisory Council

Access to Dental Services

Without exception, participants in every group identified the need for more affordable dental care. Generally, it was the first or second need mentioned, and there was strong concurrence by others in the group—from seniors to teens. In expressing concerns about cost, many shared that they neglected taking their families to a dentist due to lack of coverage. While the availability of community resources (Clinic Ole, QVMC mobile van) was acknowledged, it was noted that many of the services were limited in scope, eligibility (e.g., only for children), and availability of timely appointments. Some observed that preventive services were generally available but there was a need for more resources for adults who need extensive treatment. The "appalling condition" of some seniors' teeth "who can't even eat" because dental care was unaffordable was a sentiment echoed across several groups.

Access to Medical Care

Factors associated with access to medical care—due mostly to financial reasons, but including non-financial as well—were the second most frequently-cited health needs. Examples included not having insurance (ever or recently losing employment-based insurance due to job loss), not having affordable copayments, not being able to pay fees even based on a sliding fee scale, and not being able to find a specialist locally—either because they don't exist or don't accept Medi-Cal. A number of participants mentioned foregoing preventive services (exams, cancer screenings) due to cost concerns. One person shared that they were not able to seek treatment for cancer because they couldn't afford it.

Other access issues mentioned were waiting too long to *get* an appointment (in several groups it was said the wait at Clinic Ole was "about 6 weeks"), waiting too long *during* an appointment ("I sit for over an hour, but if I'm 5 minutes late the clinic cancels my appointment"), needing more specialists (e.g., geriatric specialists to treat the increasing numbers of seniors in Napa County) and, mentioned by only one group, needing more resources for transportation.

Services tailored to cultural/linguistic needs was infrequently mentioned, but some informative comments included people avoiding seeking health services because they "feel too ashamed" about not speaking English; being too busy with families to see health care as a high priority until it's an emergency; and not really knowing what they could/should be doing to live healthier lives.

Mental/Emotional Health

The mental health services most often described as being needed were related to "stress people are under now," anxiety, and depression. These concerns were discussed in reference to elderly people living alone and/or not being able to socialize because of transportation and personal issues, self esteem issues from loss of employment, and lack of ability to find any or any meaningful work.

Participants in several groups made the point that more "talk therapy" mental health resources were needed, not just medication. A number of people stated that "unless a person has severe mental problems they're never going to get services through the County."

Substance Abuse

Alcohol and drug-related issues—leading to alcoholism, DUIs, violence—were identified by participants across the age spectrum. When mentioned by youth participants, the needs were generally related to student drug use and the need for "alternative activities that teenagers can relate to." The impact of drug and alcohol abuse on the community, especially with regard to adolescents (e.g., "binge drinking at parties even when parents are in the next room," "kids abusing cough medicine and taking parents' prescriptions") was also described as a priority health concern. Some parent participants thought the schools were not vigilant enough in protecting children and law enforcement officials were not focusing more on the problem.

Lack of Awareness of Services

About as many participants believed most people "know where they can go when they need help whether or not they choose to go" as thought people were "generally unaware of resources and how to access them." Comments related to the former included believing the array of services were "confusing" or "fragmented" and "too many trains all going in different directions;" those who didn't think most people were unaware made comments such as "people know where to start; they just don't do it."

Lack of Preventive Health Lifestyle and Healthy Food/Eating Right

Food was a common theme among those who mentioned the need for people to take better care of themselves—to focus more on prevention. Many participants felt that families and individuals were not eating healthy, nutritious food—some blaming it on "junk food" in the schools; parents too busy with work to cook well or pack healthy lunches for their children; lack of awareness of the importance of eating properly to avoid or reduce health problems; and, unwillingness of some to change their eating habits. Childhood and adult obesity from improper nutrition and lack of adequate physical activity was a commonly-mentioned problem. Of particular mention was diabetes, especially relevant for the Latino community and seniors. Issues of prevention, education and self-management of chronic disease were referred to in the context of healthy eating.

Compared to the prior needs assessment, when having access to a wellness-type center was identified by a majority of the focus groups as the overwhelming priority prevention need, the need for more affordable exercise sites was mentioned as a distance second to the prevention theme of "eating right." Nevertheless, 3 of the groups identified the need for "safer places to walk/run" and "more physical activities for children."

Relative to lifestyle choices, several participants acknowledged "sometimes we just choose to do things we know aren't healthy because they are fun."

Jail-Related Services

A range of health-related services—better medical and dental care and more mental health counseling—for incarcerated persons was identified by two focus groups of disparate ages: the mostly-seniors group and the all-youth group. Comments from the latter group included "there should be a minimum standard of care; we are human."

Services for Seniors

The lack of in-home services for seniors was mentioned by one of the focus groups. Caregiving is expensive whether it involves a family member quitting a job to care for an elderly relative or paying someone to come into the home; many seniors without the ability to find affordable care may be trying to live independently and care for themselves but suffering ill health and detrimental isolation as a consequence, according to the participants. The need for more adult day care services was also identified by another group as were the need for low-cost hearing and vision services.

Barriers to Use of Services

While there is an overlap, factors related to the health care system and to individuals' own personal barriers affect the use of health services and adoption of preventive health practices. Functions of the healthcare system such as not enough providers taking Medi-Cal or lack of interpreter services are examples of system or structural barriers. Personal factors that serve as barriers—which tend to be less concrete—include beliefs and attitudes about illness and wellness and fear of economic loss. Both types of barriers put people at risk for not getting the amount, type, quality and timeliness of the services they need.

To identify barriers, focus group participants were asked what "stood in the way" of seeking or obtaining needed services, either for themselves or people they knew.

System Barriers

In addition to the problems with getting appointments and long waits during office visits described above, other system or provider-related barriers that were mentioned or expanded upon included:

- Provider insensitivity to type of client, e.g., because of ethnic group, low-income, English learner, substance user, single mother (viewed as perceived prejudice).
- Provider disrespect. Participants in several groups cited examples of rudeness by health personnel, receptionists particularly.
- Services not widely available in all parts of the county.
- Not all medical specialties represented or inadequate supply.
- Limited transportation options ("it's available but only goes within the city limits").

Personal Factors as Barriers

The personal or user-side barriers that were cited by the groups included:

- The cost of care, including prescriptions.
- The absence of a personal support system (e.g., immigration status, loss of family and friends in aging).
- Lack of knowledge ("people not educated in prevention, only intervention").
- The inability to get time off from work (fears about job security, economic loss).
- Not having the money to pay for child care ("I have to bring along all my kids when I go to the doctor") as the reason for not seeking care or missing or being late for appointments.
- Fear and anxiety (e.g., going to the dentist). Program closing also increases the fear for some patients; they want to know if services will still be there later. Program changes can be unsettling for some clients.
- Substance abuse. Several participants spent time talking about the challenges of getting care as a drug addict. They understood the need to tell providers they were using, but also admitted they only sometimes mentioned it when seeking care. They understood this might impact their treatment plan as well as how they were treated. (Some admitted to being "high" when they went to their medical appointment.)
- Language barriers.
- Denial. Not accepting that there's a problem was brought up by several groups.

Things People Do to Keep Themselves Healthy

With an increasing recognition that people have responsibility for controlling their own health—including managing chronic disease—by incorporating effective ways of staying fit, we asked participants what they personally did to keep themselves healthy. To get people to think outside of the "medical norm"—which was generally the initial response—the facilitator prompted with questions such as "What about things you do to stay safe?" "What about other daily habits?" If the group did not address emotional/ mental/spiritual means, she also asked "And, what about maintaining good emotional health?" Table 75 on the next page lists the most common habits people mentioned, generally in order of mention; the "x" in the right-hand column signifies the item was referred to in at least half of the groups and/or really resonated with the members (for example when others gave a resounding "yes, that's right," indicating their agreement with the item).

The most common ways people mentioned for maintaining good personal health was trying to create a balance between eating right, exercising, and getting enough rest. Whenever these health habits were mentioned—and they were identified in every group with no prompting—participants described how hard it was to adopt such lifestyle behaviors, generally because other priorities such as work (employment/housework) and "stress" intervened. Nevertheless, it was clear that focus group members across the board were aware of the importance of making even simple lifestyle changes to feel better, have more energy, look better, and think better.

Table 75. Most Commonly Identified Health Habits for Maintaining Own Health, Focus Groups

Method	Indication of Importance[1]
Physical	
▪ Walk/jog	X
▪ Ride bicycle	X
▪ Try to eat right (more vegetables, less sugar, lean meat; low calories)	X
▪ Try to get enough sleep	Y
▪ Don't do drugs/drink too much/smoke	Y
▪ Join/go to gym; use workout video	Z
▪ Drink more water	Z
▪ Take vitamins	Z
▪ Brush teeth	Z
Safety	
▪ Wear seat belt	X
▪ Don't climb on chairs	Z
▪ Wear condoms	Z
▪ Lock doors at home/be alert to danger	Z
Mental/Emotional/Spiritual	
▪ Get involved in art/music/dancing	X
▪ Have good friends to talk to	Y
▪ Pray/meditate	Y
▪ Try to laugh a lot	Y
▪ Yoga	Y
▪ Find a purpose in living	Y
▪ Volunteer somewhere	Z
▪ Make time for family	Z
▪ Reflection/self-reflection	Z
▪ Only be around people who don't judge/are positive ("ignore drama")	Z
▪ Take a warm bath (to calm down)	Z
Other	
▪ Read a lot	Y
▪ Do "brain power" exercises/play games such as Scrabble, puzzles	Y
▪ Pamper self (massage, time for self)	Z
▪ Try to have good communication skills (be able to say what you want/need)	Z
▪ Take care of/have pets	Z
▪ Try to be around younger people (said by seniors)	Z
▪ Try not to fight around my kids	Z

[1]X = mentioned by about half or more of the groups; Y= mentioned by fewer than half the groups but with a very high degree of concurrence within the group; Z=mentioned by 1-3 groups.

Many people mentioned the value of living in the Napa Valley because of the contribution to personal health of the agreeable weather, supply of fresh fruits and vegetables, and a community that promotes no-/low-cost outdoor activities such as walking. A number of parents described using time with their children differently than they had in the past as a result of understanding healthier living from reading pamphlets and websites, attending health fairs, talking with health personnel, etc. Rather than watching TV, some said they took walks to the park, rode bicycles and played sports with their kids—as means of trying to promote more family time as well as exercise.

Interestingly, that while dental services had earlier been identified as a top need in every focus group and received strong concurrence by all of the members, the activity "brushing teeth" as a way of maintaining personal health was only mentioned in one focus group. This may suggest that many people do not understand the importance of oral health to a person's overall general health.

About half of the groups identified mental/emotional/spiritual activities for staying "fit" without prompting by the facilitator. The importance of external involvement—good friends, volunteering—as well as personal activities such as prayer and meditation, music, and art (alone or with others) were the most commonly mentioned.

Recommended Solutions and Other Ideas

Focus group participants were asked to make recommendations for "improving the health of people in the community," including suggestions about the kind of programs or services they would like to see added, expanded, or improved in Napa County. While most recommendations tied back to the identified needs, some did not. Table 76 that begins on this page lists the ideas and recommendations from each focus group that participants believed should be considered by community leaders, policymakers, and funders.

Table 76. Recommendations for Improving Community Health in Napa County

Idea/Solution	Focus Group #								
	1	2	3	4	5	6	7	8	9
Provide more **affordable health care** (health insurance for adults as well as children, lower sliding fee scales).	X		X	X				X	X
Access to **dental care** (more dentists to take Denti-Cal, low-cost adult services)	X		X				Y	X	X
Improve **school lunch** options/change menus to healthier food		X	X			X			X
Affordable **housing** (for all, for seniors, for youth transitioning from foster care)	X				X	Y	X		
Increase **health education and information** activities (especially for Spanish-speaking; sex education starting earlier and every year; prevention focused)		Y	X	X		Y			
Support more **affordable exercise options** (low-cost gyms; free bicycles	X	Y		Y					X
Support more **community-based mental health/counseling** services (e.g., for substance abuse, for parents in crisis)			X	X					X
Expand capacity of **Clinic Ole** (more sites, more open hours)		Y	Y			X			
Hire **bilingual/bicultural** health workers; offer **training in sensitivity** to cultural and socioeconomic differences	X		X	X					
Open/expand **food banks** (especially for people out of work); encourage community gardens	Y		Y			X			
Offer more **same-day health appointments** (various facilities identified)					X				Y
Build low-cost **family fun places** to promote more "wholesome" family together time (e.g., community swimming pool—mentioned x 2—miniature golf, bowling)	X	X							
Find ways to persuade more **MDs to accept Medi-Cal** patients							X		X
Create **more jobs** (especially for teens)					X				Y

Table continues on next page

Additional Ideas/Solutions (mentioned by only one group):

- Support for seniors to remain independent/in their homes
- Enforce curfew for teenagers
- Involve churches so clergy are trained/can provide health information
- Reform nursing homes so that more MDs and RNs are utilized
- Take more measures to protect the environment (e.g., decrease pesticides)
- Put more lighting in local parks
- Require all young children to be in preschool
- Provide cooking classes to demonstrate healthier ways of eating familiar foods
- Support more after-school programs
- Support clubs where older teens can relate

X = The recommendation was mentioned and appeared to really resonate with the group. Y = The recommendation was mentioned by the group. A blank space indicates the idea was not mentioned.

Focus Group Key:

1 VOICES
2 QVMC Wellness Center Therapeutic Writing Group
3 McPherson Family Resource Center
4 St. Helena Family Resource Center
5 New Beginnings
6 Napa Senior Center
7 American Canyon Family Resource Center
8 Calistoga Family Center
9 QVMC Latino Advisory Council

The most commonly-recommended idea for improving community health was better access to affordable medical services. It is noteworthy that unlike the 2007 needs assessment, the need for these services in American Canyon—which was suggested by participants countywide—was rarely referred to in the current assessment. (The low attendance at the 2010 American Canyon focus group likely impacted this finding.) Specific ideas included making health insurance available to all and setting fees on a more liberal sliding scale. The availability of coverage anticipated from recent national health reform legislation was seldom brought up. In several of the discussions, the need for better customer services was noted. Recommendations along the lines of "Hire nicer people who would be polite to patients, not ignore them and keep doing their own thing" were made (not specific to any one ethnic or age group).

Consistent with the repeated identification of dental care needs, at least half of the groups suggested making more no/low cost dental services available, particularly for adults and seniors who now have been excluded from Medi-Cal dental benefits.

Preventive health recommendations included nutrition education programs ("to deal with diabetes") and affordable opportunities for physical activity such as low-cost gyms and wellness centers (which would also offer an opportunity for socializing for groups such as seniors).

Improving school menus as an idea really resonated with the groups that addressed this recommendation. Participants expressed "disgust" at the type and quality of food "that passes for school lunch." The "pizza, hamburgers and fries" were typically "cold and

hard" according to some of the participants. They suggested the community become more involved with school administrators by volunteering to help plant gardens, share produce from local fields, etc. They believed that feeding children "right" from an early age was critical to their development and success in school/life.

As aware as some people believed most residents to be about ways to improve health and where to access services, more health education and information was recommended by about half of the groups, particularly for Latino families. As noted in the table above, this suggestion was one with strong concurrence with the Spanish-only focus groups.

Also of importance in the Spanish-only groups were the ideas of making more community-based counseling/mental health services available (especially to "help parents with their children") and, as would be expected, the recommendation that health providers (Queen of the Valley was mentioned several times) hire more bilingual/ bicultural staff. At the same time, the thought was expressed by two focus groups that residents needed to learn to speak English because otherwise it creates a barrier to getting to know one another; as one person expressed it, "because not speaking it creates an 'us vs. them' situation which is negative for the community."

Other comments of interest include:

- "Promote anything that keeps kids in school and advancing; education makes for a healthier community."
- "I can't afford to get a root canal; it's cheaper to wait until it [the tooth] has to be pulled."
- "I want to be a good example for my children; I want to learn how to be a good role model and help them live healthier lives."
- "I'm just too busy taking care of my kids, making dinner for my husband, to focus on how to stay healthy."

KEY INFORMANT INTERVIEWS

Characteristics of the Sample

Twenty of the 24 (83%) individuals identified as key informants and contacted by email agreed to participate in an interview. Follow up emails and telephone calls were made to non respondents to encourage their participation. Attachment 7 lists the key informants who completed an interview. The interviewees represented a broad cross-section of the Napa County health and human service community that, in addition to health care professionals and leaders from public and community-based organizations, included policy makers, advocates, and individuals with a broad perspective about unmet health needs. While most of the interviewees spoke to the issues they knew best from their professional roles, the majority were also able to consider and describe additional health-related needs when prompted with questions to help them think about geographical, age, gender, race/ethnicity, and other factors that influence community health and access to services.

Familiarity with Prior Needs Assessment

Very few key informants were aware of the previous (2007) community health needs assessment when asked about this, and could not remember whether they'd ever seen a copy of the report.* (Because the interviewees represented a diversity of job functions, it may be that people in administrative positions were less exposed to the report than people in more direct program positions.) The most frequent use of the document, for those who were familiar with it, was as a "comprehensive resource for up-to-date data" when applying for grants and justifying the need. One individual said he also used it "to fine-tune his agency's outreach efforts."

About one-quarter of the individuals were able to comment on the extent to which they thought the 2007 priorities (when reminded what they were) had been implemented in the county. Three interviewees cited as evidence "an increased focus across the board on prevention," and two others mentioned Queen of the Valley's wellness programs and children's mobile dental services, and the Napa County Office of Education teen substance abuse program as tied to the prior set of priorities. Another individual believed there had been "subtle but important changes in some community-based organizations."

Notably, the County believed the results of the last countywide needs assessment "completely permeated the community," and described how Health & Human Services Agency (HHSA) correlated the assessment findings to services in every division,

* Note: the 2007 needs assessment report was widely circulated and a copy was posted on the County's and others' websites for many months following its presentation to the Napa County Board of Supervisors in January 2008.

including keying the internal strategic plan to the needs assessment findings. Examples included co-training of staff, increased collaboration between Alcohol and Drug and Public Health, and co-location of services with community partners such as siting Clinic Ole on the HHSA campus to better integrate behavioral health and primary care. Two individuals remarked that Napa had "gone backwards" in some of the priority areas but it was due to State funding reductions; elimination of Medi-Cal adult/seniors dental care was one example referred to.

Unique Characteristics Affecting Health

In every community there are unique factors or characteristics that contribute to health and well being or that threaten good health. The key informants were asked what distinctive characteristics about Napa County play a part in promoting or protecting health or in undermining it. The perceived positive community characteristics they identified are assets that should be "exploited" or maximized in community health improvement efforts. Conversely, the perceived negative characteristics or challenges are important for organizations and advocates to address and work around when they can't be modified or eliminated.

Supportive Factors

The natural beauty and favorable climate of Napa County were widely recognized by key informants as being important contributors to positive health and well being. Similar to respondents to the community survey, key informants cited environmental factors most commonly, such as those shown in Table 77 on the next page, as encouraging exercise (especially walking for seniors) and other healthful outdoor activities such as bicycling. The presence of open spaces and bike trails were referred to by several interviewees.

Many people also commented on characteristics that are intangible "but acknowledged by everyone." These included "the emphasis on healthful living" and "a culture of leisurely lifestyle"—even, it was said, for those who work long hours, more than one job, toil in the sun—because of the bounty of fresh produce many people have access to, a focus on "unwinding at the end of the day with a glass of wine," and community harvest festivals, bikathons, and other health oriented events.

Relative to population size, one individual summed it up as Napa County being "big enough to have an infrastructure but small enough to be close knit and watch out for one another."

Table 77. Perceived Positive Health Attributes of Napa County by Frequency of Mention, Key Informants

Environmental Factors

- Good climate encourages outdoor activities
- Natural beauty conducive to tranquility
- Plenty of open spaces, including parks; bike trails
- Slower (i.e., manageable) pace of life/leisure lifestyle
- Not overly crowded
- Relatively clean air (little pollution)/less water contamination
- Fewer people who smoke*
- "Resort destination" makes even locals feel relaxed

Other Factors

- Wealth of high-quality resources (for meeting people's needs)
- Close network of agencies; supportive, not competitive
- Low fast-food-to-population ratio compared to other places
- Availability of fresh produce/farmer's markets
- Relatively low gang activity
- Availability of funds from wine auctions to support services and programs

*However, smoking by vineyard workers was mentioned later as a specific concern.

As in the 2007 assessment, the collaborative nature of the county's non profits and other agencies was acknowledged as important to improving health. The benefits of such collaboration were described as including better coordination/less redundancy of services, more cooperation in seeking grants, and more working together to identify and reach populations in need. Turf issues and competition were said to be minimal.

In the same way, a number of individuals commented on "the tradition of caring" of those in Napa County. One key informant believed that "Napa County comes together for its own; we're very close knit," while another commented on generosity and said "people are very giving of themselves." (A couple of interviewees who acknowledged personal generosity suggested people gave to certain causes "partly to keep the undesirables out of the way.")

The county's diversity was seen by a couple of interviewees as adding to the overall quality of living in Napa County. As one person expressed, "the undocumented population is not seen as a negative—it's seen as a contributing segment of society."

Harmful Factors

The "alcohol culture" as a "big detractor" that "sends a mixed message to youth" was the main negative attribute of Napa County according to nearly all (80%) of the key informants who commented on this question. These interviewees believed the acceptance and prevalence of alcohol use in general (note: *wine* was not always specifically mentioned in this context), and the perception of "encouragement to drink

wine wherever you go" and messaging of "how to spend your day" was generally harmful to health and challenged health promotion efforts. Some of these individuals felt it was important, however, to point out they themselves enjoyed "a glass or two of wine socially" and were not "against drinking." A couple of interviewees commented that normalizing drinking behavior for children and youth and making it part of the culture contributed to adolescent risk behaviors, such as higher-than average rates of juvenile arrests for alcohol-related offenses and underage binge drinking.

Table 78. Perceived Health Detriments of Napa County by Frequency of Mention, Key Informants

- "Alcohol culture" and related issues
- Tourism-created hazards (e.g., traffic congestion, DUIs)
- Towns spread far apart/pockets of isolation
- Crop dusting; fertilizers; high diesel particulates in vineyards
- Not enough providers and others who are bilingual
- No mass transit/car-centric
- Poor-quality/inadequate sidewalks
- High cost of living

Other negative attributes mentioned included the "mixed blessing" of tourists and the geographical spread of the county that creates barriers and makes it difficult to access services. According to a couple of interviewees, the "food and wine environment" underexposed the fact that there are a substantial number of poor people living in Napa County. A related characteristic believed to challenge community health was said to be the high cost of living ("it's expensive to be healthy in Napa County"). Physical environment attributes included concerns about fertilizers and other agricultural products, and poor-quality sidewalks that some believed might contribute to Napa County's higher-than-average seniors fall rate. Issues related to language and acculturation were mentioned by one key informant.

Identified Needs

The interviews with key informants yielded fairly consistent results with the community survey and focus group responses relative to the type of top health needs identified. Because the 18 needs and gaps mentioned covered a wide range of issues, some were only identified by few interviewees. However, 4 of the priority needs received mention by more than one-third of the group. These included: community-based mental health services (mentioned by 50%); inadequate health insurance coverage; lack of dental care; and inadequate exercise/obesity (Table 79 on the next page). It is worth noting that the first three issues were also the top-ranking concerns in the 2007 community health needs assessment.

Table 79. Top Health-Related Needs Identified by Key Informants (n=20)

Need/Problem	Frequency of Mention
Mental/emotional health (e.g., resources for counseling, parents in stress)	10
Health insurance coverage for un-/under-insured; access to health services	7
Dental (primarily seniors and other adults)	7
Inadequate exercise/obesity epidemic (including diabetes)	7
Supportive services for seniors (e.g., to remain independent)	6
Youth substance use/abuse (all substances, including alcohol)	4
Alcohol abuse/alcoholism (primarily aimed at adults)	3
Access to medical services for Medi-Cal beneficiaries due to few providers	2
Transportation to services	2
Basic necessity for food (e.g., for populations who can't afford "decent" food)	2
Teen pregnancy (including awareness that it *is* a problem)	2
Not enough activities for kids/youth (especially the type *they* find acceptable)	2
Homelessness	1
Workforce housing	1
Domestic violence	1
Foster kids transitioning out of system	1
Cultural/linguistically appropriate services	1
Improvements in the built environment	1

Mental Health

Community-based mental/emotional health services received the most attention as a serious community health need in Napa County. Half of the key informants cited this concern as a top need and generally described it in terms of *gaps in service* as opposed to mental conditions. Mental health-related services were described in short supply even for those with health insurance. Observations included the lack of adequate family therapy, support groups, and school counselors. A number of key informants referred to increased levels of stress across the community due to the economic downturn and the need for even more counseling resources at this time; one remarked that "timely mental health services continue to be cut over the years." Several people commented on the County's elimination of community-based counseling for adults, and some believed the County's decision to retain more capacity for mental health services with its own professional staff was a way of retaining staff positions.

A number of interviewees described the mental health needs of specific populations. Within the broader context of citing "senior support services" as a high need, mental health services for those with feelings of isolation, depression and grief were given as examples. Three individuals observed a major shift in the last year or so, attributing it to the economy, in more "family issues"—parents and children "on edge;" kids acting out, teachers on overload. As one interviewee noted, "parents are in levels of anxiety that are not conducive to child-raising; they just don't have the same emotional energy. There are an insufficient number of resources to deal with these issues." Another observed that because there were too few counselors in youth authority law enforcement has "few choices for kids who act out or are involved in illegal activities."

The challenges associated with acculturation, such as non-English speaking parents feeling disconnected from children who can speak English, new residents trying to figure out how to make a place for themselves, fear of visibility, increasing feelings of socially isolation, were mentioned by two of the interviewees relative to the need for culturally and linguistically appropriate services.

Health Insurance/Access

The majority of the key informants acknowledged strides that have been made in improving health insurance coverage for children, as well as the availability of health services resources with a sliding fee scale such as Clinic Ole's. Nevertheless, various gaps were noted. Several individuals commented on the loss of employment-based insurance, and two observed that "many of the people we now see lining up [for health benefits] are the middle class." Two individuals specifically mentioned the inadequate number of private Medi-Cal providers in the community, and several commented on the insufficient number of various medical specialties. One person noted that recent health reform would not be helpful for the undocumented, and that it "may not help all that much to plug the holes [in the system]."

The interviewees generally believed that among age groups, adults and seniors experience the greatest extent of problems accessing services largely because of no insurance, poor coverage, and unawareness or confusion about eligibility. One individual acknowledged health disparities among ethnic groups. Notably, the need for more health services in American Canyon, which had been identified by a number of key informants in the 2007 needs assessment, was not specifically named in the present assessment. It is possible this area was alluded to, however, in the mention of the need for better geographical access.

Dental Services

Dental-related needs were generally expressed by key informants as access issues and service gaps, along the same lines as their concerns about medical needs, rather than observations about the extent of dental disease. Needs related to adults/seniors were cited most frequently, probably because of the recent elimination of Medi-Cal adult dental services. The interviewees did not offer specific details about oral health conditions except to comment, in one case, on the effects of seniors not having dentures because of cost; for example, difficulty in eating and social isolation due to embarrassment.

Exercise/Healthy Lifestyle

Lack of exercise and the growing epidemic of obesity also received a good deal of attention; these concerns were generally combined with mention of other problems associated with not adopting a preventive health/healthy lifestyle such as poor nutrition and diabetes. A few of the key informants felt inadequate exercise was largely due to the lack of availability, e.g., an inability to participate because of the cost of gym membership. Populations of concern included low-income families, Latinos, and the

elderly. One individual identified the "desk bound white population" as among those groups that needed more encouragement to exercise.

Support Services for Seniors

Although key informants were not asked to focus on any particular population, 6 of the interviewees specifically mentioned the need for "support services for seniors." The needs identified primarily related to community-based support resources to live safely and independently and resources for activities for daily living (ADLs). The need for "navigation assistance" to help seniors find their way through the maze of various systems was also mentioned along with the need for more social opportunities (which would require additional transportation resources). One interviewee remarked that there was no safety net for older adult services and further observed the problem that all interventions are now on a voluntary basis. A couple of people also specifically commented on senior's poor nutritional status (for example, from living alone and being less inclined to fix proper meals) and its affect on a range of issues from lack of engagement with others to lack of interest in physical activities.

Youth Substance Use/Abuse

Most of the interviewees who identified youth substance abuse as a top priority concern also believed there was an important need to address "normalizing" alcohol use in Napa. A couple of individuals commented that there was "the expectation that people will drink" and felt the availability of alcohol use by parents at home "encouraged young people to adopt a drinking lifestyle before they were old enough to handle it." Two of the key informants remarked "we need candid conversations about this," and that "the community has to come to terms with kids drinking if we want a healthy community."

Suggested Solutions

The key informants were asked to identify the priority recommendations that would be the "most important for improving health in Napa County/best use of resources if you were 'in charge' and had the resources." The interviewees were generally consistent in suggesting ideas and solutions for future funding/policy changes that matched the priority problems and unmet needs they identified. They also suggested system improvement ideas (Table 80 on the next page). In some cases, overlapping recommendations are listed separately to emphasize varying ideas about similar suggestions.

Table 80. Strategies Key Informants Believe Should Receive Priority Funding Support (n=20)

Recommendations	Frequency of Mention
Regarding Programs and Services	
Increase mental health services provided in community agencies, especially for non critical	3
Expand mobile dental capacity; find a way to pay for some adult/seniors dental services	3
Address youth substance abuse (primarily address alcohol use)	3
Provide food to people through food banks and community/school gardens	3
Provide more in-home services to seniors (e.g., activities of daily living)	2
Provide a day program for people with chronic needs	2
Expand efforts that increase awareness of services (eligibility, location, hours of operation)	2
Support more places/type of programs that encourage exercise	2
Support prevention strategies that affect multiple health problems; holistic approach	2
Invest in earlier intervention in schools (e.g., exercise; good food choices; no bullying)	2
Increase capacity of community clinics (e.g., Clinic Ole); particularly for behavioral health	2
Subsidize health insurance premiums ("Children's Health Initiative is the model for this for kids")	1
Pay for prescriptions for low-income seniors	1
Support a social center for single agricultural workers ("there's nothing for them to do at night")	1
Regarding Funding and Other Operational Ideas and Efficiencies	
Look at redundant services, evaluate for effectiveness, consolidate	4
Make larger (and multi-year) grants that combine efforts	2
Generally fund only proven strategies/organizations that operate like a good business	1
Find ways to maximize the positives from health care reform opportunities to get most benefit	1
Explore the potential for a single point of entry for eligibility	1
Create a comprehensive coalition of providers who will adopt guidelines for systematic change	1

Mental Health

Ideas regarding mental health were generally focused on community-placed mental health counseling and family therapy for better family functioning ("help families learn to function in stressful times so they don't take it out on their kids…….so they can be better parents"). Specific recommendations included increasing capacity at community clinics (e.g., Clinic Ole) and co-locating counseling services in other community organization sites, including youth centers. More involvement by faith-based organizations (churches, temples, synagogues) was mentioned as being a valuable strategy "as long as it's not done judgmentally." Some made the point that mental health services were needed for "all populations," not just those that couldn't afford it, because of limited resources in Napa County.

Dental Services

Suggestions related to oral health mainly concerned subsidizing services for those who lacked insurance coverage. Because of the recent Medi-Cal cuts in the adult dental program, low-income adults and seniors were the primary focus; one interviewee who felt this should be a top priority for support remarked how "the state is shirking its responsibility" with regard to this population. A specific recommendation was to set aside funds specifically to support dentures for low-income seniors ("it would be a one-

time cost and funders/donors could certainly understand how these funds were being used").

Health Promotion/Prevention

Efforts that result in behavior change so that people make healthier choices and adopt healthier lifestyles were considered one of the most important areas for grant support. According to several of the key informants, more places/programs throughout the county that offered *affordable* exercise options for all ages—and a campaign to make people aware of them—were a best-use strategy. Ramping up physical education in the schools (particularly middle school and high school) and community-based physical activity opportunities (e.g., bikathons, swimming) for teenagers were also recommended. In keeping with the theme of preventive health, these and other interviewees also suggested efforts aimed at improving food choices—including *having* good food choices through high-quality donations at food banks and improved school menus and school gardens—would be a great benefit to the community in terms of addressing the chronic problems of diabetes and obesity.

Access to Health Care Services

Specific suggestions to improve access to health care services included:

- Develop and support a low-cost health insurance product for adults.
- Subsidize premiums for children since Healthy Families may be reduced.
- Increase the capacity of Clinic Ole for medical, dental and mental health.
- Support a subsidized program for prescription medications.

Related to *expanding* comprehensive services is the need to *inform* people about the services and how to access them, according to some of the key informants. About half of them, when asked, believed people did not know how to find the help they needed and would benefit by "a clearinghouse" or more direct ways of becoming informed; the other half thought people "generally know about" the availability of community resources regardless of the extent to which they utilized them. It was acknowledged that more recent immigrants and the Spanish-speaking were likely to be less aware.

Adolescent-Specific Recommendations

Nearly all of the interviewees who identified teen substance abuse as the top priority for funding referenced the problem of underage drinking and its potential effects—DUIs, vehicle crashes, addiction, teen pregnancy. "Candidly acknowledging our community's alcohol issues" was believed by two of the key informants to be a necessary first step before developing specific strategies to address it with youth. One interviewee suggested an effective strategy would be to address the problem with parents through the schools "because that's where parents are willing to hear it." At the same time, another interviewee noted that parents have less time to attend school meetings (and to spend with their children) because some who are employed are working more than one job because of the economy.

Another top prevention area that needs addressing, according to two interviewees, concerned teen pregnancy (intended as well as unintended). Their ideas were to better understand some of the issues before putting more resources into direct services, such as: what are the cultural drivers for and against it? What are the downstream consequences, including the consequences of the decision to get pregnant/have a child? Why is teenage childbearing "ok" in some cultures?—asking mothers and grandmothers this question.

Suggestions Specifically Related to Seniors

The recommendations made relative to seniors that were not mentioned within the context of the other suggestions included:

- Provide more services to seniors who cannot leave home—or leave easily—such as "friendly visitors" to help maintain socialization and those who could assist with activities of daily living for seniors to maintain independence.

- Provide a day program—optimally with transportation—for people with various chronic needs.

Organizational and Administrative Suggestions

Although the funding priorities question was not intended to elicit recommendations relative to health system or organizational improvements, several key informants volunteered ideas that "benefit the community" in a broader context. Promoting more partnering across agencies to reduce duplication was the main recommendation, although it was clearly acknowledged that consolidation of services may result in the loss of jobs "when there's cost savings." An example for the recommendation to create a coalition of providers who would adopt guidelines for systematic change was the county mental health system; it was said to be "ineffective and stuck in a model that doesn't work anymore."

CONCLUSIONS AND RECOMMENDATIONS FOR PRIORITY CONSIDERATION

"The funding streams for non-profits are so temperamental; the economic downturn has taken its toll on available grants."—Key Informant Interview

"It's a very unique community. We bed down the homeless every night but no one wants to hear this because we're all about tourism and good wine. "—Key Informant Interview

Physical health, mental health and social conditions are interrelated to the extent that they are dependent on each other and impact each other. For example, the public health approach to mental health includes working with individuals, communities and systems and focuses on prevention and health promotion. This includes promotion of behaviors and activities to enhance overall health and well-being and prevention activities that benefit everyone in the community.[236]

The inter-relatedness of various health conditions is not limited to mental health, though many mental health conditions are clearly chronic diseases that are associated with worse health outcomes (e.g., increased risk of myocardial infarction in people with depression).[237] Sometimes, one condition may pose a barrier to accessing or receiving optimal benefits from the health care delivery system (e.g., mental illness, physical or developmental disabilities). Similarly, oral health is linked with cardiovascular disease and emerging research shows it may influence perinatal outcomes.[238,239]

[236] Mental Health, Chronic Disease and Genomics. Minnesota Department of Health. http://www.health.state.mn.us.
[237] Guck TP, et al. Assessment and treatment of depression following myocardial infarction. *Am Fam Physician.* August 2001;64(4):641-648.
[238] Boggess KA, Edelstein B. Oral health in women during preconception and pregnancy: implications for birth outcomes and infant oral health. *Matern Child Health J.* 2006;10:S169–S174.
[239] Offenbacher S, et al. Effects of periodontal therapy on rate of preterm delivery. *Am J Obstet Gynecol.* September 2009;114(3):551-559.

Overall functional status depends on numerous factors, including general fitness, positive self-image and overall sense of well-being. Although health indicators are measured in separate categories, they are inherently interrelated and collectively result in what we experience as a state of health. Improving the health of the community depends on an effective healthcare system, but is also enhanced by the social infrastructure and services that are not traditionally recognized as serving healthcare needs.[240]

Traditionally, society has focused on improving population health primarily through health care delivery systems (e.g., clinics, hospitals). However, the need for broad partnerships involving other sectors—business, education, the media, public safety—is clear to build sustainable and effective efforts to improve community health. It has become increasingly important to identify modifiable environmental attributes that can be used in planning, policy, and practice; promoting walking, for instance, is a centerpiece of public health strategy for preventing chronic disease, because of its popularity and known health benefits.[241] Strong local leadership plays a significant role in forming cooperative partnerships that can maximize resources and build capacity in a community.[242]

The 2010 Napa County Community Health Needs Assessment—which adds to and updates information gathered in the 2007 assessment—represented a cooperative partnership. It identified challenges, such as the major health risk of obesity and dental needs of adults, and high-risk behaviors like drinking and driving, and identified trends on issues of special significance to Napa County, such as the markedly growing numbers of seniors. It also sheds light on opportunities for improving health concerns related to sociodemographic factors and disparities and the community's overall health status.

The extensive data—from primary as well as secondary sources—available from this assessment process supplements information collected by others and will be a valuable resource for future planning and grantseeking. The findings give the community a lot to act on over time. The community input findings should be especially useful for understanding residents' and professionals' perspectives about community health. While a diverse segment of the population was surveyed, the lower-than-hoped for proportion of Latinos and Spanish-speaking residents and residents from American Canyon in the Community Survey decreases the representativeness of the findings for these specific populations.

Certain findings were expected and supported the Collaborative's assumptions: the percentage of the adult population without health insurance, difficulties related to language barriers, rates of childhood asthma, and the extent to which the community depends on Clinic Ole as the primary safety net for the poor, to name a few. However, some findings *were* a surprise. On the positive side, these included high rates of

[240] Karen M. Tait, MD, Lake County Health Officer. Communication to the author. August 13, 2010.
[241] Sugiyama T, et al. Associations between recreational walking and attractiveness, size, and proximity of neighborhood open spaces. *Amer J Pub Health* September 2010;100(9):1752-1757.
[242] *The 2009 Report to the Secretary: Rural Health and Human Services Issues.* The National Advisory Committee on Rural Health and Human Services. April 2009

screening for breast and colorectal cancer, low rates of effects from pesticide use, the proportion of seniors who reported getting a flu shot, the relatively high percentage of children covered by health insurance, and community awareness about the value of healthy living. Among community participants there seemed to be even more of a sense of taking responsibility for one's own health than in the 2007 needs assessment. Another unanticipated though not necessarily surprising finding was the extent to which community leaders identified collaboration as a key factor about Napa County that influences health and well-being. The supportive relationships—from planning to delivering services—was widely recognized as facilitating the great amount of cooperation that exists among provider organizations and professionals in the county.

On the other side, the growing trend toward obesity among children and adults—mirroring state and national trends—was anticipated but the extent of the problem was unexpected. The extent that alcoholic liver disease contributes to the leading causes of premature death in Napa County was not an anticipated finding.

Anxiety and stress were troublingly common themes revealed through the surveys and focus groups conducted for this assessment, and supported in similar findings by others: parents worried about kids' drug use; teenagers and adults anxious about the lack of jobs; people fearful of losing their homes. Reviewing the published data in conjunction with the results of the community input not only created a better understanding of what the mental health needs are, but suggested that while the needs—created in part by the economic downturn—may be similar across the community; the difference is access to resources.

Unlike the previous community health needs assessment where cultural issues were frequently identified, very few of the participants mentioned factors such as social isolation related to the inability to speak English, the inability to interact with/relate to one's children who are learning English and becoming more a part of U.S. society, and feeling unsafe due to immigration issues. However, some of the participants had negative experiences with the direct care system and/or provider-related experiences due to racial and ethnic disparities.

However, acculturation has been studied in relation to prevalence of chronic illnesses, and indicates that certain aspects of lifestyle (e.g., dietary habits, patterns of physical activity) may affect the development of specific diseases. [243] Beliefs about causes, treatment, and prevention of illnesses, as well as barriers to access, may also affect the utilization of health services. Napa County's large numbers of Latinos, particularly resident and seasonal agricultural and hospitality service workers, presents a unique challenge to funders in Napa County in providing culturally and linguistically accessible mental health and primary care services in an increasingly diverse county.

[243] See, for example, Hazuda HP, Stern MP, Haffner SM: Acculturation and assimilation among Mexican Americans: scales and population-based data. Soc Sc Q. 1988;69:687-706. Solis JM, Marks G, Garcia M, Shelton D: Acculturation, access to care, and use of preventive services by Hispanics: Findings from HHANES 1982-84. *Am J Public Health* 1990;80 (Suppl):11-19. Hazuda HP, Haffner SM, Stern MP, Eifler, CW: Effects of acculturation and socioeconomic status on obesity and diabetes in Mexican Americans. *Amer J Epidemiology* 1988;128:1289-1301.

Napa County, like many other counties, has a significant issue with alcohol abuse. It is not at all clear that this is related to the wine industry. Rather, it is likely related to the inter-relatedness of poverty, family dynamics, mental health, and other complex issues. Specifically with regard to youth alcohol use, it is possible that in a culture where wine is a customary factor in dining experiences and the social culture, acceptance of such may have an indirect influence on youth behavior. This theme was mentioned as a top concern throughout the community input process. Parents' drinking behavior and favorable attitudes about drinking have been positively associated with adolescents' initiating and continuing drinking.[244] Although a minority of youth in Napa County reported using alcohol and binge drinking, higher than statewide averages of juvenile arrests for alcohol and drug offenses and youth alcohol-involved motor vehicle accidents suggest areas for community intervention. Additionally, considering the beverage-specific alcohol consumption by youths—hard liquor and beer being the likely choices—is important when developing alcohol-control policies.

Overall, Napa County does not look markedly different from other California counties with regard to many commonly examined indicators of illness and death. And because the morbidity and mortality data did not show that Napa County is strikingly different than other places, it allows the Collaborative to look more closely at what the community's needs and perspectives are from the vantage point of the community.

RECOMMENDED PRIORITIES

The Collaborative recognizes that while each organization represented among the workgroup will ultimately choose to fund or support community health interventions that are a best fit with its own mission and priorities, an important opportunity exists in Napa County for all health partners to collaboratively focus on the prioritity areas identified below, maximizing the potential for community impact. In a scenario with limited resources, the Collaborative believes these areas should receive highest-priority consideration for focusing resources on community investments.

Ideas about strategies and elements needed to successfully implement the priorities in Napa County—some based on model programs elsewhere—are offered below. Some of the listed strategies intentionally overlap to address multiple proboems. The lists are not intended to be exhaustive and certainly do not imply there aren't other ways to address these issues. Any strategies to be effective must take into account in their design the following factors:

- Personal factors (such as genetic, behavioral….)
- Service availability factors (such as resources, capacity….)
- Environmental factors (such as culture, policy….)

[244] See, for example, Andrews, J.A., et al. Parental influence on early adolescent substance use: Specific and nonspecific effects. *Journal of Early Adolescence* 13(3):285-310, 1993. Hawkins, J.D., et al. Exploring the effects of age of alcohol use initiation and psychosocial risk factors on subsequent alcohol misuse. *Journal of Studies on Alcohol* 58(5):280-290, 1997.

While health and human services organizations are expected to be key players in community health improvement, some of the solutions are likely to come from the non health community as well.

Please note there is no particular significance in the order of the following priorities.

Priority: The Growing Epidemic of Obesity

It is easy to see why obesity is on the rise in the U.S. when the problems of poor food choices and overeating are combined with the fact that childrens' and adults' lifestyles have become so sedentary. Studies show that many people who cite "eating plenty of fruits and vegetables and exercising regularly" as preventive strategies, while well-intentioned, are not necessarily more likely to practice them. *Making the healthy choice the easy choice should be the goal of programs and policies aimed at improving food and physical activity environments.* Recommendations to improve community health related to the priority of healthy eating and adequate exercise include the following elements:

- Physicians recognize obesity as a national health problem, but statistics show that only about half of obese Americans (but a lower proportion of Latino and Black patients) are advised about proper nutrition by their doctors. Studies have also found that while most doctors want to help patients lose weight and think it is their responsibility to do so, they often don't know what to say. Opportunities should be explored for physician education to understand the health impact of obesity and practical ways to incorporate patient education into busy practices.

- Examples of environmental change strategies include implementing school nutrition policies, planning communities in a way that increases walkability, safe places to bike (including a free bike program), and expanding access to fresh fruits and vegetables in neighborhoods. Environmental strategies are sustained through policy and systems change.

- Other food policy decisions that could be made include menu labeling ordinances.

- Community and school gardens help engage children and adults in healthier eating. Expanding the capacity of local food banks to offer high quality *fresh* produce sends the right message about freshness, and helps meet the basic needs of people impacted by the economy.

- School integration strategies, such as Queen of the Valley Medical Center's Healthy for Life Campaign, a comprehensive social and healthcare outreach initiative, can have a ripple effect of children putting pressure on their parents to adopt some of the ideas of the campaign.

- Overweight women are more likely to experience pregnancy and birth complications. Besides education about cutting out any habits that could be harmful to a baby,

preconception services (family planning clinics, for example) should also address achieving and maintaining a healthy weight before as well as during pregnancy.

- Creating policies and comfortable environments that encourage women to breastfeed would improve rates of breastfeeding, which can contribute to overweight and obesity prevention.

- Napa County's Children & Weight Coalition, formed in 2004, provides leadership for the community and serves as a resource for evidence-based strategies and projects that schools, families, and communities can do that promote children's health through sound nutrition and physical activity. For example, schools can model healthy eating and nutrition by offering only healthy breakfast, lunch and snacks, and removing unhealthy foods from vending machines and snack areas.

- Educational interventions should be directed at what it takes to get people to make long-term behavioral change (e.g., providing meaningful incentives), and be provided in places where people already meet or gather for other purposes.

Priority: Senior Support Services

The goal of senior support should be to provide senior citizens with a full range of services to help them stay healthy (mentally as well as physically), live independently, and maintain their dignity. Such programs should offer clients and their families compassionate, practical, economical, and legal-based solutions to successfully manage difficult life situations. Strategies that address this priority area should consider the following:

- The number of Napa County residents who will suffer functional disability due to chronic conditions of arthritis, stroke, diabetes, coronary artery disease, cancer, or cognitive impairment is expected to increase. Studies have shown that education and lifestyle changes—where seniors are taught how to better manage their symptoms, adhere to medication regimens, and maintain functional ability—can reduce disability, control costs, and have a positive influence on the quality of life.

- Remedies for social isolation blur the line between improving mental and physical health, and are especially needed for those who speak only Spanish to be able to interact with neighbors and others in the community. Similarly, more oppportunities should be explored for integrating services that address depression with medical services.

- Community gardens are an ideal opportunity for promoting social interaction as well as good nutrition. Involving seniors in school gardens encourages intergenerational engagement. Fitness and healthy eating are combined goals in the gardens planted and maintained by residents of retirement centers such as Silverado Orchards Retirement Community in St. Helena.

- Whenever projects are developed for seniors they need to address solutions for seniors transportation. While public transportation is economical, it can pose challenges for seniors; for instance, sight impairment, poor balance, and inability to tolerate waiting outdoors makes public transportation options infeasible.

- Siting programs where seniors are ("seniors neighborhoods," retirement centers, assisted living facilities) rather than where they have to travel to increases the likelihood that the most-frail will be able to participate.
- Community design policies often ignore the special needs of senior residents. For instance, an asssessment might be valuable to take into account pedestrian crossings in areas where more seniors live who may need a little extra time crossing the street.

- Caregivers are at increased risk of depression and other health problems as a result of the stress of being a caregiver. Respite services provide a support system to give families the break they need to care for a loved one who has a chronic illness or disability. Typical strategies include adult day programs and in-home companion services. Ideally, respite care should be preventive, rather than the result of a crisis.

Priority: Substance Abuse/Use

Substance use and abuse includes the use of legal (tobacco, alcohol, prescription drugs) and illegal substances, and ranges from use during pregnancy to underage drinking to abuse of prescription medications. The problem impacts individuals, families, schools, businesses, and the safety of the community. The stakes are especially high for young people: teens who make it to age 21 without smoking, using illegal drugs or abusing alcohol are unlikely to ever do so, research finds. Napa County, because of its primary industry, may have a higher burden to address youth alcohol use.

- Helping parents to talk with their kids about alcohol is one way to begin. The Catalyst Coalition, a grass-roots group of interested advocates in Napa County using their collaborative strength as a "catalyst" to address and combat youth substance abuse through a number of strategies, have produced such a publication for parents in English and Spanish.

- Social Host Ordinances[245] are an effective tool in helping to reduce the problem of underage drinking. Currently, Napa County has an ordinance to address youth access to alcohol on private property, but the ordinance is limited.

[245] A Social Host Accountability Ordinance holds accountable the host of a gathering where underage drinking is allowed to occur or gatherings that are loud or unruly. Anyone 18 years of age or older who hosts such a gathering will be subject to the ordinance and a fine. If the host of such a gathering is 17 years old or younger, the parents of that minor will be held jointly responsible with their teen and subject to a fine, even if they were not present or aware of the gathering.

- A brief intervention in the emergency department (ED) may help reduce violence and alcohol abuse among teens, suggesting an opportunity for training of local ED staff. According to research, teens who received a 35-minute brief intervention delivered either by computer or a therapist addressing violence and alcohol reported reductions in peer aggression, experience of violence and consequence of violence 3 months after the intervention, along with a big drop in alcohol consequences.

- Implementing more comprehensive local policies that prevent drinking and driving, encouraging enforcement of drinking and driving laws, and strengthening community support for efforts to reduce DUI are examples of essential policy strategies. The Napa County DUI Task Force is an example of an organization committed to these policy changes.

- Ongoing continuing education programs, particularly for middle school and high school students, such as "Every 15 Minutes," can be effective, preventive strategies. Importantly, educators need to remember in their program design there are profound differences in the adolescent brain that make youth developmentally incapable of always making good judgements.

- Non traditional advocates may in some cases have more influence on youth behaviors than parents. An accountability relationship with a mentoring adult (teacher, older relative), a caring athletic coach, or a "cool" clergymember may provide the necessary support system to resist peer pressure or influence whether a young person takes up smoking. Peer education approaches, such as the State's Too Good for Drugs (TGFD) curriculum, have been well received by middle school students as well as teachers and administrators.

- Prenatal care providers need more education about the long-term impact of early alcohol exposure (use during pregnancy) as well as exposures to other drugs. A well designed training program that offers continuing education units as an incentive could be made available and offered with relatively modest cost.

- Although some experts question the cause-and-effect relationship, alcohol and drug abuse can be a significant factor in domestic violence. Alcoholism, for instance, can spiral into a full-fledged "family disease," affecting many lives. Early identification, referral, and intervention with students and parents at risk, and community-wide communication campaigns to influence community norms about substance abuse and violence are key strategies. Additionally, policies that control the availability of alcohol, tobacco, other drugs, and weapons through pricing, deterrence, incentives for not using, and restrictions on availability and use are effective at preventing behaviors associated with these substances and weapons.

Priority: Mental and Emotional Health and Well Being

Creating a healthier community also involves efforts focused on promoting good mental health and positive social and emotional development. Opportunities to support community-based mental health efforts were spelled out in Napa County's Mental

Health Services Plan assessment, though recent government funding cutbacks have limited the County's capacity for serving non acute clients.

- The foundations of many mental health problems that endure through adulthood are established early in life through the interaction of genetic predispositions and sustained, stress-inducing experiences. Practitioners and policymakers should be provided this knowledge to motivate them to address mental health problems at their origins, rather than only when they become more serious later in life.

- Mental health services for adults would have broader impact if they routinely included attention to the needs of children as well—for example, an automatic assessment of any young children in the family to see how they are experiencing the emotional consequences of their parent's problems. This suggests closer coordination between mental health providers and medical providers, childcare providers, and schools, in compliance with privacy laws.

- Multigenerational, family-centered approaches offer promising models for preventing and treating mental health problems in young children. Suggested strategies can include providing information and support to address problematic child behavior, initiating therapeutic interventions to address significant parent mental health or substance abuse problems, end domestic violence, or help families to cope with the burdens of persistent poverty.

- To increase the likelihood of continuity and success, mental health services should be integrated into programs that provide direct healthcare services, such as Clinic Ole, or help people access a range of health and human services, such as Family Resource Centers. These programs work best if they're a cultural fit.

- More "talk therapy" opportunities are needed, not just prescribing of medication. There has been a 5-fold increase in the use of psychoactive drugs for children with behavioral or mental health problems, for example.

- Community, social, and faith-based organizations that typically don't address mental health issues could play a larger role for their members. So could people in "guidance" positions such as coordinator/managers of mobile home parks and apartments. Reaching out to leaders of those groups and making them aware of the extent of the community's concerns—for example, sharing the results of this community needs assessment—would be an important first step. A community education program about depression and how to talk about it is another example of a helpful strategy.

- Post partum depression[246] is the most common complication of childbearing. Often, the depression is not recognized or treated. Strategies such as the Welcome Every Baby perinatal home visiting program—which is open to parents of every new baby in the Napa Valley—should be widely publicized and supported. Napa County

[246] Actually, depression that occurs during pregnancy or within a year after delivery is called *perinatal* depression.

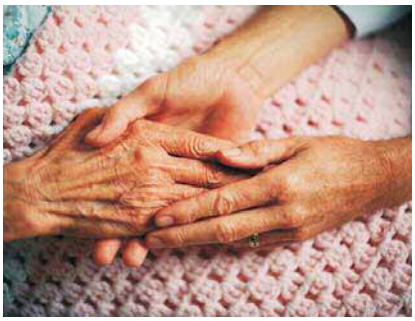
Public Health is the lead agency for the program; partners include Queen of the Valley Medical Center, St. Helena Hospital, COPE Family Center and Kaiser Clinic Napa.

- The number of veterans dealing with PTSD (Post Traumatic Stress Disorder) is staggering. A 2008 study found that 1 in 5 vets returning from Iraq and Afghanistan experience symptoms of PTSD or major depression. Even though the Veterans Affairs has resources to help, local providers should be aware of this phenomenon and that they may need to pick up some of the burden for service members and their families.

Additional Recommendations

One of the interesting findings from this assessment was that few of the key informants were aware of the original (2007) community health needs assessment and the priorities it laid out. Consequently, the Collaborative intends to ensure that the findings and recommendations from the current needs assessment are widely shared with the community—and tracked—so that awareness about the priorities and progress in implementing them will be high.

The Collaborative believes projects based in the community have the best opportunity to make a real difference in the health of individuals and their families and those providing care. Visions for future community support in all of the priority areas will require identifying suitable leadership, raising awareness of stakeholders and determining how to involve them, and agreeing in what areas and how each group will cooperate. Napa County is already paces ahead with its large network of non profits and reputation for collaborative working relationships.



ATTACHMENTS

ATTACHMENT 1

NAPA COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT COLLABORATIVE

(In Alphabetical Order)

Cynthia Verrett, Napa Solano Community Benefit Manager
Kaiser Permanente
Kaiser Foundation Health Plan

Dana Codron, R.N., Executive Director
Community Outreach
Queen of the Valley Medical Center

Donald Hitchcock, M.D., Medical Director
Community Outreach
Queen of the Valley Medical Center

Elizabeth Alessio, Coordinator
Community Benefits
Queen of the Valley Medical Center

Jennifer Henn, Ph.D., Epidemiologist
Napa County Public Health

Karen Smith, M.D., M.P.H., Public Health Officer
Napa County Public Health

Linda Schulz, M.S., Director, Community Services
St. Helena Hospital

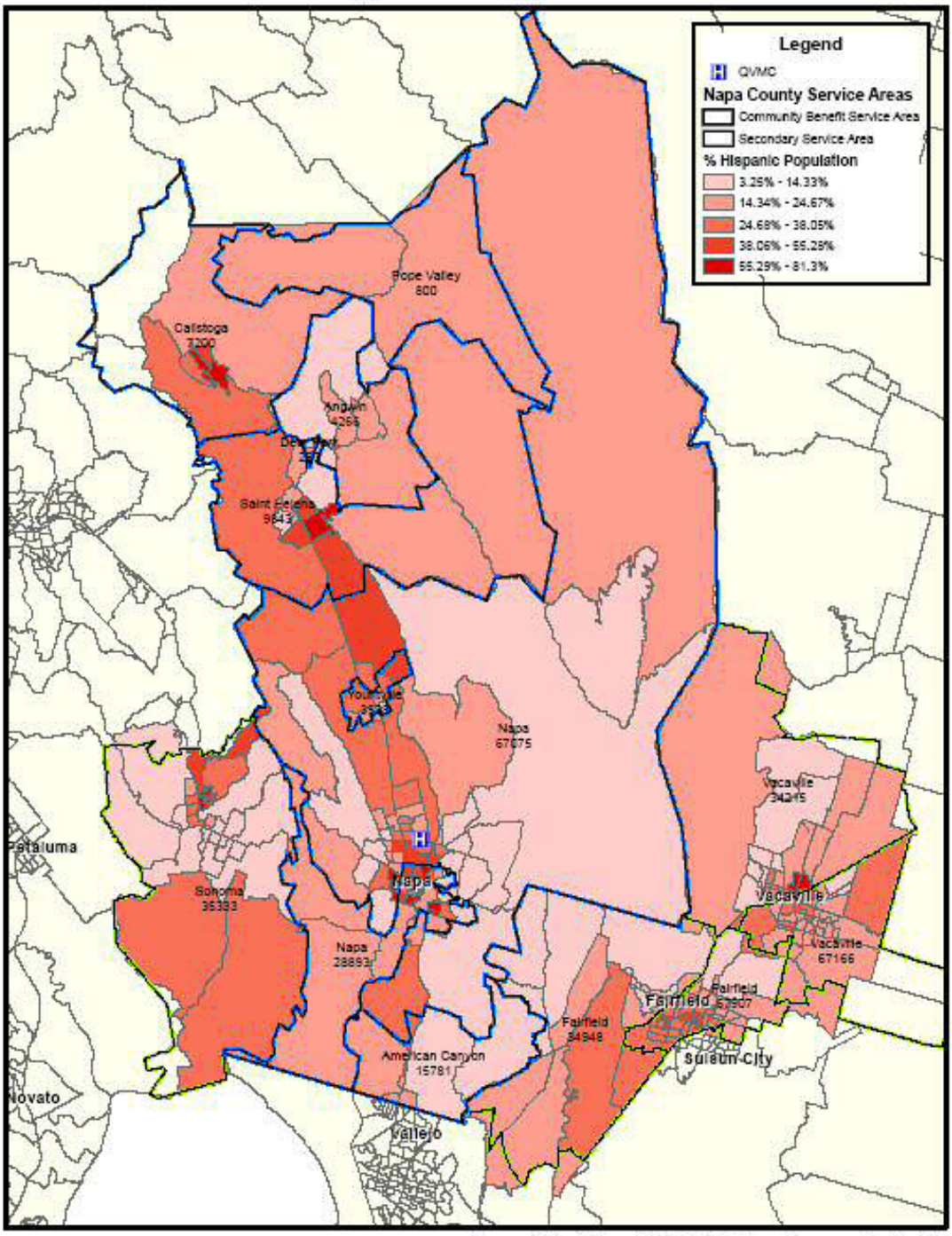
Stacey McCall, Assistant Executive Director
Community Health Clinic Ole

Susan Duke, M.A., Auction Grants Manager
Napa Valley Vintners

Suzanne Shiff, M.A., Executive Director
Napa Valley Coalition of Nonprofit Agencies

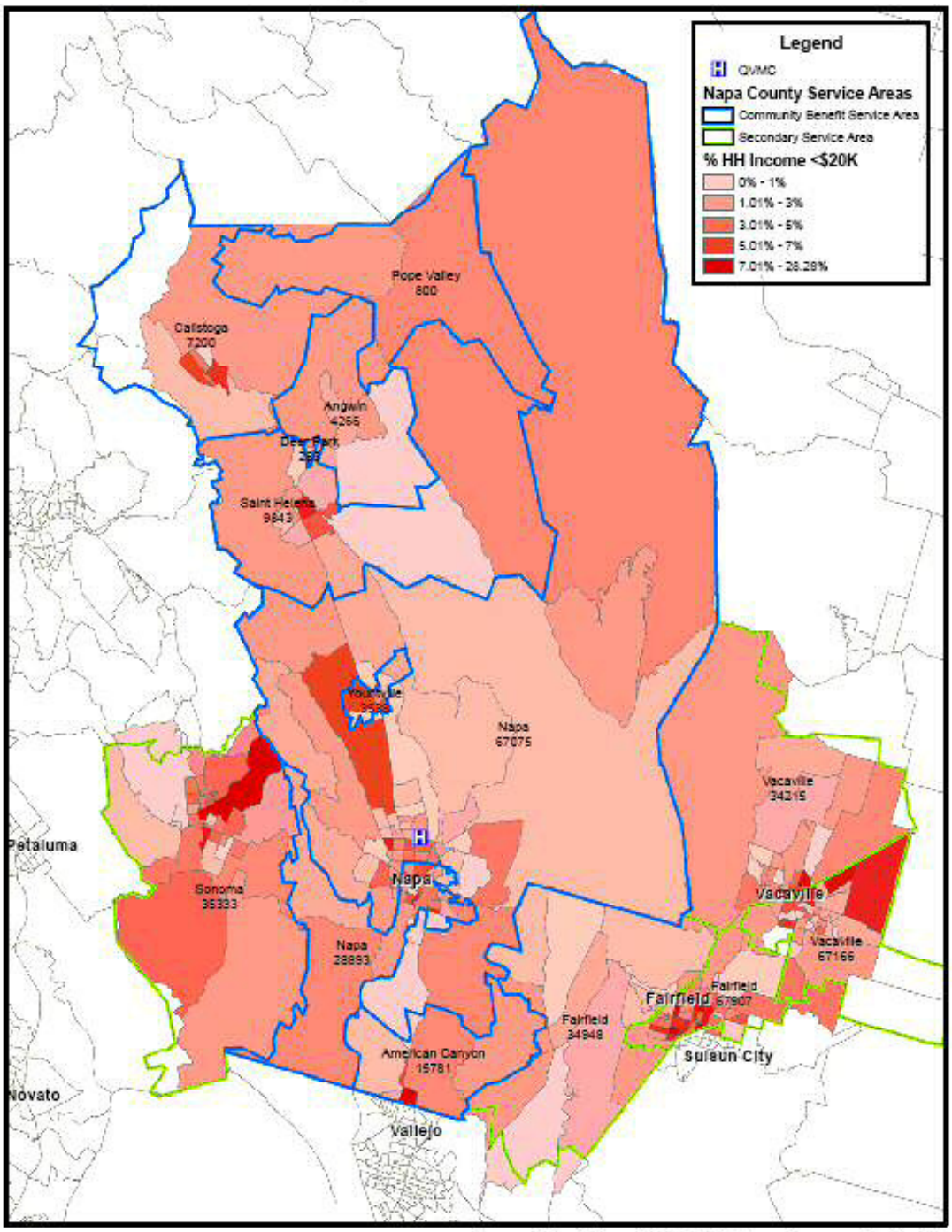
Thank you to Heather Mercadante, MPH, Touro University Student Intern, who contributed to some of the data analysis.

2009 Community Profile
Hispanic Population



Prepared by St Joseph Health System Community Health
Data Source: US Census 2009 Estimates
*Population per Zip Code Indicated

2009 Community Profile
Household Population with Income <$20k



Prepared by St Joseph Health System Community Health
Data Source: US Census 2009 Estimates
*Population per Zip Code Indicated

ATTACHMENT 4

COMMUNITY FOCUS GROUP QUESTIONS

1. **Everybody has health-related needs. When you think about people in Napa County) that you know—friends, family, neighbors, co-workers—what do you think are the most important health needs they face?** *(Note especially the things that are mentioned right off the bat without any prodding. Don't try to create a laundry list. Ask for clarification if something is vague (e.g., if someone says "women, after they've given birth"—do they mean postpartum depression? Do they mean family planning needs? Do they mean mothers needing to find a doctor for well-baby exams?....) After people have finished (or mostly finished) responding, try to get a sense of which health needs mentioned—you should repeat them if not using a flip chart—resonated most with the group so later you can summarize the top-ranked items. Don't try to get the group to go through a ranking process)*

2. **What are some of the things that you, personally, do to keep yourself as healthy as possible?** *(Just list what they say without prodding. However, if necessary to get them to think outside of the "medical norm," you might have to prod with questions like, "What about the things you do to stay safe?" "What about other daily habits?" If they don't address emotional/ mental, then ask "And, what about maintaining good mental health?")*

3. **There are a number of programs and services in this county that help people with health-related needs and problems.**

    a. **Do you think most people know about those services—about where they can go?** *(Look for familiarity, awareness of resources; note resources people mention that they depend on for information)*

    b. **Do you think the programs and services available in this county are mostly meeting people's needs? If not, why?** *(What you're looking for are answers to "Are the services effective? Appropriate? Available? Affordable?*

    c. **What are some of the main reasons people don't take care of these needs/problems or have trouble trying to?** *(With this question, you're looking for barriers—both personal and those related to "systems." Try to identify the main barriers that interfere with getting the identified health needs met; drill down on what they say contributes—consumer attitudes/beliefs/norms? Provider attitudes? Cultural and linguistic issues? Logistics—transportation and childcare? [If they say "transportation," find out specifically what they're referring to.] Financial concerns? Lack of available services?)*

4. **If you were in charge of improving things and you could improve the health of people in Napa County, what would be a couple of the things you would do to help? For example, if you won the Lottery, how would you use the money?** *(Look for ideas/solutions—particularly the ones that might resonate with the Collaborative organizations—and be sure to help the participants tie their recommendations back to the health needs they identified. Look for perceptions about what makes a healthier community)*

ATTACHMENT 5

KEY INFORMANT INTERVIEW QUESTIONS

INTRODUCTION: *

[Review purpose and intended use of the needs assessment]

QUESTIONS:

1. Are you familiar with the 2007 Napa County Health Needs Assessment? How have you used the information in this report?

2. (If "yes" to #1) What evidence have you seen over the last 3 years of implementation of any of the priorities?

3. Have you seen the Consumer Survey that was distributed recently in the community in hard copy, or the one we put online?

4. What do you believe are unique characteristics of Napa County that contribute to people's health in a positive way? What do you think threatens or contributes to poor health?

5. Thinking about the cross section of people in Napa County—adolescents, seniors, young parents, ethnic minorities, city dwellers, rural residents—what are the greatest ("top 3") health needs people here face?

6. Are there specific data that substantiate the problems you've described – data you're aware of that we might not be – that could help inform our assessment?

7. What resources are you aware of that are available to address these [the needs you identified] health needs? (examples: names of organizations, community expertise, advocacy, other identified strengths and assets…..) To what extent do you think most people who need these resources are aware of and know how to access them?

8. What do you see as the main barriers to meeting these needs? (structural + personal)

9. What are your recommendations about how funders can help meet these needs? i.e., what are your ideas for improving health in Napa County?

10. Are there any policy changes that are needed to implement your recommendations? What would it take to make those changes?

11. Do you have any additional comments or information you would like to share?

* Questions were not always asked in the same order. Questions were modified where necessary, e.g., to avoid asking something that was already well known. Additional questions were asked for purposes of clarification, to drill down on a response, or to tap into the interviewee's knowledge/experience to capture additional information. Each interview began with an explanation of the purpose (which was a repeat of the explanation provided in the introductory email contact when we requested an interview), assurance of confidentiality, and intended use of the information.

TELL US WHAT YOU THINK!

Join other Napa County residents and share your opinions about:

- What are the most important health needs in our community?
- What are your ideas for improving people's health?
- What programs and services do we need more of?

Date: Tuesday, April 27, 2010
Time: 7:00 p.m.
Place: [Name of Facility/Organization]

Refreshments!

Free gift bag!

ATTACHMENT 7

KEY INFORMANT INTERVIEWS

(In Alphabetical Order)

Person Contacted	Agency/Organization
Captain Conrad Perez	City of Napa Fire Department
Diane Dillon, Chairperson	Napa County Board of Supervisors
Drene Johnson, Executive Director	Community Action Napa Valley
James Cotter, MD, Chief Physician	Kaiser Permanente, Napa
Jaye Vanderhurst, Director	Napa County Mental Health Division
Joelle Gallagher, Executive Director	COPE Family Center
Karen Smith, MD, MPH, Public Health Officer	Napa County Public Health
Kathy Tabor, Private Consultant	Healthy Aging Population Initiative
Kristen Georges, Executive Director	St. Helena Family Resource Center
Laura Ryan, Health Services Director	Napa Unified School District
Lori Pesavento, Executive Director	Family Service Napa Valley
Margaret Payne, Director, Quality Management	Center for Behavioral Health, St. Helena Hospital
Mark Diel, Executive Director	Children's Health Initiative
Mark Fowler, Human Resources Director	St. Helena Hospital
Randy Snowden, Director	Napa County Health & Human Services Agency
Robert Moore, MD, Medical Director	Clinic Ole
Stephanie Parry, Former Executive Director	Calistoga Family Center
Tim Mitchell, Senior Pastor	Pacific Union College Church, Angwin
Tom Amato, Executive Director	Angwin Community Teen Center
Walt Mickens, Executive VP and COO	Queen of the Valley Medical Center

Health Needs by Ethnicity: Respondents who identified as Latino compared to all other respondents, Community Survey (n=793)

Health Need/Problem	All Respondents		Latino		All Others	
	n	%	*n*	%	*n*	%
Health Services	**374**	**47%**	**167**	**53%**	**207**	**44%**
Affordable and available health services	223	28%	88	28%	135	28%
Health insurance	153	19%	81	25%	72	15%
Affordable and available dental care	91	11%	55	17%	36	8%
Mental health services	54	7%	15	5%	39	8%
Home-based services	11	1%	1	0%	10	2%
Vision services	6	1%	3	1%	3	1%
Food/Nutrition/Weight	**330**	**42%**	**118**	**37%**	**212**	**45%**
Better nutrition and nutrition education	195	25%	58	18%	137	29%
Weight management/weight loss/obesity	110	14%	52	16%	58	12%
Affordable and available healthy foods	47	6%	10	3%	37	8%
Lifestyle	**274**	**35%**	**78**	**25%**	**196**	**41%**
Physical activity/exercise	225	28%	57	18%	168	35%
Stress	52	7%	17	5%	35	7%
Self-care (personal hygiene, personal needs)	40	5%	14	4%	26	5%
Sleep	19	2%	6	2%	13	3%
Other Needs	**182**	**23%**	**65**	**20%**	**117**	**25%**
Housing	33	4%	11	3%	22	5%
Employment	32	4%	21	7%	11	2%
Social support/cultural support	28	4%	9	3%	19	4%
Clean environment	24	3%	2	1%	22	5%
Transportation	24	3%	5	2%	19	4%
Basic needs (food, clothing, warmth)	15	2%	5	2%	10	2%
Spiritual support/faith	10	1%	3	1%	7	1%
Other	51	6%	22	7%	29	6%
Alcohol/Drug/Tobacco Abuse and Treatment	**127**	**16%**	**41**	**13%**	**86**	**18%**
Alcohol	67	8%	22	7%	45	9%
Drugs	55	7%	19	6%	36	8%
Tobacco	48	6%	19	6%	29	6%
Addiction/Not specified	5	1%	0	0%	5	1%

Table continues on next page

Specific Health Conditions	**111**	**14%**	**62**	**19%**	**49**	**10%**
Diabetes	53	7%	44	14%	9	2%
Cancer/cancer prevention	34	4%	20	6%	14	3%
High blood pressure/cardiac issues	18	2%	8	3%	10	2%
Allergies	17	2%	7	2%	10	2%
Depression	15	2%	13	4%	2	0%
Other health conditions (asthma, lupus, AIDS, autism, cholesterol)	42	5%	22	7%	20	4%
Prevention and Wellness	**75**	**9%**	**30**	**9%**	**45**	**9%**
Health education	42	5%	15	5%	27	6%
Prevention and wellness services	38	5%	10	3%	28	6%
Information about services available/outreach	19	2%	13	4%	6	1%
Specific Population Needs	**44**	**6%**	**22**	**7%**	**22**	**5%**
Aging/Support for Seniors	18	2%	5	2%	13	3%
Programs for Youth	16	2%	8	3%	8	2%
Information/Services in Spanish, language Barriers	13	2%	12	4%	1	0%
Missing	84	11%				
Total Respondents	793	100%	318	100%	475	100%

Health Needs by Age Group: Adults 21-64 years old compared to seniors 65+ years old, Community Survey (n=793)

Health Need/Problem	All Respondents		Adults: 21-64 years old		Seniors: 65+ years old	
	n	%	*n*	%	*n*	%
Health services	**374**	**47%**	**324**	**51%**	**36**	**39%**
Affordable and available health services	223	28%	189	30%	27	29%
Health insurance	153	19%	134	21%	13	14%
Affordable and available dental care	91	11%	84	13%	4	4%
Mental health services	54	7%	48	8%	3	3%
Home-based services	11	1%	8	1%	3	3%
Vision services	6	1%	5	1%	0	0%
Food/nutrition/weight	**330**	**42%**	**279**	**44%**	**35**	**38%**
Better nutrition and nutrition education	195	25%	163	26%	23	25%
Weight management/weight loss/obesity	110	14%	96	15%	8	9%
Affordable and available healthy foods	47	6%	41	6%	5	5%
Lifestyle	**274**	**35%**	**231**	**36%**	**29**	**31%**
Physical activity/exercise	225	28%	187	29%	25	27%
Stress	52	7%	50	8%	0	0%
Self-care (personal hygiene, personal needs)	40	5%	34	5%	5	5%
Sleep	19	2%	13	2%	2	2%
Other needs	**182**	**23%**	**138**	**22%**	**34**	**37%**
Housing	33	4%	28	4%	4	4%
Employment	32	4%	31	5%	0	0%
Social support/cultural support	28	4%	19	3%	6	6%
Clean environment	24	3%	16	3%	5	5%
Transportation	24	3%	14	2%	9	10%
Basic needs (food, clothing, warmth)	15	2%	13	2%	2	2%
Spiritual support/faith	10	1%	5	1%	3	3%
Other	51	6%	38	6%	11	12%
Alcohol/Drug/Tobacco Abuse and Treatment	**127**	**16%**	**107**	**17%**	**14**	**15%**
Alcohol	67	8%	54	8%	10	11%
Drugs	55	7%	47	7%	5	5%
Tobacco	48	6%	40	6%	6	6%
Addiction/not specified	5	1%	5	1%	0	0%

Table continues on next page

Specific health conditions	**111**	**14%**	**94**	**15%**	**11**	**12%**
Diabetes	53	7%	47	7%	5	5%
Cancer/cancer prevention	34	4%	28	4%	4	4%
High blood pressure/cardiac issues	18	2%	15	2%	2	2%
Allergies	17	2%	15	2%	1	1%
Depression	15	2%	13	2%	2	2%
Other health conditions (asthma, lupus, AIDS, autism, cholesterol)	42	5%	35	5%	5	5%
Prevention and wellness	**75**	**9%**	**63**	**10%**	**10**	**11%**
Health education	42	5%	33	5%	8	9%
Prevention and wellness services	38	5%	33	5%	4	4%
Information about services available/outreach	19	2%	17	3%	1	1%
Specific population needs	**44**	**6%**	**36**	**6%**	**6**	**6%**
Aging/support for seniors	18	2%	13	2%	4	4%
Programs for youth	16	2%	14	2%	1	1%
Information/services in Spanish, language barriers	13	2%	12	2%	1	1%
Missing	84	11%				
Total respondents	793	100%	639	100%	93	100%

Appendix A-3

Health Needs by Self Reported Health Status: Respondents who identified their health as excellent or good compared to respondents who reported their health as fair or poor, Community Survey (n=793)

Health Need	All Respondents		Excellent or Good Health		Fair or Poor Health	
	n	%	*n*	%	*n*	%
Health services	**374**	**47%**	**270**	**48%**	**98**	**49%**
Affordable and available health services	223	28%	163	29%	59	29%
Health insurance	153	19%	108	19%	41	20%
Affordable and available dental care	91	11%	58	10%	31	15%
Mental health services	54	7%	34	6%	16	8%
Home-based services	11	1%	8	1%	3	1%
Vision services	6	1%	5	1%	0	0%
Food/nutrition/weight	**330**	**42%**	**255**	**46%**	**70**	**35%**
Better nutrition and nutrition education	195	25%	155	28%	38	19%
Weight management/weight loss/obesity	110	14%	78	14%	29	14%
Affordable and available healthy foods	47	6%	42	8%	5	2%
Lifestyle	**274**	**35%**	**224**	**40%**	**49**	**24%**
Physical activity/exercise	225	28%	188	34%	36	18%
Stress	52	7%	41	7%	11	5%
Self-care (personal hygiene, personal needs)	40	5%	32	6%	8	4%
Sleep	19	2%	15	3%	4	2%
Other needs	**182**	**23%**	**129**	**23%**	**50**	**25%**
Housing	33	4%	26	5%	7	3%
Employment	32	4%	27	5%	5	2%
Social support/cultural support	28	4%	20	4%	8	4%
Clean environment	24	3%	22	4%	1	0%
Transportation	24	3%	17	3%	6	3%
Basic needs (food, clothing, warmth)	15	2%	9	2%	6	3%
Spiritual support/faith	10	1%	6	1%	4	2%
Other	51	6%	34	6%	16	8%
Alcohol/Drug/Tobacco Abuse and Treatment	**127**	**16%**	**89**	**16%**	**36**	**18%**
Alcohol	67	8%	48	9%	18	9%
Drugs	55	7%	33	6%	21	10%
Tobacco	48	6%	32	6%	16	8%
Addiction/not specified	5	1%	4	1%	0	0%

Table continues on next page

Specific health conditions	**111**	**14%**	**77**	**14%**	**31**	**15%**
Diabetes	53	7%	30	5%	22	11%
Cancer/cancer prevention	34	4%	23	4%	11	5%
High blood pressure/cardiac issues	18	2%	12	2%	5	2%
Allergies	17	2%	14	3%	3	1%
Depression	15	2%	11	2%	4	2%
Other health conditions (asthma, lupus, AIDS, autism, cholesterol)	42	5%	26	5%	14	7%
Prevention and wellness	**75**	**9%**	**55**	**10%**	**20**	**10%**
Health education	42	5%	32	6%	10	5%
Prevention and wellness services	38	5%	34	6%	4	2%
Information about services available/outreach	19	2%	12	2%	7	3%
Specific population needs	**44**	**6%**	**26**	**5%**	**18**	**9%**
Aging/support for seniors	18	2%	12	2%	6	3%
Programs for youth	16	2%	11	2%	5	2%
Information/services in Spanish, language barriers	13	2%	5	1%	8	4%
Missing	84	11%				
Total Respondents	793	100%	559	100%	201	100%

Appendix A-4

Prioritized Ideas to Improve Health in Napa County, Community Survey (n=793)

Ideas to Improve Health	First Priority		Second Priority		Third Priority		No Ranking	
	n	%	*n*	%	*n*	%	*n*	%
More affordable health insurance	173	22%	92	12%	48	6%	121	15%
More access to affordable wellness type centers and services	119	15%	73	9%	74	9%	86	11%
More affordable medical care	80	10%	88	11%	80	10%	91	11%
More year-round activities for youth	46	6%	57	7%	91	11%	98	12%
More efforts to have a cleaner environment (air, water….)	43	5%	37	5%	43	5%	64	8%
More low-cost mental health/counseling services	41	5%	61	8%	49	6%	57	7%
More support services for the homebound and frail elderly	32	4%	42	5%	58	7%	57	7%
More affordable dental care	21	3%	79	10%	71	9%	91	11%
More public transportation options	19	2%	34	4%	34	4%	32	4%
Other	6	1%	2	0%	7	1%	54	7%
Housing	*1*	*0%*	*0*	*0%*	*3*	*0%*	*1*	*0%*
Alcohol, Drug And Smoking Services	*1*	*0%*	*1*	*0%*	*0*	*0%*	*5*	*1%*
Activities/Exercise For All Ages	*1*	*0%*	*0*	*0%*	*1*	*0%*	*8*	*1%*
Healthy Food/Nutrition	*0*	*0%*	*1*	*0%*	*1*	*0%*	*4*	*1%*
Jobs	*0*	*0%*	*0*	*0%*	*0*	*0%*	*2*	*0%*
"All Of The Above"	*0*	*0%*	*0*	*0%*	*0*	*0%*	*4*	*1%*
Other (Only One Respondent)	*0*	*0%*	*0*	*0%*	*0*	*0%*	*5*	*1%*
Missing							40	5%

Note: Some respondents checked "Other" without writing in the idea for improving health.

ATTACHMENT 8

HEALTHY NAPA QUESTIONNAIRE

The Napa County Health Collaborative would like your opinion! We are working to improve the health of people in our community. Please take a moment and share your views with us.

1. What about living in Napa County contributes to people's health and well-being in a positive way? *(Name the first thing that comes to your mind)*

   _____

   What do you think about living here contributes in a negative way?

   _____

2. Which of these health habits do you think most contributes to maintaining your own health? *(Check the 2 most important for you)*

   ___ Wearing a seat belt
   ___ Brushing/flossing teeth daily
   ___ Applying sunscreen when outside
   ___ Taking vitamin pills or supplements daily
   ___ Practicing my faith/attending services
   ___ Eating fresh fruit and vegetables each day
   ___ Limiting alcohol (e.g., 1 drink/day) or not drinking
   ___ Rarely eating fast or "junk" food
   ___ Not smoking
   ___ Sleeping at least 7 hours each night
   ___ Not using illegal substances
   ___ Doing some form of exercise (e.g., walking)
   ___ Other (What? _____)

3. Thinking about all the people you know in Napa County—neighbors, friends, co-workers, family—what do you think are the "top 3" health needs people face?

   (a) _____
   (b) _____
   (c) _____

4. What are your ideas to improve people's health in our community? *(Choose 3 and put them in order of importance, starting with "1")*

Rank	*Idea*
___	More support services for the homebound and frail elderly (e.g., choreworkers)
___	More access to affordable wellness type centers and services
___	More low-cost mental health/counseling services
___	More affordable health insurance
___	Improved public transportation options
___	More affordable dental care
___	More efforts to have a cleaner environment (air, water….)
___	More affordable medical care
___	More year-round activities for youth
___	Other (What? _____)

5. When you or your family need medical/dental care, are any of the following usually a problem?

No	*Yes*	
___	___	Childcare
___	___	Transportation
___	___	Finding a place where they speak my language
___	___	Finding someone who takes my insurance (including Medi-Cal)
___	___	Finding somewhere that offers free or reduced-cost services
___	___	Finding an office or clinic that's open when I'm not working
___	___	The ability to take off work when I/my family is sick, without losing pay

6. How would you rate your general health? ___ Excellent ___ Good ___ Fair ___ Poor
7. Did you visit the dentist within the last year? ___ Yes ___ No
8. What is your gender? ___ Female ___ Male
9. What is your zip code? _____
10. What is your age group? ___Under age 21 ___ 21-64 years ___ Age 65+
11. What is your race/ethnicity? ___Asian ___ African Amer. ___Latino ___ White ___ Native Amer. ___ Other

If you have questions about this survey, please call Napa County Public Health at (707) 253-4773.