2016 Community Health Needs Assessment

Napa County, California

Approved by Napa County CHNA Advisory Group
April 8, 2016

To provide feedback about this Community Health Needs Assessment, email Mayra Vega at VegaM7@ah.org.

Executive Summary

St. Helena Hospital Napa Valley & Center for Behavioral Health

Collaborating to achieve whole-person health in our communities

St. Helena Hospital Napa Valley & Center for Behavioral Health invites you to partner with us to help improve the health and wellbeing of our community. Whole-person health—optimal wellbeing in mind, body and spirit—reflects our heritage and guides our future. St. Helena Hospital Napa Valley & Center for Behavioral is part of Adventist Health, a faith-based, nonprofit health system serving more than 75 communities in California, Hawaii, Oregon and Washington. Community has always been at the center of Adventist Health's mission—to share God's love by providing physical, mental and spiritual healing.

The Community Health Needs Assessment is one way we put our faith-based mission into action. Every three years, we conduct this assessment with our community. The process involves input and representation from all: community organizations, providers, educators, businesses, parents, and the often marginalized—low-income, minority, elderly and other underserved populations.

We use the Community Health Needs Assessment to achieve these goals:

- Learn about the community's most pressing health needs
- Understand the health behaviors, risk factors and social determinants that impact our community's health
- Identify community resources and prioritize needs
- Collaborate with community partners to develop collective strategies

Partnering with our communities for better health

While conducting the Community Health Needs Assessment we solicited feedback and input from a broad range of stakeholders. Contributors to the process included these partners:

- Napa County Health and Human Services Agency
- Live Healthy Napa County
- Kaiser Permanente
- St. Joseph Health Queen of the Valley Medical Center
- Consultants: Harder+Company Community Research; Rami + Associates

Data Sources

The assessment used a mixed-methods approach to collect and compile data to provide a robust assessment of health in Napa County. A broad lens in qualitative and quantitative data allowed for the consideration of many potential health needs as well as an in-depth analysis. Data sources included an analysis of over 150 health indicators from publicly available data sources such as the California Health

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

Prioritization process

Data was used to score each health need. Potential needs were included in the prioritization process if a) multiple indicators were reviewed in secondary data demonstrated that the county estimate was greater than the 1% "worse" than the benchmark comparison estimate (in most cases, the benchmark used was the California state average) and b) the health issue was identified as a key theme in at least half of the interviews OR in at least one focus group.

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

Top priorities identified in partnership with our communities

Adventist Health Top Priority Health Needs for 2016-2019

Prioritized Need	Health Indicator
Education	In Napa County, extreme disparities exist among subpopulations in key educational outcomes. Hispanic/Latino students and English Language Learners (ELL) are at high risk for dropping out of high school. Only 22.0% of tenth grade English Language Learners passed the California High School Exit Exam in English Language Arts; only 39.0% passed in Mathematics. Residents and stakeholders also identified harassment and bullying as issues of high concern for health.
Economic and Housing Security	The high cost of living in Napa County poses a significant challenge for residents, many of whom spend 30% or more of their income on housing costs. Malnutrition and food insecurity are also key issues for Napa County residents, as many are forced to spend most of their income on housing, but do not qualify for public benefits.
Mental Health	Mental health – emotional, behavioral, and social well-being – was identified as a high concern for Napa County residents, especially Latinos, youth, and older adults. Napa residents have a high risk of suicide. An estimated 10.3% of residents report having seriously considered suicide; among Latinos in the county,

	this estimate is 27.9%. Residents and stakeholders identified suicide as a significant concern, and noted that social stigma and the geographic distribution of treatment facilities pose challenges to people seeking mental health care.
Obesity and Diabetes	One quarter of Napa County residents are obese, and more than a third are overweight. Access to affordable healthy food was identified as a concern, particularly in specific areas of Napa County included American Canyon and rural communities. An estimated 24.0% of adults are obese, and 37.05 overweight. Among youth, 14.8% are obese and 19.5% are overweight. Since economic disadvantage is strongly linked to barriers that inhibit healthy consumption of foods and an active lifestyle, low-income residents, as well as older adults and residents experiencing homelessness, are disproportionately affected by this health need.
Access to Primary and Oral Health Care	A lack of access to dental insurance or inadequate utilization of dental care is an important issue affecting oral health in Napa County. Premiums for health insurance remain high, and many providers do not accept Medi-Cal or have long waiting lists. Dental insurance was not included in recent health insurance reform and 43.7% of the adult population in the county lacks dental insurance.
Substance Use	Substance abuse was identified as a concern, particularly with respect to alcohol consumption. Among adults 21.3% of residents report heavy alcohol consumption. Youth were also noted as a high risk population with high abuse rates of cigarettes, binge drinking, and use of marijuana.
Cancers	Compared to California state averages, Napa County has higher incidence of breast, prostate, colon and rectum, and lung cancer, as well as a high all-cancer mortality rate. Racial/ethnic disparities exist in cancer morbidity and mortality.

Making a difference: Results from our 2013 CHNA/CHP

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

Education

- In partnership with author, Shalini Singh Anand, we provided over 200 students at Calistoga Elementary school with “Lee the Bee” books (totaling $2,314) and personal readings with the author which encouraged students to stay in school and gave the students exposure to the benefits of getting a great educated.

- Through the St. Helena Unified School District, we have provided over 100 hours at school Field Days at St. Helena Primary School, St. Helena Elementary School, Foothills Elementary, PUC Elementary School, Vichy Elementary School, and Pueblo Vista Elementary.
- Through Girls on the Run Napa & Solano, a $5,000 donation was able to impact 775 girls at 44 different schools, a 40% increase from the previous year. This program is a year-long process that guides girls in grades 3rd to 8th where volunteer life coaches lead the girls through experiential activities and discussions. The program ends with a 5K event that had a participation of over 1,000.

Economic and Housing Security

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

Mental Health

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

Obesity and Diabetes

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

- In partnership with the Rianda House, five free health screenings were provided for adults of the Napa County testing for blood glucose, blood pressure, and body composition. An average of 20 older adults participated in each screening with 2-3 suggestions of a follow up with a primary care physician.

Access to Primary and Oral Health Care

- A new intensivist team of three doctors were added to the Intensive Care Unit allowing us to have 24-hour coverage for the patients with the highest acuity. With that, one of the doctors within that group created what is a referred to as an "angel cart" in which there are donated goods that are available for patients and their families at any time.
- We actively participate in local health fairs and employee benefit fairs to educate the community on the services we offer. Combined, these events reached approximately 2000 individuals across Napa County.
- Doctors within our specialty, destination services such as the Coon Joint Replacement Institute or the St. Helena Arrhythmia Center travel throughout the educate and inform patients about the services that are available at St. Helena Hospital.

Substance Abuse

- Peer support groups and a recovery program are provided through the St. Helena Recovery Center. A recovery center alumni group is also provided for people who had previously participated in addiction therapy and need support for ongoing sobriety. The attendance for the initial recovery program is between 30 and 40, while the alumni group has around half of that attendance.

Cancers

- We provided educational materials regarding risk factors for cancer, heart disease, and cerebrovascular disease, used CDC-endorsed My Plate curricula, Champions of Change cookbooks and brochures at health fairs, health seminars, classes, support groups, and health screenings. In total 5,000 people in our target communities received education on how to prevent leading causes of death.

Acknowledgements
Many individuals and organizations participated in the success of this Community Health Needs Assessment.

Partner hospitals have worked closely together throughout the CHNA to ensure the CHNA complied with the requirements of the Affordable Care Act and included data on which to build effective implementation strategies. Members of the Napa County CHNA Advisory Group include:

- Napa County Health and Human Services Agency
  - Jennifer Henn, Epidemiologist
- Live Healthy Napa County
  - Jennifer Henn
- Kaiser Permanente
  - Cynthia Verrett, Community Benefit Manager
- St. Helena Hospital Napa Valley
  - Mayra Vega, Director of Client Services
- St. Joseph Health Queen of the Valley Medical Center
  - Dana Codron, Executive Director of Community Outreach
  - Elizabeth Alessio, Community Benefit Coordinator
- Consultants
  - Harder+Company Community Research and Raimi + Associates were instrumental in supporting the community health need prioritization process by presenting extensive data in a useful way and facilitating a meaningful conversation that resulted in the establishment of community priorities on which future decisions can be based. The team also prepared this report.

Several other organizations were also instrumental to the CHNA process, including:

  - Multiple social service and nonprofit organizations who helped coordinate and recruit participants for focus groups, participated in key informant interviews, and attended the prioritization session.
  - Community members who participated in focus groups and provided invaluable insight into the needs of their community.

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I. EXECUTIVE SUMMARY

The 2016 Community Health Needs Assessment (CHNA) presents an overview of community health in Napa County that includes the conditions that impact health in our county. Conducting a triennial CHNA is a requirement for not-for-profit hospitals as part of the Patient Protection and Affordable Care Act (ACA).

A. Community Health Needs Assessment (CHNA) Background

The goal of the CHNA is to inform and engage local decision-makers, key stakeholders and the community-at-large in collaborative efforts to improve the health and well-being of all Napa County residents. The development of the 2016 CHNA report has been an inclusive and comprehensive process guided by an Advisory Group.

While many hospitals have conducted CHNAs for many years to identify needs and resources in their communities, these new requirements have provided an opportunity for hospitals to revisit their needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency, and toward leveraging emerging collaborations, innovations, and technologies.

B. Summary of Prioritized Needs

Napa County is a generally healthy and affluent county, especially compared to California as a whole, but has an aging population and substantial disparities in socioeconomic status. These issues present challenges for the health of Napa County residents. After a review of county data, key stakeholders and residents identified seven specific health needs in Napa County.

1) **Education:** Napa County has significant disparities in educational outcomes and educational attainment. Hispanic/Latino students and English Language Learners are of particular concern, as they are at high risk for dropping out of high school. Residents and stakeholders also identified harassment and bullying as issues of high concern for health.

2) **Economic and Housing Insecurity:** The high cost of living in Napa County poses a significant challenge for residents, many of whom spend 30% or more of their income on housing costs. Malnutrition and food insecurity are also key issues for Napa County residents, as many are forced to spend most of their income on housing, but do not qualify for public benefits.

3) **Mental Health:** Mental health was identified as a high concern for Napa County residents, especially Latinos, youth, and older adults. Residents and stakeholders identified suicide as a significant concern, and noted that social stigma and the geographic distribution of treatment facilities pose challenges to people seeking mental health care.

4) **Obesity and Diabetes:** One quarter of Napa County residents are obese, and more than a third are overweight. Access to affordable healthy food was identified as a concern, particularly in specific areas of Napa County including American Canyon and rural communities. Since economic disadvantage is strongly linked to barriers that inhibit healthy consumption of foods and an active lifestyle, low-income residents, as well as older adults and residents experiencing homelessness, are disproportionately affected by this health need.

5) **Access to Primary and Oral Health Care:** A lack of access to dental insurance or inadequate utilization of dental care is an important issue affecting oral health in Napa County. Premiums for health insurance remain high, and many providers do not accept Medi-Cal or have long waiting lists. Dental insurance was not included in recent health insurance reform, and nearly half of all adults in Napa County lack dental insurance.

6) **Substance Use:** The abuse of alcohol by adults emerged as a significant substance abuse issue in the county. Residents and stakeholders also identified youth as being at a particularly high risk for

abuse of tobacco, alcohol, prescription drugs, and illegal drugs.

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

C. Summary of Needs Assessment Methodology and Process

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

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

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

a) Multiple indicators reviewed in secondary data demonstrated that the county estimate was greater than 1% "worse" than the benchmark comparison estimate (in most cases, the benchmark used was the California state average).
b) The health issue was identified as a key theme in at least half of interviews OR in at least one focus group.

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

The CHNA is an important first step towards taking action to effect positive changes in the health and well-being of county residents. The results will be used to inform the development of an implementation strategy for each hospital outlining the priority health needs the hospital will address. These strategies will build on community assets and resources, as well as on evidence-based strategies, wherever possible.

The CHNA and the hospital-specific implementation strategies will be developed to contribute to action in a strategic, innovative, and equitable way.

II. INTRODUCTION/BACKGROUND

Guided by the understanding that health encompasses more than disease or illness, the 2016 CHNA process uses a comprehensive framework for understanding health that considers how a variety of social, environmental, and economic factors – also referred to as "social determinants" – impact health. The CHNA process has been designed to identify the top health needs in the community through a consideration of a broad range of social, economic, environmental, behavioral, and clinical care factors that contribute to each health need.

Every three years, partners in Napa County conduct a needs assessment to determine the most critical health needs in the community. In 2013, the following overall priorities emerged: improve wellness and healthy lifestyles; ensure access to high quality services and supports; address social determinants of health; and create and strengthen sustainable partnerships for Collective Impact.

Formed in 2012 as a public-private-community partnership, Live Healthy Napa County (LHNC) convenes representatives from health and healthcare organizations, business, public safety, education, government, and the general public, to build strategies to realize a shared vision of a healthier Napa County. LHNC aims to increase the well-being and quality of life for all individuals, families, and communities in Napa County by moving away from a focus exclusively on sickness and disease to one based on prevention and wellness. LHNC recognizes that health starts long before illness – in our homes, schools, and jobs – and the ability to make meaningful change to improve health requires the collective impact of actors from different sectors committed to a shared agenda. Only a comprehensive approach that considers the effects of social, environmental, and economic factors on health will create sustainable change. To this end, LHNC has collaborated closely with the nonprofit hospitals in Napa County to engage in this CHNA process, which brings together countywide partners to identify and prioritize issues affecting health and wellness.

The exploration of health in Napa County through the 2016 CHNA process builds upon work done in prior years. The health needs identified in the 2016 CHNA process are: education, economic and housing insecurity, mental health, obesity and diabetes, access to primary and oral health care, substance use, and cancers. These needs align closely with and expand upon the top health needs identified in the 2012-13 CHNA: overweight and obesity, mental health, alcohol and substance use and abuse, and health inequities. Developing shared aims across the county requires building on community strengths in Napa; among key strengths identified in the 2012-13 CHNA are strong partnerships and collaboration, and clean and safe neighborhoods.

While the leading causes of death in California continue to be chronic diseases, evidence indicates that addressing and improving social and environmental conditions will have a positive impact on trends in morbidity and mortality, and will diminish disparities in health. Many chronic diseases and conditions are caused in part by preventable factors such as poor diet and physical inactivity, and there is growing awareness of the important link between how communities are structured and the opportunities for people to lead safe, active, and healthy lifestyles.

In addition to considering a broad definition of county-wide health, this assessment explores the particular impact of identified health issues among vulnerable populations. These populations may be residents of particular geographic areas, or may represent particular race/ethnicities or age groups. In an effort to work toward health equity, the CHNA process places strong emphasis on the needs of high-risk populations in the process of identifying health needs and as a criterion for prioritization.

With the passage of the ACA, completion of a CHNA has been codified into the Internal Revenue Code and required to assure the nation's not-for-profit hospitals maintain their 501(c)(3) status. The Code requires the CHNA to include:

- Data Research & Prioritization of Identified Health Needs
- Report on Findings
- Implementation Plan

Napa's hospitals (Kaiser Foundation Hospital-Vallejo, Queen of the Valley Medical Center, and St. Helena Hospital) have come together to meet these requirements of the ACA. Their work was supported by the Napa County Health and Human Services Agency.

In order to identify health needs, the Napa County CHNA Advisory Group and the consultant team (Harder+Company Community Research and Raimi + Associates) utilized a mixed-methods approach, examining existing or secondary data sources, as well as speaking to community leaders and

residents, to understand key health issues in Napa County. The Napa County CHNA Advisory Group and the consultant team reviewed secondary data available through the CHNA data platform and compiled additional data from national, statewide, and local sources to provide a more complete picture of health in Napa County. These data were compared to benchmark data and analyzed to identify potential areas of need. In addition, the consultant team collected and analyzed primary data about issues that most impact the health of the community. The team also considered existing resources and new ideas to address those needs from community members and local experts across sectors (e.g., public health, education, and government). The scored quantitative data and coded qualitative data were analyzed to identify the top health needs in the county. Once these health needs were identified, a cross-sector group of stakeholders reviewed summarized data in health need profiles (see Appendix A) and prioritized the health needs based on criteria (see Appendix E) determined by the Napa County CHNA Advisory Group. The resulting prioritized community health needs are presented in this report.

This CHNA serves as the basis for the development of hospital-specific implementation plans, which will support and build upon (rather than replace) the data and action plan outlined in the 2013 CHNA and Implementation Strategy.

III. BACKGROUND ON NAPA COUNTY CHNA ADVISORY GROUP MEMBERS

The following partner hospitals and organizations have worked closely together throughout the CHNA to ensure the CHNA complied with the requirements of the ACA and included data on which to build effective implementation strategies.

A. About Live Healthy Napa County

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

B. About St. Helena Hospital Napa Valley

St. Helena Hospital Napa Valley (SHNV) and St. Helena Hospital Center for Behavioral Health (SHBH) are affiliates of Adventist Health, a faith-based, not-for-profit, integrated health care delivery system headquartered in Roseville, California. Adventist Health provides compassionate care in communities throughout California, Hawaii, Oregon and Washington.

Adventist Health entities include: 19 hospitals with more than 2,700 beds; more than 235 clinics and outpatient centers; 14 home care agencies and 7 hospice agencies; four joint-venture retirement centers; and a workforce of 28,600 (which includes more than 20,500 employees, 4,500 medical staff physicians, and 3,600 volunteers).

Every individual, regardless of his/her personal beliefs, is welcome in Adventist Health facilities. Adventist Health is also eager to partner with members of other faiths to enhance the health of the communities they serve.

More than a century later, the health care system sponsored by the Seventh-day Adventist Church circles the globe with more than 170 hospitals and nearly 500 clinics, nursing homes and dispensaries

worldwide. The same vision to treat the whole person—mind, body and spirit—continues to provide the foundation for their progressive approach to health care.

Located two miles north of St. Helena in the Napa Valley, SHNV is a 151-bed full-service, nonprofit community hospital renowned for excellence in cardiac care and a holistic approach to healing. SHNV also includes 61 psychiatric beds at the SHBH in Vallejo and 14 residential wellness program rooms in the St. Helena Center for Health. Since opening its doors in 1878, SHNV has remained committed to one basic mission: sharing God's love by providing physical, mental and spiritual healing.

Offering expertly skilled doctors, the latest medical technology and highly-trained staff, SHNV serves as a regional center for cancer care, cardiac services, orthopedics, general surgery, obstetrics, plastic & reconstructive surgery, sleep disorders, home care, and women's services. A comprehensive range of acute care, behavioral health, and wellness programs draw patients from the San Francisco Bay Area and beyond.

The facility was established in 1878 as the Rural Health Retreat. After the turn of the century, SHNV became a full-service, nonprofit community hospital. In 1969, a new wing opened to house the St. Helena Center for Health, thus enhancing the hospital's focus on personal and community wellness. In 1997, SHNV purchased First Hospital in Vallejo, a 61-bed mental health facility now known as the St. Helena Hospital Center for Behavioral Health.

C. About St. Joseph Health, Queen of the Valley Medical Center

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

As a member of St. Joseph Health, a Catholic health system founded by the Sisters of St. Joseph of Orange, SJH-QVMC devotes resources to outreach activities and services that help rebuild lives and care for the underserved and disadvantaged. SJH-QVMC recognizes and embraces the social obligation to create, collaborate on and implement programs that address identified needs and provide benefits to the communities they serve. Partnerships it has developed with schools, businesses, local community groups and national organizations allow the hospital to focus tremendous skills and commitment on solutions that have an enduring impact on the community. Based on identified community needs, SJH-QVMC provides and/or supports an extensive matrix of nationally recognized, award winning, well-organized and coordinated community benefit service programs and activities addressing issues such as obesity, mental health, chronic disease management, dental health, education and empowerment, access to food, housing, and preventive health care.

D. Community Benefit Governance and Management Structure

SJH-QVMC Board of Trustees and Administration take an active and informed role in the development and oversight of the Community Benefit Strategic Plan, programs and initiatives. The Community Benefit Committee (CBC) is composed of trustees, SJH-QVMC Executive Leadership, physicians, and community representatives, and is staffed by SJH-QVMC Community Outreach employees. The CBC serves as an extension of the medical center's Board of Trustees and is charged with the governance of Community Benefit planning and activities. In addition, community benefit plans, processes and programs reflect both system-level and local hospital strategic goals and initiatives.

SJH-QVMC demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation and collaboration. The Vice President of Mission Integration and Executive Director for Community Outreach are responsible for coordinating implementation of community benefit provisions related to The Patient Protection and ACA. In addition, this team provides the opportunity for community leaders and internal hospital executive management team members, physicians and other staff to work together in planning and carrying out the Community Benefit Plan.

The Community Benefit management team provides orientation for all new medical center employees and physicians on Community Benefit programs and activities, including opportunities for participation. Key opportunities for SJH-QVMC employee participation in community benefit activities for FY 2013 included: cooking and serving monthly soup kitchen meals; employee blood drives; migrant worker health fairs; Gang Tattoo Removal Program; and "Operation with Love from Home," which sends care packages to military troops serving abroad.

E. About Kaiser Permanente

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

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

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

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

F. About Kaiser Permanente Community Benefit

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of its members and the communities it serves. Kaiser Permanente believes good health is a fundamental right shared by all, and recognizes that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which it calls Total Community Health, requires equity and social and economic well-being.

Like its approach to medicine, Kaiser Permanente's work in the community takes a prevention-focused, evidence-based approach. It goes beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, it has

focused its investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in its communities.

For many years, Kaiser Permanente has worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. It has also conducted CHNAs to better understand each community's unique needs and resources. The CHNA process informs its community investments and helps it develop strategies aimed at making long-term, sustainable change—and it allows Kaiser Permanente to deepen the strong relationships it has with other organizations that are working to improve community health.

G. Purpose of the Community Health Needs Assessment (CHNA) Report

The Patient Protection and ACA, enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a CHNA and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each St. Helena Hospital Napa Valley at https://www.adventisthealth.org/napa-valley/pages/default.aspx

H. Napa County CHNA Advisory Group's Approach to Community Health Needs Assessment

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

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

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

In conjunction with this report, St. Helena Hospital Napa Valley will develop an implementation strategy for the priority health needs their hospitals will address. These strategies will build on the assets and resources, as well as evidence-based strategies, wherever possible. The IS will be filed with the IRS using Form 990 Schedule H. Both the CHNA and the IS, once they are finalized, will be posted publicly on https://www.adventisthealth.org/napa-valley/pages/default.aspx.

IV. COMMUNITY SERVED

In order to determine the health needs of the Napa County CHNA Advisory Group member hospital service areas, it is first important to understand the communities of interest. The following section

describes the service area community by geography, demographics, and socioeconomic indicators, as well as indicators of overall health, and climate and the physical environment.

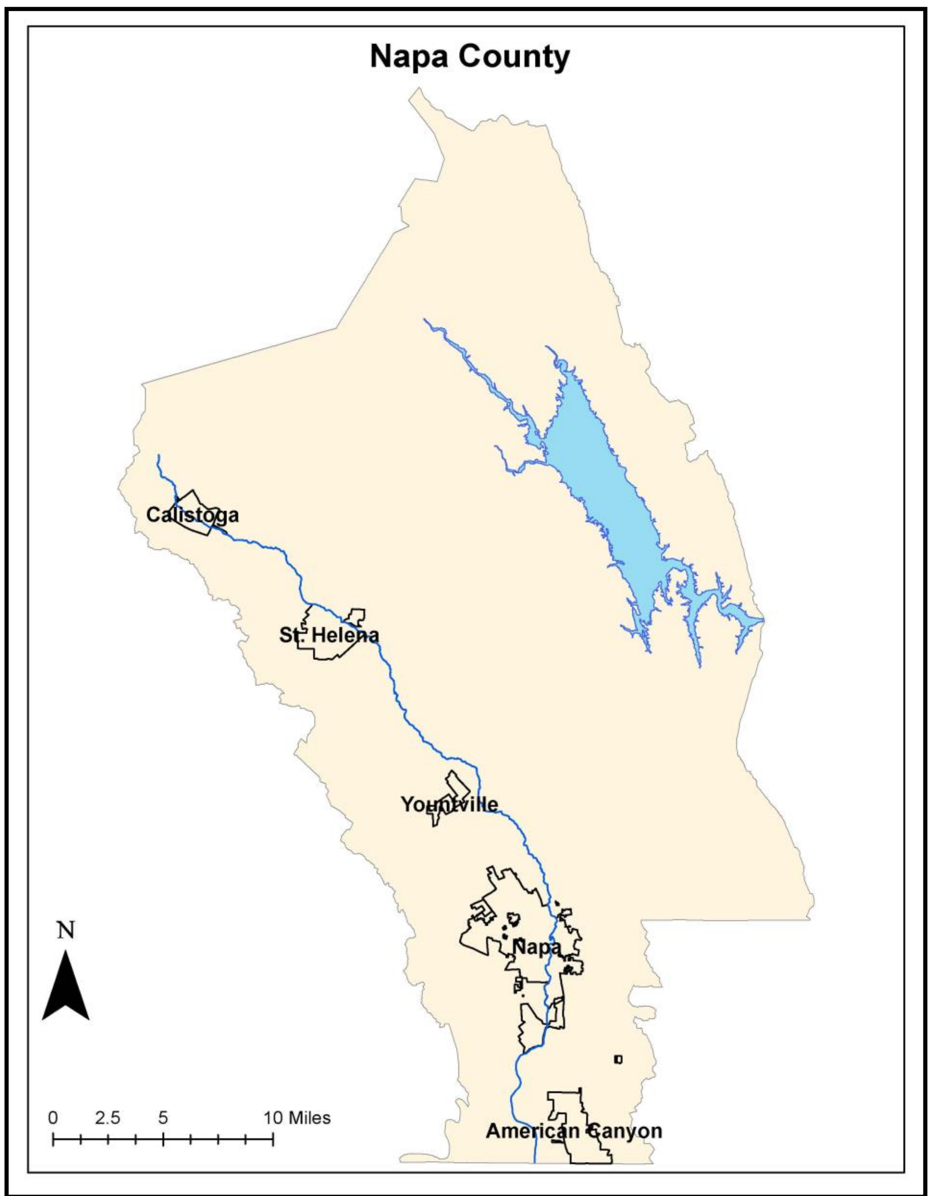
A. Definition of Community Served

Each hospital in the Napa County CHNA Advisory Group defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations. For the county-wide CHNA, the service area for each hospital is Napa County. KFH-Vallejo service area includes parts of Solano County; this hospital will produce a separate CHNA report based on the work of the Napa County CHNA Advisory Group to incorporate additional information regarding this specific service area.

B. Map and Description of Community Served

i. Map

The map below depicts Napa County, the geographic region assessed in this CHNA.



ii. Geographic Description of the Communities Served

The Kaiser Foundation Hospital - Vallejo service area includes communities in Napa and Solano counties. The major communities are Benicia and Vallejo in Solano County and American Canyon, Calistoga, Napa, Oakville, Rutherford, St. Helena, and Yountville in Napa County. The service area is further defined by Highway 29 leading from Vallejo to Napa and Interstate 80 in Solano County.

Queen of the Valley Medical Center service area is comprised of both the Primary Service Area (PSA) as well as the Secondary Service Area (SSA) and is established based on the following criteria:

- PSA: 70% of discharges (excluding normal newborns)
- SSA: 71-85% of discharges (draw rates per ZIP code are considered and PSA/SSA are modified accordingly)
- Includes ZIP codes for continuity
- Natural boundaries are considered (i.e., freeways, mountain ranges, etc.)
- Cities are placed in PSA or SSA, but not both

St. Helena Hospital Napa Valley service area is comprised of communities in Napa and Solano counties. The major communities are the upper valley cities of St. Helena and Calistoga. Although we primarily serve those in the Napa and Solano counties, our destination services also bring us patients from larger and further demographics.

iii. Demographic Profile

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

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

Napa County and California Demographic and Socioeconomic Data[1]		
Indicator	**Napa County**	**California**
Demographic and Socioeconomic Information		
Total Population	139,253	38,066,920
Median Age	40.3 years	35.6 years
Under 18 Years Old	22.4%	24.2%
65 Years Old and Older	16.0%	12.1%
White	77.2%	62.1%
Hispanic/Latino	33.0%	38.2%
Some Other Race	8.9%	12.9%
Asian	7.4%	13.5%
Multiple Races	3.6%	4.5%
Black	2.1%	5.9%
Native American/ Alaskan Native	0.5%	0.8%
Pacific Islander/ Native Hawaiian	0.3%	0.4%
Median Household Income	$70,925	$61,489
Unemployment[2]	5.6%	6.8%
Linguistically Isolated Households	6.8%	9.6%
Households with Housing Costs > 30% of Total Income	42.6%	45.0%

Napa County and California Health Profile Data[3]

[1] Unless noted otherwise, all data presented in this table is from the US Census Bureau, 2010-14 American Community Survey 5-Year Estimate.
[2] US Department of Labor, Bureau of Labor Statistics, June 2015.
[3] Unless noted otherwise, all data presented in this table is from the US Census Bureau, 2009-13 American Community Survey 5-Year Estimate.

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

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

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

V. WHO WAS INVOLVED IN THE ASSESSMENT

The Napa County CHNA was a collaborative effort that included Napa's hospitals as well as partner organizations and individuals throughout the community who worked alongside a team of consultants to collect and analyze data and ultimately produce this report.

A. Identity of Hospitals that Collaborated on the Assessment

The Napa County CHNA Advisory Group –KFH-Vallejo, SJH-QVMC, and St. Helena Hospital—worked in collaboration to complete this county-wide CHNA. Representatives from these non-profit hospitals, joined by representatives from Napa County Department of Health and Human Services, formed the 2015 CHNA Advisory Group.

B. Other Partner Organizations that Collaborated on the Assessment

The Napa County hospitals, in partnership with the following organizations, made up the Napa County CHNA Advisory Group:

- Napa County Health and Human Services Agency
- Live Healthy Napa County

C. Identity and Qualifications of Consultants Used to Conduct the Assessment

- **Harder+Company Community Research:** Harder+Company Community Research is a comprehensive social research and planning firm with offices in San Francisco, Sacramento, Los Angeles, and San Diego. Harder+Company works with public sector, nonprofit, and philanthropic clients nationwide to reveal new insights about the nature and impact of their work. Through high-quality, culturally based evaluation, planning, and consulting services, Harder+Company helps organizations translate data into meaningful action. Since 1986, Harder+Company has worked with health and human service agencies throughout California and the country to plan, evaluate, and improve services for vulnerable populations. The firm's staff offers deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts – including conducting needs assessments; developing and operationalizing strategic plans; engaging and gathering meaningful input from community members; and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation, which is

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

essential to both healthcare reform and the CHNA process in particular. Harder+Company is also the evaluation partner on several other CHNAs throughout the state including in Marin, San Joaquin, and Sonoma Counties.

- **Raimi + Associates:** Raimi + Associates is a community planning, research, and evaluation firm with offices in Riverside, Los Angeles, and Berkeley. Raimi + Associates' mission is to provide consulting services that support community health, sustainable neighborhoods, and social equity. Raimi + Associates is nationally recognized for its commitment to elevating community health in all aspects of its work. The Raimi + Associates' team views community health broadly, and seeks to integrate cross-sector perspectives into their projects. They use data to understand how a range of factors—or social determinants of health—affect the health of communities. The firm brings deep expertise in qualitative and quantitative research methods, including community surveys, focus groups, key informant interviews, reviewing secondary data sources, and crafting innovative policies for community assessments, community change evaluation, and strategic planning. Raimi + Associates has a successful track record partnering effectively with nonprofits, government agencies, community collaboratives, and foundations to achieve their long-term visions.

VI. PROCESS AND METHODS USED TO CONDUCT THE CHNA

Harder+Company and Raimi + Associates staff used a mixed-methods approach to collecting and compiling data to develop a robust assessment of community health in Napa County. A broad lens on qualitative and quantitative data allowed for the consideration of many potential health needs as well as in-depth analysis. The following section outlines the data collection and analysis methods used to conduct the CHNA.

A. Secondary Data

i. Sources and Dates of Secondary Data Used in the Assessment

The Napa County CHNA Advisory Group used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publicly available data sources. Additional secondary data was compiled and reviewed from existing sources including California Health Interview Survey, American Community Survey, and California Healthy Kids Survey, among other sources. Where more recent data was readily available and current estimates were critical to assessing changing landscapes such as health insurance status, Kaiser Permanente CHNA Data Platform information was updated as new data was publicly released, to reflect more recent data. In addition to statewide and national survey data, previous community health assessments and other relevant external reports were reviewed to identify additional existing data on additional indicators at the county level. For details on the specific source and year for each indicator reported, please see Appendix B.

ii. Methodology for Collection, Interpretation, and Analysis of Secondary Data

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

Where available, Napa County data was considered alongside relevant benchmarks including the California state average, Healthy People 2020, and the United States average. Each indicator was compared to a relevant benchmark, most often the California state average. These scores were used to generate an average score for each potential health need. If no appropriate benchmark was available, an indicator could not be scored; however, such indicators remain in the final data book (Appendix B) and were used to provide supplementary information about identified health needs. In areas of particular health concern, data were also collected at smaller geographies, where available, to allow for more in-depth analysis and identification of community health issues. Data on gender and race/ethnicity breakdowns were analyzed for key indicators where subpopulation estimates were available.

B. Community Input

i. Description of the Community Input Process

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

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

Community partners provided invaluable assistance in recruiting and enrolling focus group participants. Many individuals who participated in focus groups identified as leaders, representatives, or members of medically underserved, low-income, chronically diseased, and minority populations. For more information about specific populations reached in focus groups, see Appendix C.

ii. Methodology for Collection and Interpretation of Primary Data

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

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

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

C. Written Comments

PLACEHOLDER.

D. Data Limitations and Information Gaps

The Kaiser Permanente CHNA data platform includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. While changes to the platform are ongoing, the data presented in this report reflect estimates from the Kaiser Permanente CHNA data platform on September 9, 2015. Supplementary secondary data were obtained from reliable data platforms including U.S. Census Bureau American FactFinder, AskCHIS, and others. However, as with any secondary data estimates, there are some limitations. With attention to these limitations, the process of identifying health needs was based on triangulating primary data and multiple indicators of secondary data estimates. The following considerations may result in unavoidable bias in the analysis:

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

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

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

VII. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

A. Identifying Community Health Needs

i. Definition of "Health Need"

For the purposes of the CHNA, the Napa County CHNA Advisory Group defines a "health need" as a health-related outcome (e.g., access to care), the related conditions that contribute to a defined health need (e.g., access to housing), or the health need itself (e.g., cancers). In this context, potential health needs are intended to identify a condition or related set of conditions, rather than a specific population of high need. Within each health need, high risk populations are explored as well. For this reason, information about needs of specific at-risk subpopulations such as older adults is included within the context of the health needs. Health needs are identified through the comprehensive identification, interpretation, and analysis process of a robust set of primary and secondary data.

A total of 18 potential health needs were examined, as outlined in the Table below.

Health Need	Definition
Access to Care	Data related to health insurance, care access, and preventative care utilization for physical, mental, and oral health
Access to Housing	Data related to cost, quality, availability, and access to housing
Asthma and COPD	Known drivers of asthma and other respiratory diseases, and health outcomes related to these conditions
Cancers	Known drivers of cancers, and health outcomes related to cancers
Child Mental and Emotional Development	Data related to development of mental and emotional health in young children, particularly age 0-5

Climate and Health	Data related to climate and environment, and related health outcomes
CVD and Stroke	Known drivers of heart disease and stroke, and related cardiovascular health outcomes
Economic Security	Data related to economic well-being, food insecurity, and drivers of poverty including educational attainment
Education	Data related to educational attainment and academic success, from preschool through post-secondary education
HIV/AIDS/STI	Known drivers of sexually transmitted infections including HIV, and related STI and AIDS outcomes
Mental Health	Data related to mental health and well-being, access to and utilization of mental health care, and mental health outcomes
Obesity and Diabetes	Data related to healthy eating and food access, physical fitness and active living, overweight/obesity prevalence, and downstream health outcomes including diabetes
Oral Health	Data related to access to oral health care, utilization of oral health preventative services, and oral health disease prevalence
Overall Health	Data related to overall community health including self-rated health and all-cause mortality
Pregnancy and Birth Outcomes	Data related to behaviors, care, and outcomes occurring during gestation, birth, and infancy; includes health status of both mother and infant
Substance Abuse and Tobacco	Data related to all forms of substance abuse including alcohol, marijuana, tobacco, illegal drugs, and prescription drugs
Vaccine-Preventable Infectious Disease	Data related to vaccination rates and prevalence of vaccine-preventable disease
Violence and Injury	Data related to intended and unintended injury such as violent crime, motor vehicle accidents, domestic violence, and child abuse

ii. Criteria and Analytical Methods Used to Identify the Community Health Needs

The first step in the process of identifying community health needs for Napa County was to score all secondary data against a benchmark, in most cases the California state estimate, and to apply a score to each potential health need based on the aggregate score of the indicators assigned to that health need. Additionally, content analysis was used to analyze key themes in both the Key Leader Interviews and Focus Groups. Section V contains more information on quantitative and qualitative data analysis.

Potential health needs were identified as a health need in Napa County if:

a. Multiple indicators reviewed in secondary data demonstrated that the county estimate was greater than 1% "worse" than the benchmark comparison estimate (in most cases, this benchmark was the California state average).
b. The health issue was identified as a key theme in at least nine interviews OR in at least one focus group.

If a health need was mentioned overwhelmingly in primary data but did not meet the criteria for secondary data, the analysis team conducted an additional search of secondary data to confirm that all valid and reliable data concurred with the initial secondary data and to examine whether indicators within the health need disproportionately impact specific geographic, age, or racial/ethnic subpopulations. In the few cases where either qualitative or quantitative data presented strong evidence of being a potential health need, the Napa County CHNA Advisory Group discussed the data and came to consensus about whether or not to include the health need.

The consultant team summarized the results of the analysis of potential health needs in a matrix which was then reviewed and discussed by the Napa County CHNA Advisory Group.

The consultant team and Napa County CHNA Advisory Group identified ten health needs which met the first criteria of having at least two distinct indicators that performed >1% worse than benchmark estimates. Of these, five met the additional criteria of being identified as a theme in key leader interviews and focus groups and were thus designated as health needs. One potential health need, Access to Housing, did not meet the criteria for inclusion as a health need based on its secondary data score, though it was a significant theme in the majority of interviews and focus groups. Therefore, the Napa County CHNA Advisory Group decided to include data about Access to Housing along with Economic Insecurity (which met both criteria for inclusion) because access to safe and affordable housing is very closely linked to economic security.

The Napa County CHNA Advisory Group also decided to combine two other interrelated potential health needs that met the criteria for inclusion when considered together but not separately. Specifically, Access to Care did not meet the secondary data criteria, but was a strong theme in primary data. Similarly, Oral Health was not a salient theme in interviews and focus groups but secondary data revealed that there are important issues related to *access* to oral health care in Napa County. As a result, these two health needs are presented together as Access to Primary and Oral Health Care for Napa County. Finally, the potential health need of Cancers demonstrated considerable need in secondary data, but was not identified as a theme in primary data. The Napa County CHNA Advisory Group reasoned that this may indicate a lack of knowledge about cancer incidence and mortality in Napa County. In order to address this gap, the Napa County CHNA Advisory Group decided to include Cancers as an identified health need. Thus, a total of seven health needs were identified in Napa County.

B. Process and Criteria Used for Prioritization of the Health Needs

The Criteria Weighting Method—a rigorous mathematical process whereby participants establish a relevant set of criteria and assign a priority ranking to issues based on how they measure against the criteria—was used to prioritize the seven health needs. This method was selected as it enabled consideration of each health need from different perspectives, and allowed the Napa County CHNA Advisory Group to weight certain criteria and use a multiplier effect in the final score.

To determine the scoring criteria, Napa County CHNA Advisory Group members reviewed a list of potential criteria and selected a total of four criteria as seen below:

Criteria	Definition
Severity	The health need has serious consequences (morbidity, mortality, and/or economic burden) for those affected.
Disparities	The health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations.
Prevention	Effective and feasible prevention is possible. There is an opportunity to intervene at the prevention level and impact overall health outcomes. Prevention efforts include those that target individuals, communities, and policy efforts.
Co-benefit	Solution could impact multiple problems. Addressing this issue would impact multiple health issues.

In order to develop a weighted formula to use in prioritization, each member of the Napa County CHNA Advisory Group assigned a weight to each criterion between 1 and 5. A weight of 1 indicated the criterion is not very important in prioritizing health issues whereas a weight of 5 indicated the criterion is extremely important in prioritizing health issues. The average of weights assigned by members of the Napa County CHNA Advisory Group for each criterion were used to develop the formula below to provide a final formula for use in scoring health needs for prioritization.

Overall Score= (2*Severity) + (2*Disparities) + (1*Prevention) + (1*Co-benefit)

In order to review and prioritize identified health needs, a half-day prioritization session was held on December 18, 2015, at the SJH-QVMC. A total of 34 stakeholders representing sectors such as health, education, public safety, and child welfare attended. The goals of the meeting were to: review health needs identified in Napa County; discuss key findings from the CHNA; and prioritize health needs in Napa County. After each health need was reviewed and discussed, participants voted on each health need using the four criteria discussed above. The table below outlines the results of the voting on each health need.

Health Needs in Priority Order	
Final Results	**Unweighted Scores by Criteria**

Health Need	Weighted Score	Severity	Disparities	Prevention	Co-benefit
1. Education	**37.37**	6.13	6.36	6.09	6.30
2. Economic and Housing Insecurity	**36.39**	6.39	6.18	5.27	5.97
3. Mental Health	**34.71**	6.15	5.53	5.27	6.09
4. Obesity and Diabetes	**33.68**	5.69	5.29	5.97	5.77
5. Access to Primary and Oral Health Care	**32.52**	5.52	5.42	5.09	5.55
6. Substance Use	**32.09**	5.77	4.83	5.09	5.80
7. Cancers	**27.57**	5.00	4.41	4.31	4.43

C. Prioritized Description of the Community Health Needs Identified Through the CHNA

In descending priority order, the following health needs have been prioritized as follows in Napa County:

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

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

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

   The high cost of living in Napa exacerbates issues related to economic security and stable housing. Among all households, 42.9% spend 30% or more of household income on housing costs.[26] Malnutrition and food insecurity are also key issues for Napa County residents, as many are forced to spend most of their income on housing, and do not qualify for public benefits.

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

[25] California Department of Education, 2013-14.
[26] US Census Bureau, American Community Survey, 2009-13.

Mental health was raised as a high concern. Most notably, Napa residents have a high risk of suicide. An estimated 10.3% of Napa County residents report having seriously considered suicide; among Latinos in the county, this estimate is 27.9%.[27] Older adults, transition age youth, LGBTQ youth, and Latinos were noted as populations of high concern for mental health issues. Social stigma and the geographic distribution of resources were considered as barriers to receiving appropriate mental health services.

4. **Obesity and Diabetes:** Weight that is higher than what is considered as a healthy weight for a given height is described as overweight or obese.[28] Overweight and obesity are strongly related to stroke, heart disease, some cancers, and type 2 diabetes.

   In Napa County, an estimated 24.0% of adults are obese,[29] and 37.0% are overweight.[30] Among youth, 14.8% are obese and 19.5% are overweight.[31] Access to affordable healthy food was identified as a concern, particularly in specific areas of Napa County including American Canyon and rural communities. Since economic disadvantage is strongly linked to barriers that inhibit healthy consumption of foods and an active lifestyle, low-income residents, as well as older adults and residents experiencing homelessness, are disproportionately affected by this health need.

5. **Access to Primary and Oral Health Care:** Ability to utilize and pay for comprehensive, affordable, quality physical and mental health care is essential in order to maximize the prevention, early intervention, and treatment of health conditions. Nationwide, there is a focus on integrating oral health services into primary care. Utilization of oral health care is extremely important to health, as tooth and gum disease can lead to multiple health problems such as oral and facial pain, problems with the heart and other major organs, as well as digestion problems.

   With the implementation of the ACA, many adults in Napa County have access to insurance coverage and regular healthcare. However, disparities persist. Premiums for health insurance remain high, and many providers do not accept Medi-Cal or have long waiting lists. Dental insurance was not included in recent health insurance reform, and 43.7% of the adult population in the county lacks dental insurance.[32]

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

   In Napa County, substance abuse was identified as a concern, particularly with respect to alcohol consumption. Among adults, 21.3% of residents report heavy alcohol consumption.[33] Youth were noted as a high risk population, and data indicates that in the prior 30 days 11.8% of 11th grade students reported using cigarettes, 22.8% reported binge drinking, and 24.9% reported using marijuana.[34]

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[27] California Health Interview Survey, 2014.
[28] http://www.cdc.gov/obesity/adult/defining.html
[29] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[30] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2011-12.
[31] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[32] California Health Interview Survey, 2009.
[33] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2006-12.
[34] California Healthy Kids Survey, 2011-13.

7. **Cancers:** Cancer is a broad term which encompasses over 100 specific diseases, all of which begin with abnormal cell growth.[35] Cancer is typically defined by the primary site of abnormal growth, and the progression of the disease is affected by the cancer type, as well as the phase of detection, and available treatment options.

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

The seven health needs that emerged as top concerns in Napa County highlight the importance that Napa County stakeholders give to addressing the social determinants of health in order to build a healthier and stronger community. Access to quality education, safe and affordable housing, and economic stability rose to the top of the list of prioritized health needs. This list of health needs underscores the importance of multi-sector collaboration and cross-cutting strategies that address multiple health needs simultaneously.

Furthermore, the list of prioritized health needs corroborates findings from the Napa County 2013 Community Health Assessment (CHA). The 2016 CHNA updates data included in the 2013 CHA, reinforces priorities determined during the CHA/Community Health Improvement Planning process, and confirms that multi-sector efforts to address these health needs remain critical to improved health in Napa County.

In addition to the supporting data presented for each identified health need, several cross-cutting themes emerged in the primary data that speak to a broader consideration of community structure and cohesion. In working towards equal opportunities for people to lead safe, active, and healthy lifestyles, Napa residents and key stakeholders cited challenges related to isolation that impact specific populations within the county and the community as a whole. Poor transportation across the county contributes to this isolation, as well as social norms segregating different subpopulations within communities county-wide. In particular, older adults were noted as a population often suffering from social isolation, as well as those for whom immigration status or language is a barrier to social cohesion in the community at large. Discrimination towards people experiencing homelessness was also raised as a concern among stakeholders, as well as discrimination towards members of the LGBTQ population. For many residents, feelings of invisibility, segregation, and isolation can have profound impacts on both mental and physical health, as well as on overall quality of life.

D. Community Resources Potentially Available to Respond to the Identified Health Needs.

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

[35] American Cancer Society. Accessed at http://www.cancer.org/cancer/cancerbasics/what-is-cancer, December 2015.

VIII. APPENDICES

A. **Health Need Profiles**

B. **Secondary Data, Sources, and Years**

C. **Community Input Tracking Form**

D. **Primary Data Collection Protocols**

E. **Prioritization Scoring Matrix**

Appendix A

Napa County Community Health Needs Assessment Health Need Profiles

Contents

Access to Primary and Oral Health Care … A 2

Economic and Housing Insecurity………. A 7

Education………………………………. A 11

Cancers………………………………… A 16

Mental Health…………………………. A 21

Substance Use…………………………. A 26

Obesity and Diabetes…………………… A30

Indicator Key

Throughout the health need profiles, California state average estimates are included where available for reference. Differences between Napa County and California state estimates are not necessarily statistically significant, and are color coded as follows:

≥ 2% better than benchmark data

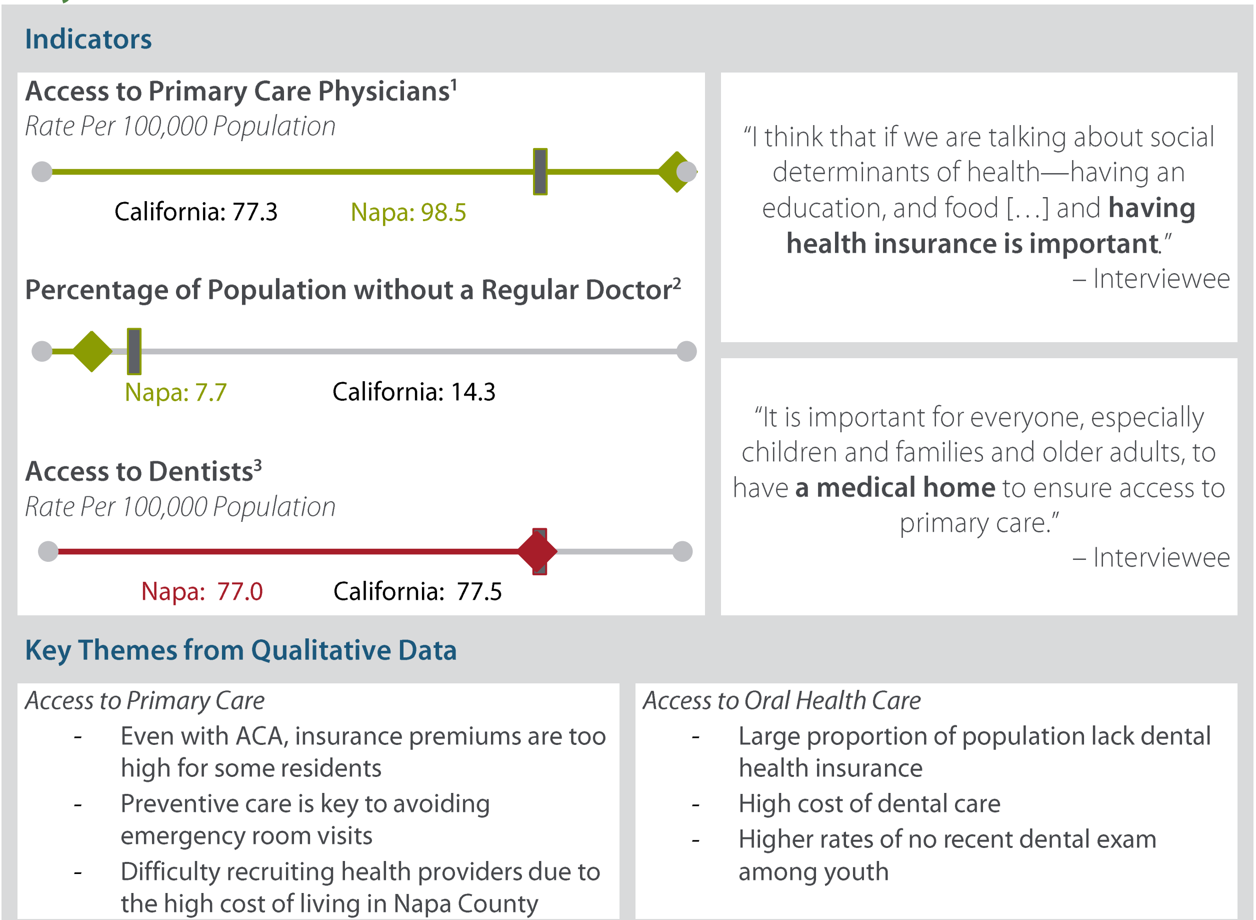
Within 2% better than benchmark data

≥ Worse than benchmark data

Access to Primary and Oral Health Care

Access to comprehensive, affordable, quality primary and oral health care is critical to the prevention, early intervention, and treatment of health conditions. With the implementation of the Affordable Care Act (ACA), many people within Napa County are now able to access insurance coverage and access regular primary healthcare. However, some issues related to access to primary care still persist. Specifically, the cost of care, including insurance premiums and medications, is a serious barrier to access. Since the ACA did not increase dental insurance coverage, a large percentage of adults still lack dental insurance and a significant percentage of youth do not receive regular dental exams. Additionally, recruiting health care providers has been difficult given the high cost of living in Napa County. Interviewees indicate that this impacts the availability of providers and thus may prolong appointment wait times. Furthermore, disparities in access to primary and dental care exist throughout the county. Residents in isolated rural areas must travel to access needed services and facilities, and as a result many often do not access health care. Older adults have specific needs that present additional barriers to accessing care, such as mobility and transportation challenges. Immigration status and stigma are also noted barriers that prevent people from accessing available care; undocumented immigrants are not eligible for health insurance under the ACA.

Key Data



Note: California state average estimates are included for reference. Differences between Napa County and California state estimates are not necessarily statistically significant.

Napa County Community Health Needs Assessment

Access to Primary and Oral Health Care (continued)

Additional Data and Key Drivers

Additional Data: Oral Health Care

Poor Dental Health, Adults
Percent of adults with poor dental health [4]

7.6 | 11.3
Napa | California

Lack of Affordable Dental Care, Youth
% of youth unable to afford dental care[5]

4.1 | 6.3
Napa | California

"There are **limited number of places people can go to for dental care**; people need to travel far distances."
– Interviewee

"Restorative dental care for older adults is very expensive. Very **few providers take Medi-Cal for dental care**."
– Interviewee

Additional Data: Primary and Mental Health Care

Lack of Primary Care Professionals
% of population living in primary health care professional shortage area[6 †]

1.3 | 25.2
Napa | California

"There are **long wait periods** before appointments are available. For one resident, it was 8 months."
– Interviewee

Access to Mental Health Providers
Rate per 100,000 population [7]

247.2 | 157.0
Napa | California

Driver: Insurance Coverage

Uninsured Population
% of population without health insurance[8]

13.9 | 16.7
Napa | California

Lack of Dental Health Insurance, Adults
% of adults without dental insurance [9]

43.7 | 40.9
Napa | California

Insured Population Receiving Medi-Cal
% of insured population receiving Medi-Cal[10]

16.0 | 24.4
Napa | California

"Health insurance is necessary for access to primary care; a large population in Napa County still does not have health insurance. Even with health insurance, premiums are high."
– Interviewee

"Access to insurance has improved because of ACA, [but] I'm not certain that everyone is accessing [it]. ER [use] is higher, because people are using it because they can't find a doctor."
– Interviewee

"Medications are also very expensive and are not fully covered by health insurance or Medi-Cal."
– Interviewee

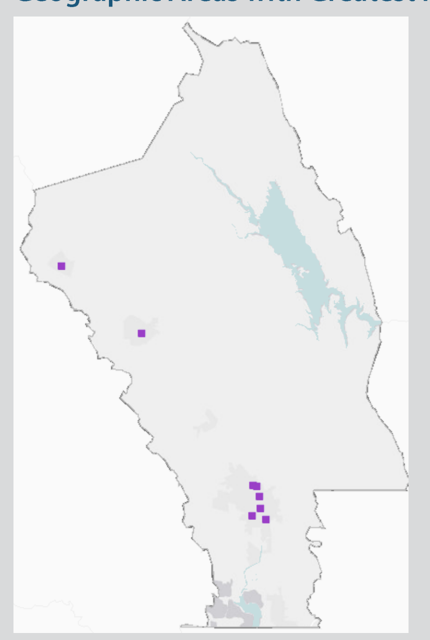
*Unstable estimate; findings should be interpreted with caution.
† Primary Care Health Professional Shortage Area (HPSA) is defined as an area with 3,500 or more people per primary care physician (U.S. Department of Health and Human Services, http://www.hrsa.gov/shortage/). As a note, there is no generally accepted ratio of physician to population ratio. Care needs of an individual community will vary due to a myriad of factors. Additionally, this indicator does not take into account the availability of additional primary care services provided by Nurse Practitioners and Physician Assistants in an area.

Napa County Community Health Needs Assessment

Access to Primary and Oral Health Care (continued)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Federally Qualified Health Centers[11]

The map displays geographic disparities in location of federally qualified health centers. The majority of centers are located in the southern part of the county in and around the City of Napa.

Key

Federally Qualified Health Centers

Populations at Greatest Risk

Older adults

Older adults present specific needs and challenges to accessing health care, such as mental health needs. Seniors also have transportation barriers and challenges, especially in rural areas of the county.

Other disparities

- Qualitative data indicates populations with **lower socioeconomic status**, such as agricultural workers, face barriers to health care access.
- Qualitative data details the stigma that **undocumented workers** related to their immigration status, which often affects their ability to access health care.
- **Rural areas** of the county do not have immediate access to preventive care, education, or resources.
- In 2012-13, nearly 20% of **transgender people** reported that their healthcare providers did not display sensitivity or competency regarding LGBTQ needs.[12]

"I have taken an inventory of **Calistoga**, for example, which we have identified in previous health need assessments to be a vulnerable community. I met with the leader of Clinic Ole and [. . .] we think there is a third of the population of Calistoga that doesn't access health care at all."

– Interviewee

Napa County Community Health Needs Assessment

Access to Primary and Oral Health Care

(continued)

Assets and Recommendations

Examples of Existing Community Assets†

Community Health Initiative

Family Resource Centers

Federally Qualified Health Centers

Community Recommendations for Change

Expand Accessibility

- Expand mobile dental clinic van services for children to provide oral health care for older adults
- Expand health care service hours to evenings and weekends
- Strengthen transportation services, especially for older adults
- Offer hospital shuttle service
- Support separate healthcare networks to fill service gaps, particularly in geographically isolated regions, and offer services to out-of-network patients
- Offer health care home visits, particularly for older adults in geographically isolated areas like Calistoga

Provide Culturally Competent Care

- Continue efforts to ensure that community-based organizations and health providers provide culturally competent care

Increase Awareness of Resources

- Increase marketing and outreach efforts to promote awareness of existing health care resources

Increase Affordable Housing to Promote the Growth of the Health Workforce

According to one interviewee, "**The high cost of living is driving a lot of people to live outside of Napa County**. I'll say that from our perspective, it's very, very difficult to recruit physicians and clinicians to the area because a lot of folks who would want to work for us are young, recent graduates from medical school, and they are coming out of school with a lot of debt. Once they come to Napa and look at the housing cost, they choose to work elsewhere because of the disparities between income and cost of living. That is definitely taking quite a toll. I think that's true both for behavioral health clinicians and also primary care clinicians. At some point Napa County should look at ways to create and sustain some lower-income affordable places to live. **They are going to end up in a situation where it is increasingly difficult to recruit professionals – highly needed professionals – into the area because of the housing situation.**"

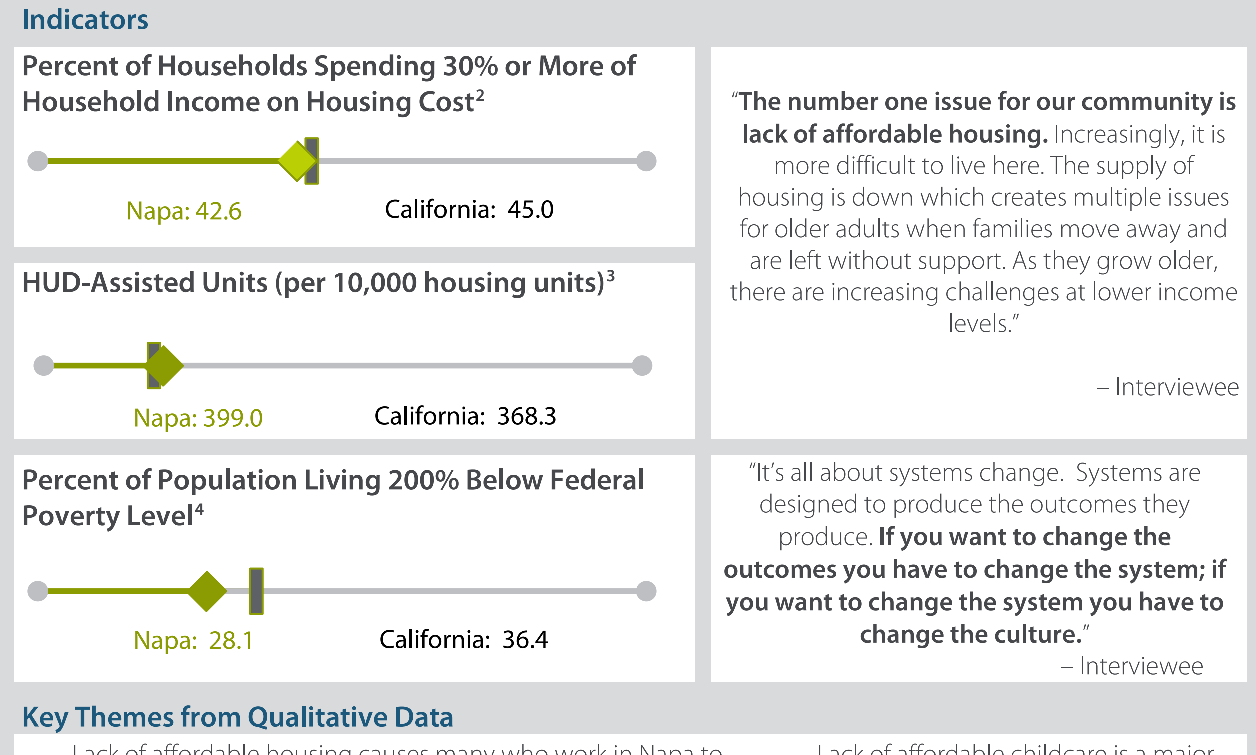
† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2012.
[2] University of California Center for Health Policy Research, California Health Interview Survey, 2011-12.
[3] US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2013.
[4] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2006-10.
[5] California Health Interview Survey, 2009.
[6] Ibid.
[7] University of Wisconsin Population Health Institute, County Health Rankings, 2014.
[8] US Census Bureau, American Community Survey, 2010-14.
[9] California Health Interview Survey, 2009.
[10] US Census Bureau, American Community Survey, 2010-14.
[11] US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, Sept. 2015.
[12] LGBTQ Connection, "Napa County LGBTQ Needs Assessment," 2012-13.

Economic & Housing Insecurity

Economic security is a key determinant of health: having limited economic resources can impact access to opportunities to be healthy, including access to healthy food, medical care, and safe environments.[1] Access to stable, affordable housing also contributes to a strong foundation for good health, whereas substandard housing and homelessness exacerbate other physical and mental health issues. A high cost of living contributes to both economic and housing issues. In Napa County, while many economic indicators such as unemployment and housing costs rank better than statewide, the cost of living is higher in the county than other parts of the state, forcing families who work in Napa to move and live outside the county. Malnutrition and food insecurity are also key issues for Napa County residents, as many are forced to spend most of their income on housing, and do not qualify for public benefits. Community members and key stakeholders recommended increasing access to affordable housing, childcare, and healthy food.

Key Data



Key Themes from Qualitative Data

- Lack of affordable housing causes many who work in Napa to live outside the county
- Low 4th grade reading levels predict later educational success, which can lead to poverty, unemployment, and barriers to healthcare access (e.g., low health literacy/education)
- Lack of affordable childcare is a major financial stressor on families
- Cost of living is so high many are unable to afford food or housing but do not qualify for public benefits

† Reports counts of all housing units receiving assistance through the US Department of Housing and Urban Development (HUD). Assistance programs include Section 8 housing choice vouchers, Section 8 Moderate Rehabilitation and New Construction, public housing projects, and other multifamily assistance projects. Units receiving Low Income Housing Tax Credit assistance are excluded from this summary.

Note: California state average estimates are included for reference. Differences between Napa County and California state estimates are not necessarily statistically significant.

Economic & Housing Insecurity

Additional Data

Housing Stock and Quality

Vacant Housing Units
% of housing units that are vacant[5,†]

9.9 | 8.6
Napa | California

Substandard Housing
% of housing with substandard housing[6]

44.4 | 48.4
Napa | California

Overcrowded Housing
% of adults living in overcrowded conditions (>1.5 persons/room)[7]

3.6 | 5.2
Napa | California

"People are living in storage sheds and garages that are really uninhabitable. Some people even live in their cars, because **there is not enough housing**."
– Interviewee

Poverty and Unemployment

Children in Poverty
% of children (age <18) living below 100% of Federal Poverty Level[8]

14.0 | 22.7
Napa | California

Older Adults in Poverty
% of adults (age 65+) living below 100% of Federal Poverty Level[9]

6.8 | 9.9
Napa | California

Unemployment Rate
% of civilian non-institutionalized population age 16 and older that is unemployed[10]

5.6 | 6.8
Napa | California

Children Eligible for Free/Reduced Price Lunch
% of public school students eligible for free or reduced price lunches[11]

45.4 | 58.1
Napa | California

"Even though I only had enough money to pay for my car and rent and 500 dollars in my account, I didn't qualify for food stamps, even with my dependent."
– Focus Group Participant

Population Receiving SNAP
% of the population receiving Supplemental Assistance Program (SNAP) benefits[12]

5.3 | 10.6
Napa | California

Food Insecurity
% of the population that experienced food insecurity at some point during the report year[13]

12.0 | 16.2
Napa | California

" We surveyed our patients, and about 40% of them indicated that close to the end of the month they were **running out of food due to lack of money**."
– Interviewee

Households with No Vehicles
Number of households with no motor vehicle[14]

4.6 | 7.8
Napa | California

† Vacant housing reported as an indicator of blight across the city. Research demonstrates links between foreclosed, vacant, and abandoned properties with reduced property values, increased crime, increased risk to public health and welfare, and increased costs for municipal governments. (U.S. Department of Housing and Urban Development, Evidence Matters, Winter 2014).

Napa County Community Health Needs Assessment

Economic & Housing Insecurity

Populations Disproportionately Affected

Geographic Areas with Greatest Risk

Percentage of Residents Living Below 200% of the Federal Poverty Level (FPL) by Census Tract, 2009-2013
Napa County

Calistoga
St. Helena
Yountville
Napa
American Canyon
N

% with income <200% FPL
1.5 - 20.6
20.7 - 36.0
36.1 - 50.5
Data suppressed due to small numbers
Data Unstable

Source: ACS 2013, 5 yr, C17002
Author: Kimberly Foster
Napa County Public Health

0 3 6 12 Miles

The map (left) depicts the percentage of the population living below 200% of the Federal Poverty Level by census tract in Napa County. The city of Napa, greater Calistoga region, Yountville, American Canyon, and the region northeast of St. Helena are areas with notably high percentages of the population living in poverty.

Populations with Greatest Risk

Racial/Ethnic disparities

Interviewees and focus group participants identified Latino residents as being at particularly high risk of experiencing problems accessing quality housing in Napa County.

Economic & Housing Insecurity

Assets and Recommendations

Examples of Existing Community Assets†

Early Childhood Programs	Food Assistance Programs	Homeless Services and Shelters

Community Recommendations for Change

- Enforce a living wage
- Advocate for agricultural workers' rights
- Implement policy changes that address affordable housing
- Increase access to affordable child care
- Increase access to affordable housing
- Increase access to affordable grocery stores
- Increase access to educational opportunities (e.g., post-secondary education)

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

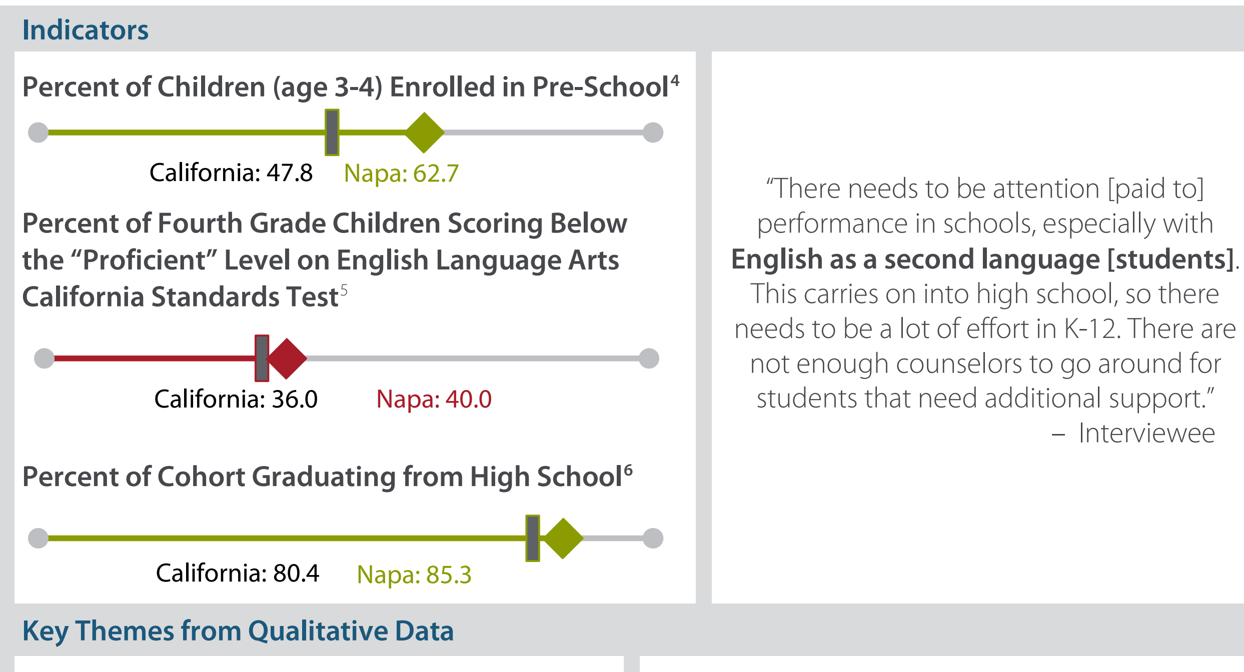
[1] "Health & Poverty," Institute for Research on Poverty, Accessed October 19, 2015, http://www.irp.wisc.edu/research/health.htm.
[2] US Census Bureau, American Community Survey, 2010-14.
[3] US Department of Housing and Urban Development, 2013.
[4] US Census Bureau, American Community Survey, 2010-14.
[5] US Census Bureau, American Community Survey, 2009-13.
[6] Ibid.
[7] Ibid.
[8] US Census Bureau, American Community Survey, 2010-14.
[9] US Census Bureau, American Community Survey, 2009-13.
[10] US Department of Labor Bureau of Labor Statistics, June 2015.
[11] National Center for Education Statistics, NCES - Common Core of Data, 2013-14.
[12] US Census Bureau Small Area Income & Poverty Estimates, 2011.
[13] Feeding America, 2012.
[14] US Census Bureau, American Community Survey, 2009-13.

Napa County Community Health Needs Assessment

Education

Educational attainment is a key determinant of health: people with low levels of education are prone to experience poor health outcomes and stress, whereas people with more education are likely to live longer, practice healthy behaviors, experience better health outcomes, and raise healthier children.[1] Completing formal education is a key pathway to employment and to higher paying jobs that can provide the means to lead a healthier life.[2] From preschool to post-secondary education, primary and secondary data indicate that retention and quality education are key needs in Napa County. Bullying and harassment among students is also a concern in Napa County. While key education outcomes, such as percent of students graduating from high school in four years, are higher for Napa County than the rest of California, evidence of extreme racial/ethnic disparities remain concerning. In particular, secondary data reveal that Hispanic/Latino students and English Language Learners (ELL) are at high risk for dropping out of high school.[3] To improve county-wide access and decrease disparities, community members and key stakeholders recommended strategies such as increasing support for programs that work closely with low performing students to improve access to post-secondary education.

Key Data



Key Themes from Qualitative Data

- High numbers of students do not complete high school, especially among Latino students
- Educational needs of English Language Learners and Hispanic/Latino students are not identified and addressed at a young age
- Educational attainment for ELL students is poor; gaps need to be addressed sooner (e.g., higher percentage of high school dropouts)
- Harassment and bullying occurs frequently in schools

Note: California state average estimates are included for reference. Differences between Napa County and California state estimates are not necessarily statistically significant.

Education (continued)

Additional Data

Early Childhood Education

Head Start Program Facilities

Rate of Head Start program facilities per 10,000 children under age 5[7]

7.4 | 6.3

Napa | California

English Language Learners

English Language Performance (Grade 10)

% of all students versus English language learners (grade 10) who passed the California High School Exit Exam in English Language Arts[8]

85.0 | 22.0 | 38.0

Napa: All | Napa: ELL | California: ELL

Math Performance (Grade 10)

% of all students versus English language learners (grade 10) who passed the California High School Exit Exam in Math[9]

87.0 | 39.0 | 54.0

Napa: All | Napa: ELL | California: ELL

Retention/Discipline

Expulsion

Rate of expulsion per 100 enrolled K-12 public school students[10]

0.02 | 0.05

Napa | California

Suspension

Rate of suspension per 100 enrolled K-12 public school students[11]

3.51 | 4.04

Napa | California

Educational Attainment

Less than High School Diploma

% of population age 25+ with no high school diploma or equivalent[12]

16.9 | 18.8

Napa | California

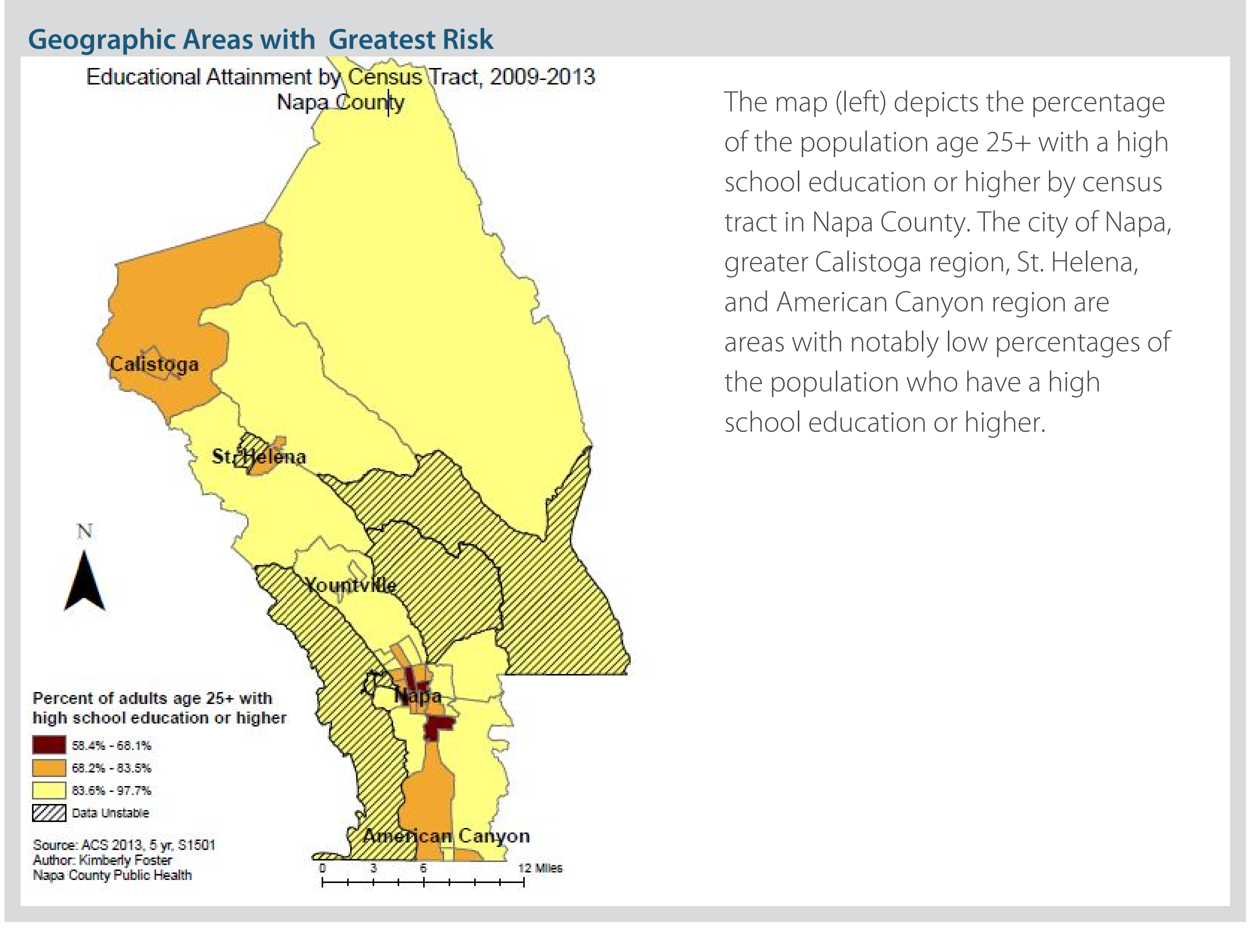
"If [low-performing students] never get caught up, then they will continue to be disadvantaged. **English Language Learners are at a disadvantage**, so there is some connection to the trajectory, which starts in 3rd [and 4th] grade. I think the dropout rate does not fully capture what fully happens."

– Interviewee

Education (continued)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



The map (left) depicts the percentage of the population age 25+ with a high school education or higher by census tract in Napa County. The city of Napa, greater Calistoga region, St. Helena, and American Canyon region are areas with notably low percentages of the population who have a high school education or higher.

Education (continued)

Populations Disproportionately Affected

Populations at Greatest Risk

Percentage of Students Dropping out of High School by Race/Ethnicity, 2013-2014[13]

	Napa County	California
Overall	10.0	11.5
African American (Not Hispanic)	14.0	20.3
American Indian/Alaska Native (Not Hispanic)	23.1	18.8
Asian (Not Hispanic)	5.0	4.5
Filipino (Not Hispanic)	2.9	4.4
Hispanic/Latino	14.2	13.9
Pacific Islander (Not Hispanic)	10.0	12.4
White (Not Hispanic)	5.8	7.6
Multiracial (Not Hispanic)	8.0	8.4

Percentage of Students Dropping out of High School by Program, 2013-2014[14]

	Napa County	California
All Students	10.0	11.5
English Learners	22.4	20.8
Migrant Education	20.0	15.7
Special Education	18.3	16.0
Socioeconomically Disadvantaged	15.0	14.4

Interviewees and focus group participants highlighted that Latino students, in particular, are at risk of low educational attainment or poor academic performance.

One interviewee said, "My primary work is with Latino families and Latino kids. The county has not identified the educational equity disparities. The disparities…for post high school education are huge. **We don't have a graduation problem; we have a group that graduates that are un-educated and un-skilled.** So many of those kids have straight Ds or they have not taken the right classes in order to apply for a UC or a CSU, so they are going nowhere."

Education (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Robotics STEM course for middle school students	Community-based organizations focused on strengthening early childhood education	UC Davis Math Institute (works with middle school students the summer before high school)

Community Recommendations for Change

- Continue support for programs that work closely with low performing students to help them become college-ready and to ensure access to post-secondary education
- Increase financial aid support, especially for high-need populations
- Partner with Napa Valley College
- Develop career tracks to encourage students to pursue careers in the healthcare field
- Increase services/resources in schools
- Provide college counseling for all students
- Strengthen early childhood education system
- Bridge the education gap between students who are English Language Learners and English speaking students

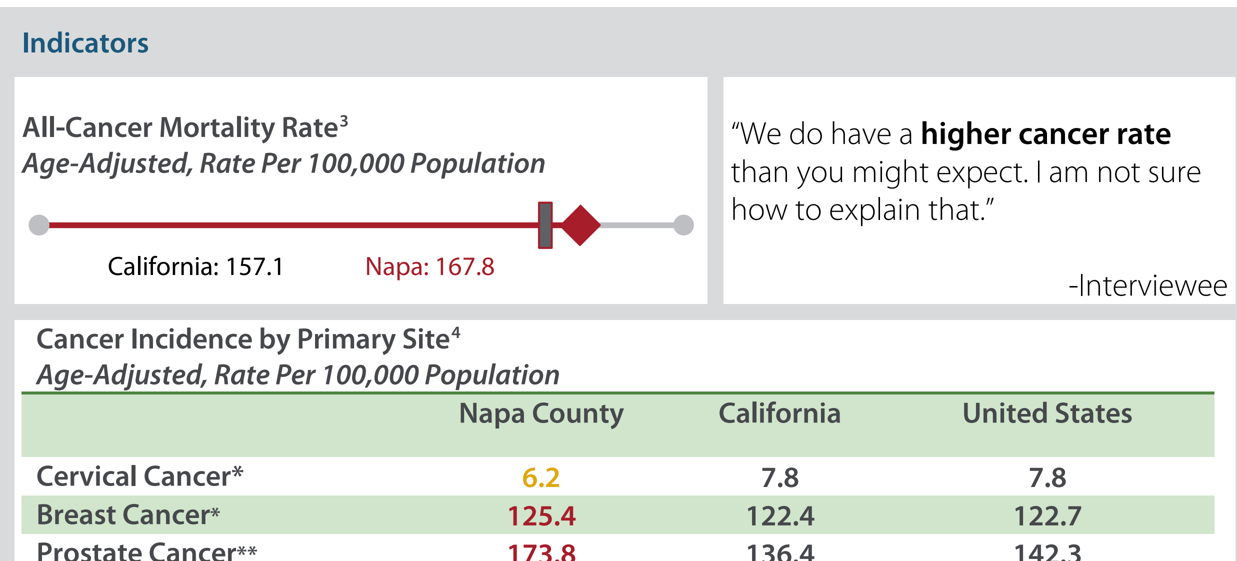
† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] "Exploring the Social Determinants of Health: Education and Health," Robert Wood Johnson Foundation, Accessed October 19, 2015, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70447.
[2] Napa County Community Health Assessment Report, 2013
[3] Ibid.
[4] US Census Bureau, American Community Survey, 2014.
[5] California Department of Education, 2012-13.
[6] California Department of Education, 2013.
[7] US Department of Health & Human Services Administration for Children and Families, 2014.
[8] California Department of Education, 2013-14.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] US Census Bureau American Community Survey, 2010-14.
[13] California Department of Education, 2013-14.
[14] Ibid.

Cancers

Cancer is a broad term which encompasses over 100 specific diseases, all of which begin with abnormal cell growth.[1] Cancer is typically defined by the primary site of abnormal growth, and the progression of the disease is affected by the cancer type, as well as the phase of detection, and available treatment options. Cancer is the second leading cause of death in the United States,[2] and has emerged as an important health need in Napa County according to a review of county health data. For example, Napa County residents experience a higher rate of all-cancer mortality, as well as a higher incidence of breast, prostate, colon and rectum, and lung cancer compared to California on average. Disparities in incidence and mortality exist across racial/ethnic subpopulations in the county. While cancer did not emerge as an important theme in primary data during this assessment process, secondary data revealed concerning trends, indicating a need to educate community members and stakeholders about the risk of many types of cancer in Napa County.

Key Data



Cancer Incidence by Primary Site[4]
Age-Adjusted, Rate Per 100,000 Population

	Napa County	California	United States
Cervical Cancer*	6.2	7.8	7.8
Breast Cancer*	125.4	122.4	122.7
Prostate Cancer**	173.8	136.4	142.3
Colon and Rectum Cancer	45.4	41.5	43.3
Lung Cancer	62.0	49.5	64.9

*Rate per 100,000 female population
** Rate per 100,000 male population

Notes on Limited Primary Data

Although cancer is a leading cause of death in Napa County, it was not a key theme in focus groups or Key Informant Interviews. The limited references to cancer in primary data may be due in part to the following factors:

- Lack of education about high rates of cancer morbidity and mortality; and
- Low priority of cancer compared to social needs such as affordable housing or economic security among community members.

Note: California state average estimates are included for reference. Differences between Napa County and California state estimates are not necessarily statistically significant.

Cancers (continued)

Key Drivers and Additional Data

Key Driver: Physical Environment

Liquor Store Access
Rate of liquor stores per 100,000 population[5]

36.6 | 10.0
Napa | California

Air Quality, PM 2.5
% of days exceeding standards of Particulate Matter 2.5, pop. adjusted average[6]

6.3 | 4.2
Napa | California

Pesticide Use

1,259,700
pounds of pesticides applied in Napa in 2013.[7]

Key Driver: Health Behaviors

Excessive Alcohol Consumption, Adult
% of adults age 18 and older who self-report heavy alcohol consumption[8]

21.3 | 17.2
Napa | California

Low Fruit and Vegetable Consumption, Adult
% of adults (18+) who self-report consuming <5 servings of fruits and vegetables each day[9]

64.7 | 71.5
Napa | California

Physical Inactivity, Adult
% of adults (20+) who self-report that they perform no leisure time activity[10]

13.4 | 16.6
Napa | California

Key Driver: Related Health Conditions

Overweight, Adult
% of adults (18+) who self-report Body Mass Index (BMI) between 25.0 and 30.0[11]

37.0 | 35.9
Napa | California

Obesity, Adult
% of adults (20+) who self-report Body Mass Index (BMI) > 30.0[12]

24.0 | 22.3
Napa | California

Additional Data: Screenings and Clinical Care

Colon Cancer Screening
% of adults (50+) who self-report that they ever had a sigmoidoscopy or colonoscopy, age-adjusted[13]

58.3 | 57.9
Napa | California

Pap Test Screening
% of women (18+) who self-report that they have had a Pap test in the past three years, age-adjusted[14]

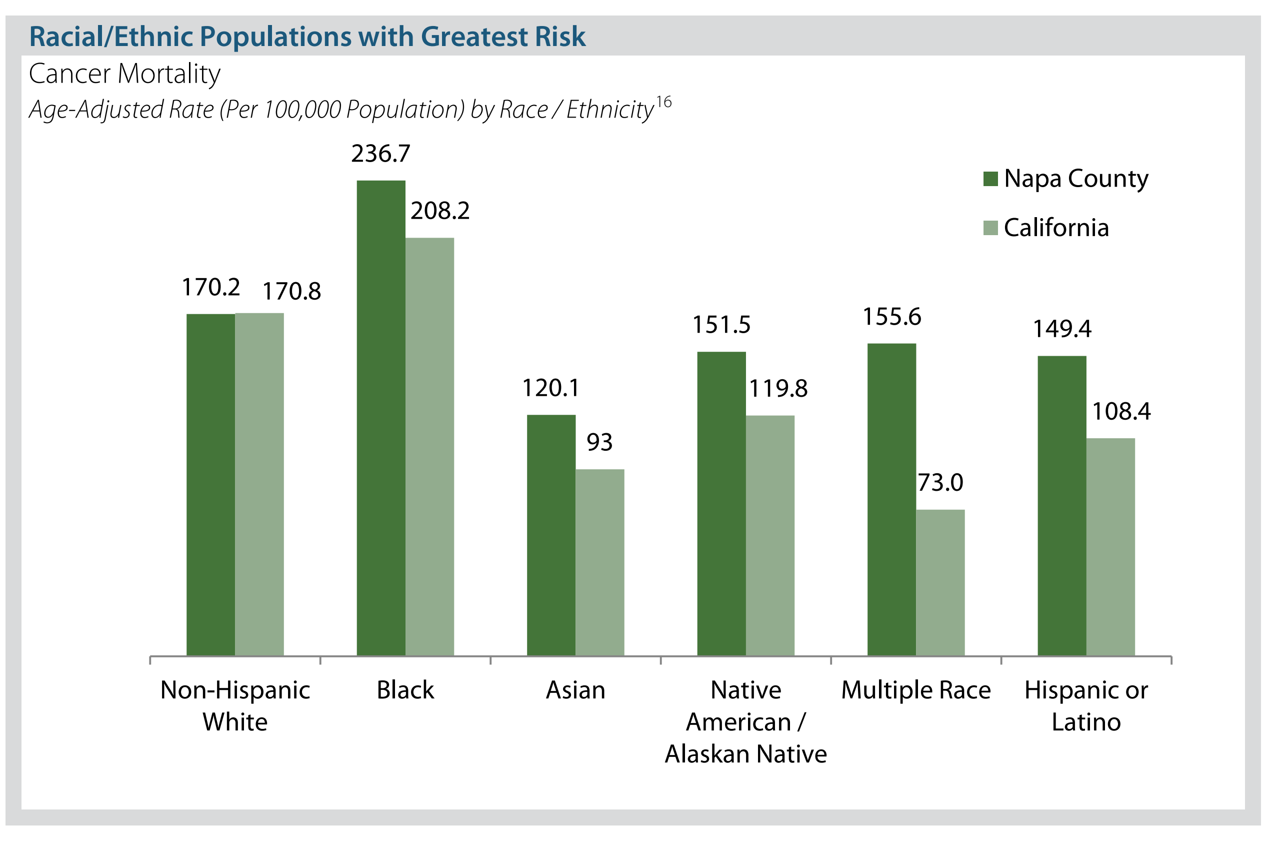
75.0 | 78.3
Napa | California

Breast Cancer Screening, Older Adults
% of female Medicare enrollees (67-69+) who have received one or more mammograms in the past two years[15]

63.5 | 59.3
Napa | California

Cancers (continued)

Populations Disproportionately Affected



Cancers (continued)

Populations Disproportionately Affected and Assets

Annual Cancer Incidence by Primary Site

Age-Adjusted Rate (Per 100,000 Population) by Race / Ethnicity[17]

	Black	White	Asian / Pacific Islander	Hispanic or Latino
Prostate Cancer	240.4	176.1	78.4	107.2
Breast Cancer	*	128.9	98.4	97.0
Lung Cancer	*	66.0	33.0	31.4
Colon and Rectum Cancer	*	48.4	41.3	47.3

**Races not shown are suppressed due to small numbers.*

*** Rate per 100,000 male population.*

**** Rate per 100,000 female population.*

Examples of Existing Community Assets†

Hospitals

American Cancer Society

Cancer Rehabilitation at Synergy Medical Fitness Center

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] American Cancer Society. Accessed at http://www.cancer.org/cancer/cancerbasics/what-is-cancer, December 2015.
[2] Centers for Disease Control. Accessed at http://www.cdc.gov/cancer/dcpc/data/types.htm, December 2015.
[3] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, Death Public Use Data, 2010-12.
[4] National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2007-11.
[5] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2012.
[6] Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, 2008.
[7] California Department of Pesticide Regulation (CDPR), Pesticide Use Reporting, 2013.
[8] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via US Department of Health & Human Services, Health Indicators Warehouse, 2006-12.
[9] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the US Department of Health & Human Services, Health Indicators Warehouse, 2005-09.
[10] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.

[11] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2011-12.
[12] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[13] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the US Department of Health & Human Services, Health Indicators Warehouse, 2006-12.
[14] Ibid.
[15] Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2012.
[16] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, Death Public Use Data, 2010-12.
[17] National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles, 2007-11.

Mental Health

Mental health includes emotional, behavioral, and social well-being. Poor mental health — including the presence of chronic toxic stress or psychological conditions such as anxiety, depression or Post-Traumatic Stress Disorder — has profound consequences on health behavior choices and physical health.[1,2] Stressors such as economic insecurity, harassment and bullying in school, and lack of social and emotional support are significant determinants of mental health. In Napa, mental health emerged as a key concern among community members and other key stakeholders, as well as in some existing secondary data sources. Notably, Napa County's suicide rate is higher than both the statewide rate and the Healthy People 2020 objective. Accessing mental health services can be challenging in Napa County, and there is limited capacity to meet needs. Older adults, youth — particularly LGBTQ youth, Latinos, and Native Americans face unique challenges in accessing mental health care. Other interviewees discussed how emotional stress related to economic instability, such as struggling to provide basic needs like affordable housing, is an important concern throughout Napa County.

Key Data

Indicators

Suicide Rate[3]

Age-adjusted; Rate Per 100,000 Population

California: 9.8 Napa: 12.7

Average Number of Mentally Unhealthy Days/Month[4]

California: 3.6 Napa: 4.0

Youth Age 12-18 Needing Emotional/ Mental Health Care During Past 12 Months[5]

California: 20.8 Napa: 24.7*

"Some families […] **struggle with accessing** mental health or behavioral health services because there is a **social stigma** associated with that."

– Interviewee

"Many of our clients are suffering from mental health and substance abuse issues. They often have been suffering from years from very stressful, traumatic life situations, sometimes even from childhood."

– Interviewee

Key Themes from Qualitative Data

Health Outcomes and Drivers:

- Economic insecurity is an important source of stress
- Harassment and bullying is a concern among youth
- High suicide risk, particularly among Latinos

Access to Mental Health Services:

- High need for mental health services and perception of limited capacity to meet demand
- Older adults, especially those who are isolated, have higher needs for mental health services
- Resistance to seeking treatment due to stigma
- High needs among LGBTQ youth
- Disparities exist related to the location of mental health treatment facilities across the county

Note: California state average estimates are included for reference. Differences between Napa County and California state estimates are not necessarily statistically significant.

*Unstable estimate; findings should be interpreted with caution.

Napa County Community Health Needs Assessment

Mental Health (continued)

Additional Data and Key Drivers

Additional Data: Related Health Outcomes

Indicator	Napa	California
Depression, Older Adults *% of Medicare beneficiaries with depression*[6]	12.8	13.4
Depression, Youth *% of 11th grade students who felt sad or hopeless almost every day for 2 weeks or more*[7]	32.5	32.5
Intentional Injury, Youth *Rate per 100,000 population*[8]	537.9	738.7

Key Driver: Access to Mental Health Care

Indicator	Napa	California
Adults Needing Treatment *% of adults reporting need for treatment for mental health, or use of alcohol /drug*[9]	11.3	15.9
Mental Health Providers *Rate of mental health providers per 100,000 population*[10]	247.2	157.0

"I feel that we need more mental health services, more places to go. If you are **on Medi-Cal** and from Napa County, they **offer certain services, but not all**."
– Focus Group Participant

Key Driver: Social Support and Stress

Indicator	Napa	California
Social Support, Adult *% adults without adequate social / emotional support (age-adjusted)*[11]	21.0	24.6
Harassment for Sexual Orientation, Youth *% of 11th grade students reporting harassment related to sexual orientation*[12]	8.3	7.6

"We certainly know there is a really high demand for [mental health] services, and we **do not have enough capacity to meet the demand**. So that is a big problem."
– Interviewee

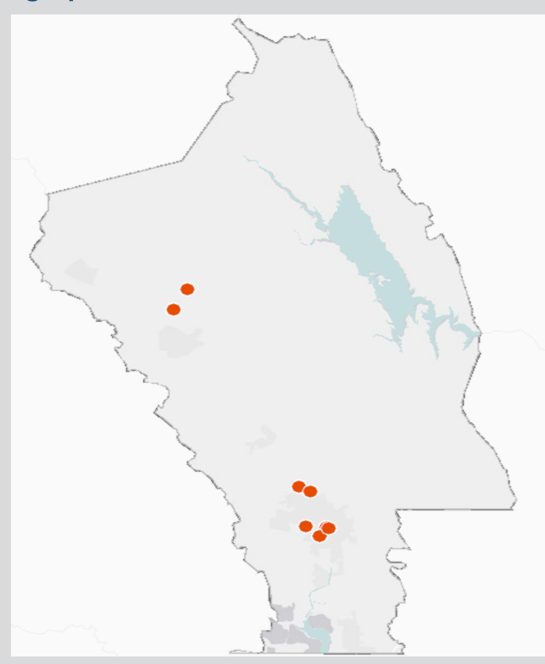
Key Driver: Social and Economic Risks

Indicator	Napa	California
Exposure to Violence *Age-adjusted homicide mortality rate; per 100,000 population)*[13]	1.2	5.2
Exposure to Poverty *% population with income at or below 200% Federal Poverty Line*[14]	28.1	36.4
Substandard Housing *% of occupied housing units with one or more substandard conditions*[15]	44.4	48.4

Mental Health (continued)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Mental Health Treatment and Prevention Resources[16]

Primary data indicates a lack of available and accessible mental health care services. Secondary data corroborates this finding. This map displays the location of the few mental health treatment facilities in the county, and the areas in which treatment is concentrated. In particular, many geographic regions outside of Calistoga and the City of Napa experience limited access to mental health treatment and prevention resources.

Key

● Mental Health Treatment Facilities

Populations with Greatest Risk

Age disparities

Focus group participants and interviewees noted that **older adults**, particularly those who are socially isolated, are less likely to access mental health services.

Youth, notably **transition age youth and LGBTQ youth**, are also disproportionately affected by mental health issues. Primary and secondary data identified bullying and harassment in schools as a key issue.

Racial/Ethnic disparities

Although suicide risk is high on average for Napa County residents compared to California state, Latino residents are one group with disproportionately high risk. **27.9%** of Latinos in Napa County report **ever having seriously thought about suicide**, compared to 10.3% on average across racial groups.[17]

"Four groups are being focused on in Napa County based on the number of people accessing mental health services. **Native Americans, Latinos, LGBTQ, and Veterans—those are the groups identified as not accessing mental health services**."

- Interviewee

Mental Health (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Mental Health Centers	Strong partnerships and sense of community	Mobile Crisis Team

Community Recommendations for Change

Increase Access to Mental Health Services

- Increase mental health services for older adults, especially at day centers and adult shelters
- Increase access to mental health specialists, particularly in Calistoga
- Ensure mental health services are culturally appropriate, and available in Spanish
- Decrease stigma related to accessing mental health services (for Latinos)
- Increase outpatient services

Increase Interventions for Youth

- Increase mental health intervention staff in schools
- Focus efforts on reducing/eliminating harassment and bullying among youth, especially LGBTQ youth

"We need to think of behavioral or mental health as **part of primary care**. We need to embed in these [services] in various places."
- Interviewee

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

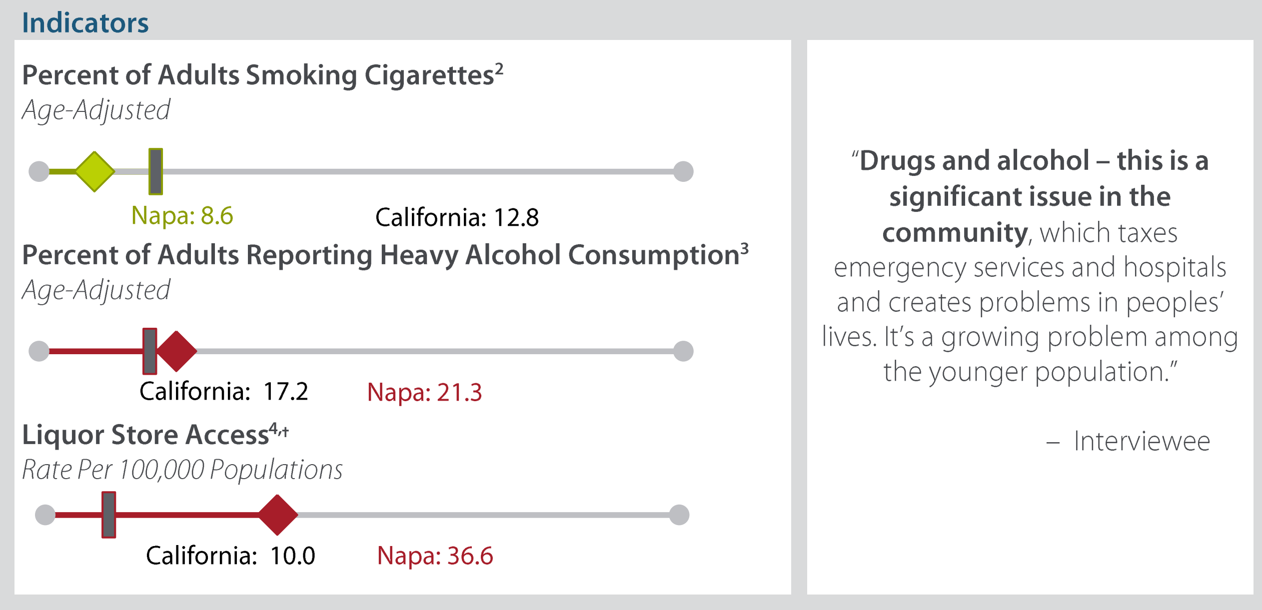
[1] Chapman DP, Perry GS, Strine TW. "The Vital Link Between Chronic Disease and Depressive Disorders," Preventing Chronic Disease, 2005; 2(1):A14.
[2] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS, "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: the Adverse Childhood Experiences (ACE) Study." American Journal of Preventive Medicine ,1998; 14:245–258.
[3] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[4] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2006-12.
[5] California Health Interview Survey, 2013-14.
[6] Centers for Medicare and Medicaid Services, 2012.
[7] California Healthy Kids Survey, 2011-13.
[8] California EpiCenter data platform for Overall Injury Surveillance, 2011-13.
[9] California Health Interview Survey, 2013-2014.
[10] University of Wisconsin Population Health Institute, County Health Rankings, 2014.
[11] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. U.S. Department of Health & Human Services, Health Indicators Warehouse, 2006-12.

[12] California Healthy Kids Survey, 2011-13.
[13] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[14] U.S. Census Bureau, American Community Survey, 2010-14.
[15] U.S. Census Bureau, American Community Survey, 2009-13.
[16] Substance Abuse and Mental Health Services Administration, 2014.
[17] California Health Interview Survey, 2014.

Substance Abuse

Substance abuse is defined as harmful or hazardous use of psychoactive substance, and can include use or abuse of tobacco, alcohol, prescription drugs, and illegal drugs, which may have profound health consequences.[1] Substance use and abuse was identified as a health need in existing data sources, and emerged as a salient theme in interviews and focus groups. For example, among both adults and youth the percent of the population drinking heavily is higher for Napa County than California overall. Youth were identified as a population of high concern, as binge drinking, e-cigarette use, and drug use were all noted as rising trends among younger residents. Residents and stakeholders noted several key resources that exist in the community, including tobacco cessation programs and community-based organizations focused on addressing substance abuse issues.

Key Data



Key Themes from Qualitative Data

Effects of Substance Use and Abuse

- Mental health and substance abuse are connected to other health and economic problems.
- Binge drinking can affect other issues including family cohesion, violence, injury, and traffic crashes.
- Substance abuse can decrease chance of graduating high school.
- Drinking and smoking in parks often limits children's use of the park.

Co-morbidity of Substance Use and Mental Health

- Alcohol or drug use can be a symptom of depression.
- Service systems within and across the county that address these health issues operate separately; however the root causes of the problems are intertwined.

"Many of our clients *[domestic violence victims]* are suffering from mental health and substance abuse issues. They often have been suffering with years of **very stressful, traumatic life situations**, sometimes even from childhood." – Interviewee

† A liquor store is defined by North American Industry Classification System (NAICS) Code 445310 as a business primarily engaged in retailing packaged alcoholic beverages, such as beer, wine, and spirits.

Note: California state average estimates are included for reference. Differences between Napa County and California state estimates are not necessarily statistically significant.

Substance Abuse (continued)

Additional Data

Tobacco Use

Cigarette Smoking, Youth
% of 11th grade students reporting cigarette use within the last 30 days[5]

Napa	California
11.8	10.2

Key Theme About Cigarette Use

- Tobacco is on the rise in school aged children.

Key Themes About E-cigarettes

- Decrease in smoking rate; increase in e-cigarette use
- Fruit flavors and marketing are designed to attract youth
- Evidence of carcinogenic effects
- Further research needed on health effects

Alcohol Use

Binge Drinking, Youth
% of 11th grade students reporting binge drinking at least once within the last 30 days[6]

Napa	California
22.8	20.7

Key Themes from Qualitative Data

- Safe use of alcohol is a problem among both adults and youth
- Binge drinking is increasing
- Binge drinking leads to poor health choices
- Wine industry is a primary employer in the county

Drug Use

Marijuana Use, Youth
% of 11th grade students reporting marijuana use within the last 30 days[7]

Napa	California
24.9	22.0

Key Themes from Qualitative Data

- Easy to obtain recreational marijuana
- High prevalence of medical marijuana
- High prevalence of street drugs

Clinical Care

Key Themes from Qualitative Data
Barriers to Receiving Treatment:

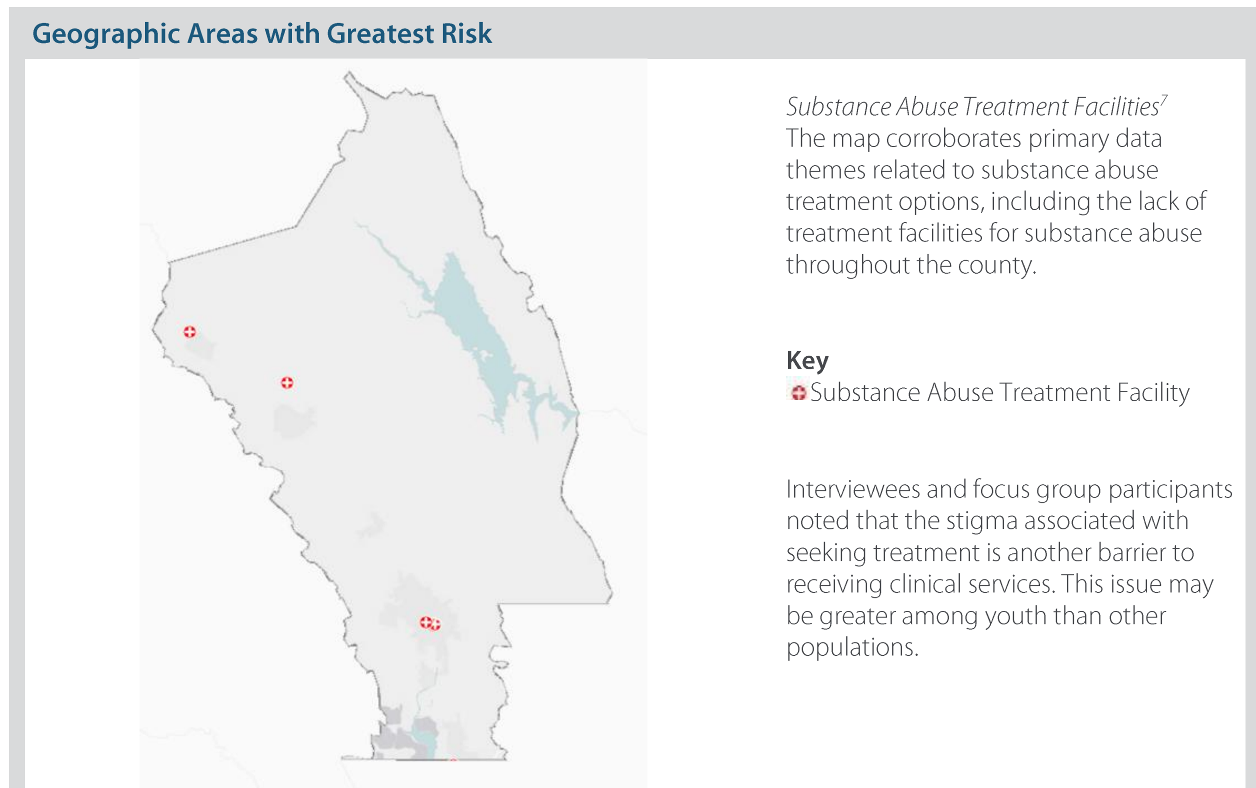
- There is a lack of services, particularly for hospitalization.
- Maintaining confidentiality in support groups is difficult in a small community.
- Stigma or fear (especially among young people) exists about seeking help for substance abuse.
- Residents do not know about ways to enter treatment proactively (e.g., without first being apprehended by law enforcement).
- Support groups for depression and alcohol abuse are too expensive.

"As far as substance abuse, I am just not sure that the services are available to [community members] in an accessible way."
– Interviewee

Substance Abuse (continued)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Substance Abuse Treatment Facilities[7]
The map corroborates primary data themes related to substance abuse treatment options, including the lack of treatment facilities for substance abuse throughout the county.

Key
Substance Abuse Treatment Facility

Interviewees and focus group participants noted that the stigma associated with seeking treatment is another barrier to receiving clinical services. This issue may be greater among youth than other populations.

Substance Abuse (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Napa County Health and Human Services Agency; Alcohol and Drug Services (ADS)

Nonprofit CBOs providing: Mental Health (e.g., Mentis, Aldea); ADS Services (e.g., Wolfe Center, McAllister); Alcoholics Anonymous

St. Helena Hospital

Community Recommendations for Change

Increase Partnership with Schools

- Increase after-school programs and increase opportunities for inexpensive, safe youth activities
- Offer immediate intervention services to youth (rather than allowing the problem to go untreated)
- Increase parent education about drugs and alcohol abuse among youth

Use Policy Strategies to Decrease Substance Abuse

- Support e-cigarette regulation regarding marketing to youth

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

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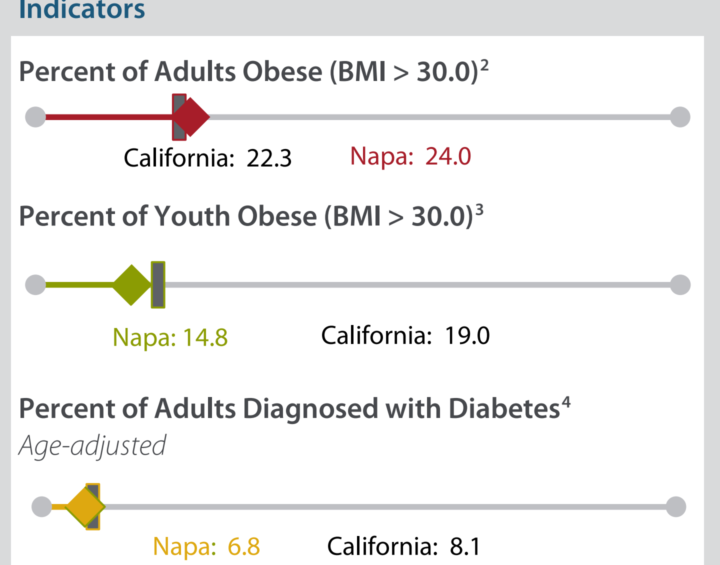
[1] World Health Organization, Health Topics: Substance abuse, http://www.who.int/topics/substance_abuse/en/, Accessed December 2015.
[2] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2006-12.
[3] Ibid.
[4] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2012.
[5] California Healthy Kids Survey, 2011-13.
[6] Ibid.
[7] Ibid.

Obesity and Diabetes

Overweight and obesity are strongly related to stroke, heart disease, some cancers, and type 2 diabetes. These chronic diseases represent some of the leading causes of death nationwide.[1] There is a high prevalence of adults and youth who are obese or overweight throughout the county. Primary and secondary data indicate that throughout Napa County access to *affordable* healthy food is limited, and lack of physical activity may be driven in part by a lack of affordable exercise options and a lack of time. Specific geographic regions in Napa County, including rural communities and American Canyon, experience disproportionately high levels of inadequate access to healthy food compared to other areas of the county.

Key Data

Indicators



"**Obesity and poor nutrition** is huge and crosses all ages and lifestyles."
– Interviewee

"The issue of nutrition affects our clients. They are living on such low incomes that in order to make their money stretch, they are not able to afford fruits and vegetables. So I think obesity and health issues related to diet and exercise are part of their lives. **Many are living in survival mode.** They are working hard for low incomes, sometimes working two jobs, and that affects their ability to enjoy life in general."
– Interviewee

Key Themes from Qualitative Data

Poor Nutrition

- Poor access to healthy and affordable foods, particularly for low-income residents
- Several grocery stores have recently closed
- High consumption of sugary beverages
- Many residents are food insecure
- Lack of access to information about nutrition
- Lack of knowledge of healthy, culturally appropriate recipes
- Farmer's markets are accessible, but expensive

Lack of Physical Activity

- Trend towards more sedentary lifestyles (e.g., increased screen time among children and adults)
- Lack of adequate, affordable recreational facilities
- Long work hours and long commute time limits time to exercise
- Lack of safe, walkable roads in rural areas

Note: California state average estimates are included for reference. Differences between Napa County and California state estimates are not necessarily statistically significant.

Obesity and Diabetes (continued)

Additional Data and Key Drivers

Additional Data: Clinical Care

Diabetes Hospitalizations
Age-adjusted discharge rate per 10,000 pop. [5]

7.4 | 10.4
Napa | California

Diabetes Management, Older Adult
% of diabetic Medicare patients with hemoglobin A1c (hA1c) test a in the past year [6,†]

80.1 | 81.5
Napa | California

Additional Data: Related Health Outcomes

Overweight, Adult
of adults (18+) who self-report Body Mass Index (BMI) between 25.0 and 30.0 [7]

37.0 | 35.9
Napa | California

"The number one cause of death is **cardiovascular disease**. As an underlying risk factor: obesity is part of this. We have a high obesity rate in the county."
-- Interviewee

Overweight, Youth
% of children in grades 5, 7, and 9 ranking within the "Needs Improvement" category (Overweight) for body composition [8]

19.5 | 19.3
Napa | California

Stroke Mortality
Age-adjusted mortality rate per 100,000 pop. [9]

38.0 | 37.4
Napa | California

Ischaemic Heart Disease Mortality
Age-adjusted mortality rate per 100,000 pop. [10]

152.9 | 163.2
Napa | California

Heart Disease Prevalence
% of adults (18+) ever told by a doctor that they have coronary heart disease or angina [11]

9.9 | 6.3
Napa | California

Key Driver: Nutrition

Low Fruit and Vegetable Consumption, Adult
% adults consuming <5 servings of fruit and vegetables [12]

64.7 | 71.5
Napa | California

WIC Authorized Food Stores
% of food stores authorized to accept WI C program benefits per 100,000 pop vegetables [13]

17.4 | 15.8
Napa | California

Fast Food
Fast food establishments per 100,000 pop. [14]

63.0 | 74.5
Napa | California

Low Fruit and Vegetable Consumption, Youth
% youth age 2-13 consuming <5 servings of fruit and vegetables [15]

51.6 | 47.4
Napa | California

Grocery Stores
Grocery stores per 100,000 pop. [16]

27.8 | 21.5
Napa | California

† Hemoglobin A1c (hA1c) test is a blood test which measures blood sugar levels and is used for diabetes management.

Obesity and Diabetes (continued)

Key Driver: Physical Activity

Low Physical Activity, Adult
% adults with no leisure time activity[17]

13.4 | 16.6
Napa | California

Low Physical Activity, Youth
% youth in grades 5,7,9 with "high risk" or "needs improvement" aerobic capacity[19]

31.1 | 35.9
Napa | California

"Napa is a rural county; public health infrastructure doesn't exist. The community **isn't set up to promote physical activity**. It's hard to walk."

– Interviewee

Park Access
% population living ½ mile from a park[18]

57.6 | 58.6
Napa | California

Fitness Centers
Recreation and fitness centers per 100,000 pop.[20, †]

12.5 | 8.7
Napa | California

Key Driver: Social and Economic Risks

"Poverty is a big issue. The average person who is **struggling financially** is not able to access healthy foods."
– Interviewee

Food Insecurity
% population experiencing food insecurity (i..e., the household-level economic and social condition of limited or uncertain access to adequate food) [21]

12.0 | 16.2
Napa | California

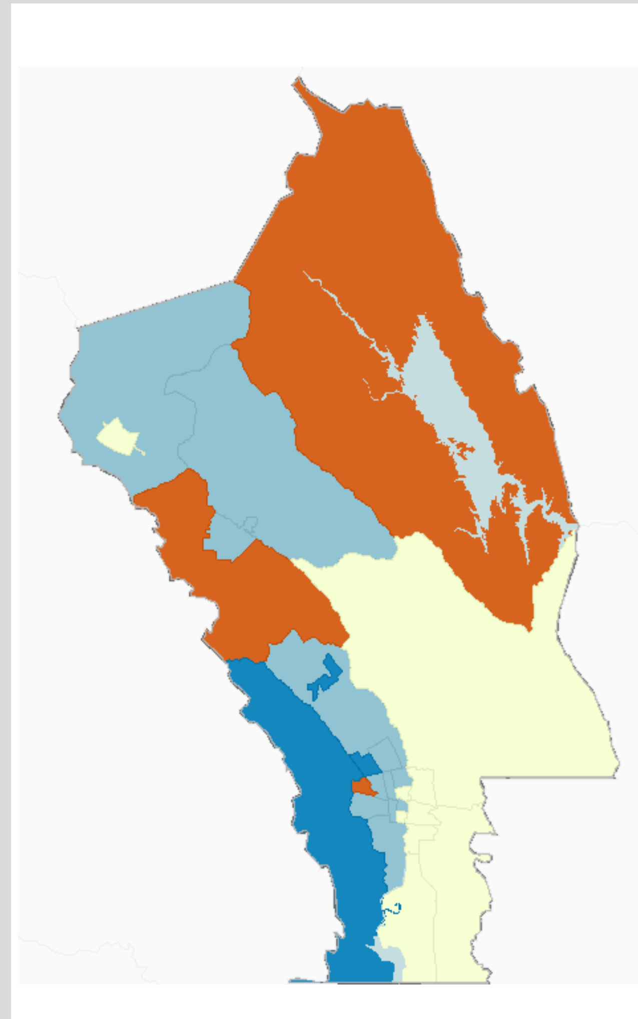
"Food insecurity in Napa largely reflects **economic status**…This has probably not improved much. For children, this is extremely important."
– Interviewee

† Fitness and recreation centers (defined by North American Industry Classification System (NAICS) code 713940) are establishments primarily engaged in operating fitness and recreational sports facilities featuring exercise and other active physical fitness conditioning or recreational sports activities, such as swimming, skating, or racquet sports. The method used to identify recreational facilities in the County Business Patterns data does not include YMCAs and intramural/amateur sports clubs, both of which may be important venues for physical activity, especially for low- and middle-income community members. Furthermore, this measure does not account for the opportunity to engage in fitness activities in parks or other public areas.

Obesity and Diabetes (continued)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Modified Retail Food Environmental Index Score by Tract[22]

The Modified Retail Food Environmental Index (mRFEI) measures the number of healthy and less healthy food retailers in an area. The mRFEI represents the percentage of health food retailers (including supermarkets, larger grocery stores, supercenters, and produce stores) within census tracts or ½ mile from the tract boundary. This does not include farmers markets. This map displays geographic disparities in access to healthy foods across Napa County.

Interviewees and focus group participants noted that **American Canyon and rural areas of the county have low access to healthy foods**. **Young children, older adults, and the Latino population** were also noted as populations at high risk for food insecurity and low access to healthy foods.

One interviewee noted, "A lot of our low income families don't have transportation. They are going to these little corner stores with all the junk food. So there doesn't seem to be anything to motivate these small stores to sell healthier stuff."

Key

- Index Score Over 30 (High Access)
- Index Score 15 - 30 (Moderate Access)
- Index Score 5 - 15 (Low Access)
- Index Score Under 5 (Poor Access)
- No Healthy Retail Food Outlet (No Access)
- No Retail Food Outlets Present (Food Desert)

Populations with Greatest Risk

Age disparities

Interviewees and focus groups highlighted that obesity is a serious concern for **older adults**. While obesity is an issue across the lifespan, interviewees noted that obesity is a risk factor for dementia, and that there is an increased risk of dementia from high blood sugar. Physical activity, nutritious food, and loneliness are highly predictive of dementia. Older adults living on fixed and low income may go without meals because they need to make difficult financial decisions between spending money on medication and on food.

Other disparities

Residents experiencing homelessness were also noted as a population of high risk. The food available to families in shelters is often unhealthy (e.g., pizza and soda), and residents living in cars do not have the means to cook.

Obesity and Diabetes (continued)

Assets and Recommendations

Examples of Existing Community Assets†

Food Banks	Community Gardens	Parks, Trails and Walkable Communities

Community Recommendations for Change

Increase Accessibility of Healthy Foods

- Create safe, welcoming places such as community gardens, school gardens, and farmers markets
- Change nutrition policies (e.g., remove sugary beverages from school settings)
- Engage local faith-based and nonprofit groups to deliver vegetable boxes to low-income households

Increase Opportunities for Physical Activity

- Offer a warmer pool, or raise the temperature of the public pool on designated day each week, so that it is accessible to seniors (e.g., in partnership with the Arthritis Foundation)
- Strengthen partnerships between cities, school districts, nonprofits, and local foundations to increase wellness activities in communities (e.g., provide more low-cost or free exercise classes)
- Enhance the safety of roads and sidewalks to make Napa County more walkable, especially for people with disabilities

"Make fresh fruits and vegetables cheaper and more readily available so that single moms **will be able to make a healthier choice**. You can keep educating about these things and they know it but given their living situation they are not going to choose the healthiest option."

– Interviewee

Increase Education about Healthy Eating and Active Living

- Provide culturally relevant nutrition information and cooking classes at community fairs (e.g., for Latino, Indian, and Asian communities)
- Provide multilingual education about healthy food choices
- Include prenatal and early life nutrition as a topic in prenatal programs
- Utilize physicians, integrative medicine specialists, or nutritionists to educate parents and children in a school setting

"Educating people is not enough. It's not enough to say it's just about education. **We need to restructure things so that the healthy choice is the easy choice.**"

– Interviewee

† Examples derived from qualitative data and Napa County CHNA Advisory Group. For a comprehensive list of county assets and resources, see http://211bayarea.org/napa/.

[1] "Obesity Health Risks," Harvard School of Public Health, Obesity Prevention Source, Accessed November 2015, http://www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/health-effects/.
[2] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[3] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[4] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[5] California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES, 2011.
[6] Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2012.
[7] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES, 2011-12.
[8] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[9] University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data, 2010-12.
[10] Ibid.
[11] California Health Interview Survey, 2011-12.
[12] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse, 2005-09.
[13] US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas, 2011.
[14] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2011.
[15] California Health Interview Survey, 2011-12.
[16] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2011.
[17] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2012.
[18] US Census Bureau, Decennial Census. ESRI Map Gallery, 2010.
[19] California Department of Education, FITNESSGRAM® Physical Fitness Testing, 2013-14.
[20] US Census Bureau, County Business Patterns. Additional data analysis by CARES, 2012.
[21] Feeding America. Child Food Insecurity Data, 2012.
[22] Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity, 2011.

Health Indicators								Benchmarks		Needs Score			
Potential Health Needs	Core/ Related	Indicators	Data Source Year	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Desired Direction	Napa County	Difference from the State Value	Stastistically Unstable County Data
Access to Care	Core	Access to Dentists	2013	Clinical Care	Rate	140,326	n/a	77.5	63.2	Above Benchmark	77.0	-0.49	
		Access to Primary Care	2012	Clinical Care	Rate	139,045	n/a	77.3	74.5	Above Benchmark	98.5	21.28	
		Lack of a Consistent Source of Primary Care	2011-12	Clinical Care	Percentage	133,000	n/a	14.3%	no data	Below Benchmark	7.7%	-6.60%	
		Access to Mental Health Providers	2014	Clinical Care	Rate	144,030	n/a	157.0	134.1	Above Benchmark	247.2	90.17	
	Related	Insurance - Uninsured Population	2010-14	Social & Economic Factors	Percentage	137,294	n/a	16.7%	14.2%	Below Benchmark	13.9%	-2.80%	
		Federally Qualified Health Centers	2014, June	Clinical Care	Rate	136,484	n/a	2.0	1.9	Above Benchmark	5.9	3.89	
		Health Professional Shortage Area - Primary Care	2015, March	Clinical Care	Percentage	136,484	n/a	25.2%	34.1%	Below Benchmark	1.3%	-23.86%	
		Preventable Hospital Events	2011	Clinical Care	Rate	no data	n/a	83.2	no data	Below Benchmark	78.8	-4.33	
		Insurance - Population Receiving Medicaid	2014	Social & Economic Factors	Percentage	no data	n/a	14.0%	no data	Below Benchmark	17.5%	3.50%	
		Health Professional Shortage Area - Dental	2015, March	Clinical Care	Percentage	136,484	n/a	4.9%	32.0%	Below Benchmark	0.0%	-4.93%	
		Cancer Screening - Mammogram	2012	Clinical Care	Percentage	918	n/a	59.3%	63.0%	Above Benchmark	63.5%	4.21%	
		Cancer Screening - Pap Test	2006-12	Clinical Care	Percentage	86,293	n/a	78.3%	78.5%	Above Benchmark	75.0%	-3.30%	
		Cancer Screening - Sigmoid/Colonoscopy	2006-12	Clinical Care	Percentage	37,694	n/a	57.9%	61.3%	Above Benchmark	58.3%	0.40%	
Access to Housing	Core	Housing - Vacant Housing	2009-13	Physical Environment	Percentage	54,851	n/a	8.6%	12.5%	Below Benchmark	9.9%	1.25%	
		Housing - Cost Burdened Households	2010-14	Social & Economic Factors	Percentage	49,631	n/a	45.0%	34.9%	Below Benchmark	42.6%	-2.40%	
		Housing - Substandard Housing	2009-13	Physical Environment	Percentage	49,431	n/a	48.4%	36.1%	Below Benchmark	44.4%	-4.00%	
		Housing - Assisted Housing	2013	Physical Environment	Rate	54,759	n/a	368.3	384.3	Below Benchmark	399.4	31.09	
		Percent living in overcrowded housing conditions (>1.5 persons/room)	2009-13	Physical Environment	Percentage	no data	n/a	5.2%	2.1%	Below Benchmark	3.6%	-1.65%	
Asthma and COPD	Core	Asthma - Prevalence	2011-12	Health Outcomes	Percentage	96,628	n/a	14.2%	13.4%	Below Benchmark	13.8%	-0.42%	
		Percent of children ever diagnosed with asthma (ages 0-17)	2013-2014, 2013-US	Health Outcomes	Percentage	no data	n/a	14.5%	12.7%	Below Benchmark	20.5%	6.00%	x
		Asthma - Hospitalizations	2011	Health Outcomes	Rate	no data	n/a	8.9	no data	Below Benchmark	7.0	-1.86	
	Related	Air Quality - Ozone (O3)	2008	Physical Environment	Percentage	136,484	n/a	2.5%	0.5%	Below Benchmark	0.2%	-2.32%	
		Tobacco Usage	2006-12	Health Behaviors	Percentage	104,042	n/a	12.8%	18.1%	Below Benchmark	8.6%	-4.20%	
		Tobacco Expenditures	2014	Health Behaviors	Percentage	no data	n/a	1.0%	1.6%	Below Benchmark	suppressed		
		Air Quality - Particulate Matter 2.5	2008	Physical Environment	Percentage	136,484	n/a	4.2%	1.2%	Below Benchmark	6.3%	2.10%	
		Obesity (Adult)	2012	Health Outcomes	Percentage	103,831	n/a	22.3%	27.1%	Below Benchmark	24.0%	1.68%	
		Overweight (Adult)	2011-12	Health Outcomes	Percentage	93,030	n/a	35.9%	35.8%	Below Benchmark	37.0%	1.10%	
		Obesity (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.0%	no data	Below Benchmark	14.8%	-4.15%	
		Overweight (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.3%	no data	Below Benchmark	19.5%	0.21%	
Cancers	Core	Cancer Incidence - Breast	2007-11	Health Outcomes	Rate	67,925	n/a	122.4	122.7	Below Benchmark	125.4	3	
		Mortality - Cancer	2010-12	Health Outcomes	Rate	136,484	<= 160.6	157.1	no data	Below Benchmark	167.8	10.71	
		Cancer Incidence - Cervical	2007-11	Health Outcomes	Rate	67,925	<= 7.1	7.8	7.8	Below Benchmark	6.2	-1.6	
		Cancer Incidence - Colon and Rectum	2007-11	Health Outcomes	Rate	135,377	<= 38.7	41.5	43.3	Below Benchmark	45.4	3.9	
		Cancer Incidence - Prostate	2007-11	Health Outcomes	Rate	67,452	n/a	136.4	142.3	Below Benchmark	173.8	37.4	
		Prostate cancer age adjusted mortality rate	2011-2013, 2013-US	Health Outcomes	Rate/100,000	no data	<= 21.2	20.2	19.2	Below Benchmark	23.4	3.2	
		Cancer Incidence - Lung	2007-11	Health Outcomes	Rate	135,377	n/a	49.5	64.9	Below Benchmark	62	12.5	
	Related	Alcohol - Excessive Consumption	2006-12	Health Behaviors	Percentage	104,042	n/a	17.2%	16.9%	Below Benchmark	21.3%	4.10%	
		Alcohol - Expenditures	2014	Health Behaviors	Percentage	no data	n/a	12.9%	14.3%	Below Benchmark	suppressed		
		Liquor Store Access	2012	Physical Environment	Rate	136,484	n/a	10.0	10.4	Below Benchmark	36.6	26.61	
		Overweight (Adult)	2011-12	Health Outcomes	Percentage	93,030	n/a	35.9%	35.8%	Below Benchmark	37.0%	1.10%	
		Obesity (Adult)	2012	Health Outcomes	Percentage	103,831	n/a	22.3%	27.1%	Below Benchmark	24.0%	1.68%	
		Cancer Screening - Mammogram	2012	Clinical Care	Percentage	918	n/a	59.3%	63.0%	Above Benchmark	63.5%	4.21%	
		Low Fruit/Vegetable Consumption (Adult)	2005-09	Health Behaviors	Percentage	101,137	n/a	71.5%	75.7%	Below Benchmark	64.7%	-6.80%	
		Fruit/Vegetable Expenditures	2014	Health Behaviors	Percentage	no data	n/a	14.1%	12.7%	Above Benchmark	suppressed		
		Food Security - Food Desert Population	2010	Social & Economic Factors	Percentage	136,484	n/a	14.3%	23.6%	Below Benchmark	13.0%	-1.35%	
		Tobacco Usage	2006-12	Health Behaviors	Percentage	104,042	n/a	12.8%	18.1%	Below Benchmark	8.6%	-4.20%	
		Tobacco Expenditures	2014	Health Behaviors	Percentage	no data	n/a	1.0%	1.6%	Below Benchmark	suppressed		
		Cancer Screening - Pap Test	2006-12	Clinical Care	Percentage	86,293	n/a	78.3%	78.5%	Above Benchmark	75.0%	-3.30%	

Health Indicators								Benchmarks		Needs Score			
Potential Health Needs	Core/ Related	Indicators	Data Source Year	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Desired Direction	Napa County	Difference from the State Value	Stastistically Unstable County Data
		Physical Inactivity (Adult)	2012	Health Behaviors	Percentage	103,786	n/a	16.6%	22.6%	Below Benchmark	13.4%	-3.19%	
		Cancer Screening - Sigmoid/Colonoscopy	2006-12	Clinical Care	Percentage	37,694	n/a	57.9%	61.3%	Above Benchmark	58.3%	0.40%	
		Pesticide Use - Pounds of Pesticides Applied	2013	Physical Environment	Number	n/a	n/a	n/a	n/a	n/a	1,259,700		
		Pesticide Use - Rank of Pesticide Use Among CA Counties	2013	Physical Environment	Rank	n/a	n/a	n/a	n/a	n/a	26.0		
		Air Quality - Particulate Matter 2.5	2008	Physical Environment	Percentage	136,484	n/a	4.2%	1.2%	Below Benchmark	6.3%	2.10%	
Child Mental and Emotional Development	Core	Poverty - Children Below 100% FPL	2009-13	Social & Economic Factors	Percentage	134,215	n/a	22.2%	21.6%	Below Benchmark	14.1%	-8.10%	
		Percent of 11th grade students who felt sad or hopeless almos everyday for 2 weeks or more so that they stopped doing	2011-2013, 2013-US	Health Outcomes	Percentage	no data	n/a	32.5%	31.7%	Below Benchmark	32.5%	0.00%	
		Percent of 11th grade students reporting harassment on school property related to their sexual orientatior	2011-2013	Social & Economic Factors	Percentage	no data	n/a	7.6%	no data	Below Benchmark	8.3%	0.70%	
		Substantiated allegations of child maltreatment per 1,000 children ages 0-17	2014, 2013- US	Social & Economic Factors	Rate/1,000	no data	<=8.5	9.0	9.1	Below Benchmark	8.1	-0.9	
Climate and Health	Core	Air Quality - Particulate Matter 2.5	2008	Physical Environment	Percentage	136,484	n/a	4.2%	1.2%	Below Benchmark	6.3%	2.10%	
		Drinking Water Safety	2012-13	Physical Environment	Percentage	76,453	n/a	2.7%	10.3%	Below Benchmark	14.4%	11.73%	
		Air Quality - Ozone (O3)	2008	Physical Environment	Percentage	136,484	n/a	2.5%	0.5%	Below Benchmark	0.2%	-2.32%	
		Climate & Health - Heat Index Days	2014	Physical Environment	Percentage	4,015	n/a	0.6%	4.7%	Below Benchmark	0.0%	-0.63%	
		Climate & Health - Drought Severity	2012-14	Physical Environment	Percentage	no data	n/a	92.8%	45.9%	Below Benchmark	93.0%	0.18%	
		Climate & Health - Heat Stress Events	2005-12	Physical Environment	Rate	152	n/a	11.1	no data	Below Benchmark	13.7	2.64	
		Asthma - Hospitalizations	2011	Health Outcomes	Rate	no data	n/a	8.9	no data	Below Benchmark	7.0	-1.86	
		Percent of children ever diagnosed with asthma (ages 17 and below)	2013-2014, 2013-US	Health Outcomes	Percentage	no data	n/a	14.5%	12.7%	Below Benchmark	20.5%	6.00%	
		Asthma - Prevalence	2011-12	Health Outcomes	Percentage	96,628	n/a	14.2%	13.4%	Below Benchmark	13.8%	-0.42%	
	Related	Low Birth Weight	2011	Health Outcomes	Percentage	136,484	n/a	6.8%	no data	Below Benchmark	6.0%	-0.77%	
		Transit - Road Network Density	2011	Physical Environment	Rate	789	n/a	4.3	2.0	Below Benchmark	1.4	-2.86	
		Transit - Public Transit within 0.5 Miles	2011	Physical Environment	Percentage	136,484	n/a	15.5%	8.1%	Above Benchmark	0.0%	-15.53%	
		Climate & Health - Canopy Cover	2011	Physical Environment	Percentage	136,484	n/a	15.1%	24.7%	Above Benchmark	14.6%	-0.58%	
		Climate & Health - No Access to Air Conditioning	2011, 2013	Physical Environment	Percentage	54,759	n/a	33.8%	11.4%	Below Benchmark	no data		
		Diabetes Hospitalizations	2011	Health Outcomes	Rate	no data	n/a	10.4	no data	Below Benchmark	7.4	-3.03	
		Mental Health - Poor Mental Health Days	2006-12	Health Outcomes	Rate	104,042	n/a	3.6	3.5	Below Benchmark	4.0	0.4	
		Mortality - Ischaemic Heart Disease	2010-12	Health Outcomes	Rate	136,484	<= 100.8	163.2	no data	Below Benchmark	152.9	-10.24	
		Commute to Work - Alone in Car	2009-13	Health Behaviors	Percentage	64,876	n/a	73.2%	76.4%	Below Benchmark	76.1%	2.92%	
		Obesity (Adult)	2012	Health Outcomes	Percentage	103,831	n/a	22.3%	27.1%	Below Benchmark	24.0%	1.68%	
		Obesity (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.0%	no data	Below Benchmark	14.8%	-4.15%	
CVD/Stroke	Core	Heart Disease Prevalence	2011-12	Health Outcomes	Percentage	102,000	n/a	6.3%	no data	Below Benchmark	9.9%	3.60%	
		Mortality - Ischaemic Heart Disease	2010-12	Health Outcomes	Rate	136,484	<= 100.8	163.2	no data	Below Benchmark	152.9	-10.24	
		Mortality - Stroke	2010-12	Health Outcomes	Rate	136,484	n/a	37.4	no data	Below Benchmark	38.0	0.65	
	Related	Physical Inactivity (Adult)	2012	Health Behaviors	Percentage	103,786	n/a	16.6%	22.6%	Below Benchmark	13.4%	-3.19%	
		Physical Inactivity (Youth)	2013-14	Health Behaviors	Percentage	4,724	n/a	35.9%	no data	Below Benchmark	31.1%	-4.78%	
		Park Access	2010	Physical Environment	Percentage	136,484	n/a	58.6%	no data	Above Benchmark	57.6%	-0.98%	
		Transit - Walkability	2012	Physical Environment	percentage	no data	n/a	1.7%	2.0%	Below Benchmark	no data		
		Recreation and Fitness Facility Access	2012	Physical Environment	Rate	136,484	n/a	8.7	9.4	Above Benchmark	12.5	3.81	
		Tobacco Usage	2006-12	Health Behaviors	Percentage	104,042	n/a	12.8%	18.1%	Below Benchmark	8.6%	-4.20%	
		Tobacco Expenditures	2014	Health Behaviors	Percentage	no data	n/a	1.0%	1.6%	Below Benchmark	suppressed		
		Alcohol - Excessive Consumption	2006-12	Health Behaviors	Percentage	104,042	n/a	17.2%	16.9%	Below Benchmark	21.3%	4.10%	
		Alcohol - Expenditures	2014	Health Behaviors	Percentage	no data	n/a	12.9%	14.3%	Below Benchmark	suppressed		
		Liquor Store Access	2012	Physical Environment	Rate	136,484	n/a	10.0	10.4	Below Benchmark	36.6	26.61	
		Overweight (Adult)	2011-12	Health Outcomes	Percentage	93,030	n/a	35.9%	35.8%	Below Benchmark	37.0%	1.10%	
		Obesity (Adult)	2012	Health Outcomes	Percentage	103,831	n/a	22.3%	27.1%	Below Benchmark	24.0%	1.68%	
		Overweight (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.3%	no data	Below Benchmark	19.5%	0.21%	
		Obesity (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.0%	no data	Below Benchmark	14.8%	-4.15%	
		Diabetes Prevalence	2012	Health Outcomes	Percentage	103,923	n/a	8.1%	9.1%	Below Benchmark	6.8%	-1.25%	
		Diabetes Hospitalizations	2011	Health Outcomes	Rate	no data	n/a	10.4	no data	Below Benchmark	7.4	-303.00%	

Health Indicators								Benchmarks		Needs Score			
Potential Health Needs	Core/ Related	Indicators	Data Source Year	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Desired Direction	Napa County	Difference from the State Value	Stastistically Unstable County Data
		Diabetes Management (Hemoglobin A1c Test)	2012	Clinical Care	Percentage	11,517	n/a	81.5%	84.6%	Above Benchmark	80.1%	-1.35%	
		High Blood Pressure - Unmanaged	2006-10	Clinical Care	Percentage	102,821	n/a	30.3%	21.7%	Below Benchmark	47.5%	17.15%	
Economic Security	Core	Economic Security - Unemployment Rate	December, 2015	Social & Economic Factors	Rate	71,701	n/a	6.8	5.4	Below Benchmark	5.6	-1.2	
		Income Inequality	2009-13	Social & Economic Factors	Rate	49,431	n/a	0.5	0.5	Below Benchmark	0.5	-0.02	
		Poverty - Population Below 100% FPL	2010-14	Social & Economic Factors	Percentage	134,215	n/a	16.4%	15.6%	Below Benchmark	10.3%	-6.10%	
		Poverty - Population Below 200% FPL	2010-14	Social & Economic Factors	Percentage	135,571	n/a	36.4%	no data	Below Benchmark	28.1%	-8.30%	
		Poverty - Children Below 100% FPL	2010-14	Social & Economic Factors	Percentage	135,571	n/a	22.7%	no data	Below Benchmark	14.0%	-8.69%	
	Related	Education - High School Graduation Rate	2013	Social & Economic Factors	Rate	1,630	>= 82.4	80.4	no data	Above Benchmark	85.3	4.84	
		Education - Reading Below Proficiency	2012-13	Social & Economic Factors	Percentage	1,475	<= 36.3%	36.0%	no data	Below Benchmark	40.0%	4.00%	
		Liquor Store Access	2012	Physical Environment	Rate	136,484	n/a	10.0	10.4	Below Benchmark	36.6	26.61	
		Children Eligible for Free/Reduced Price Lunch	2013-14	Social & Economic Factors	Percentage	20,844	n/a	58.1%	52.4%	Below Benchmark	45.4%	-12.76%	
		Food Security - Population Receiving SNAP	2011	Social & Economic Factors	Percentage	133,788	n/a	10.6%	15.2%	Below Benchmark	5.3%	-5.27%	
		Insurance - Population Receiving Medicaid	2014	Social & Economic Factors	Percentage	no data	n/a	14.0%	no data	Below Benchmark	17.5%	3.50%	
		Education - Less than High School Diploma (or Equivalent)	2009-13	Social & Economic Factors	Percentage	93,928	n/a	18.8%	14.0%	Below Benchmark	16.9%	-1.86%	
		Insurance - Uninsured Population	2009-13	Social & Economic Factors	Percentage	135,843	n/a	17.8%	14.9%	Below Benchmark	14.5%	-3.27%	
		Education - School Enrollment Age 3-4	2014	Social & Economic Factors	Percentage	no data	n/a	47.8%	47.1%	Above Benchmark	62.7%	14.90%	
		Education - Head Start Program Facilities	2014	Social & Economic Factors	Rate	8,131	n/a	6.3	7.6	Above Benchmark	7.4	1.04	
		Food Security - School Breakfast Program	2013	Social & Economic Factors	Rate	no data	n/a	3.9	4.2	Below Benchmark	no data		
		Food Security - Food Insecurity Rate	2012	Social & Economic Factors	Percentage	136,644	n/a	16.2%	15.9%	Below Benchmark	12.0%	-4.24%	
		Housing - Vacant Housing	2009-13	Physical Environment	Percentage	54,851	n/a	8.6%	12.5%	Below Benchmark	9.9%	1.25%	
		Housing - Cost Burdened Households	2010-14	Physical Environment	Percentage	49,631	n/a	45.0%	34.9%	Below Benchmark	42.6%	-2.40%	
		Housing - Substandard Housing	2009-13	Physical Environment	Percentage	49,431	n/a	48.4%	36.1%	Below Benchmark	44.4%	-4.00%	
		Housing - Assisted Housing	2013	Physical Environment	Rate	204,572	n/a	36830.0%	38430.0%	Below Benchmark	39939.0%	31.09	
		Economic Security - Commute Over 60 Minutes	2009-13	Social & Economic Factors	Percentage	61,338	n/a	10.1%	8.1%	Below Benchmark	9.0%	-1.10%	
		Economic Security - Households with No Vehicle	2009-13	Social & Economic Factors	Percentage	49,431	n/a	7.8%	9.1%	Below Benchmark	4.6%	-3.16%	
		Percent People 65 years or Older In Poverty (100%FPL)	2009-13	Social & Economic Factors	Percentage	no data	n/a	9.9%	9.4%	Below Benchmark	6.8%	-3.02%	
		Percent living in overcrowded housing conditions (>1.5 person	2009-13	Physical Environment	Percentage	no data	n/a	5.2%	2.1%	Below Benchmark	3.6%	-1.65%	
		Percent of English language learners (grade 10) who passed the	2013-14 school year	Social & Economic Factors	Percentage	no data	n/a	38.0%	no data	Above Benchmark	22.0%	-16.00%	
		Percent of English language learners (grade 10) who passed the	2013-14 school year	Social & Economic Factors	Percentage	no data	n/a	54.0%	no data	Above Benchmark	39.0%	-15.00%	
Education	Core	Education - High School Graduation Rate	2013	Social & Economic Factors	Rate	1,630	>= 82.4	80.4	no data	Above Benchmark	85.3	4.84	
		Percent of English language learners (grade 10) who passed the	2013-14 school year	Social & Economic Factors	Percentage	no data	n/a	38.0%	no data	Above Benchmark	22.0%	-16.00%	
		Percent of English language learners (grade 10) who passed the	2013-14 school year	Social & Economic Factors	Percentage	no data	n/a	54.0%	no data	Above Benchmark	39.0%	-15.00%	
		Education - Reading Below Proficiency	2012-13	Social & Economic Factors	Percentage	1,475	<= 36.3%	36.0%	no data	Below Benchmark	40.0%	4.00%	
		Education - Less than High School Diploma (or Equivalent)	2009-13	Social & Economic Factors	Percentage	93,928	n/a	18.8%	14.0%	Below Benchmark	16.9%	-1.86%	
		Education - School Enrollment Age 3-4	2009-13	Social & Economic Factors	Percentage	3,150	n/a	49.1%	47.7%	Above Benchmark	51.9%	2.84%	
		Education - Head Start Program Facilities	2014	Social & Economic Factors	Rate	8,131	n/a	6.3	7.6	Above Benchmark	7.4	1.04	
		Violence - School Suspensions	2013-14	Social & Economic Factors	Rate	41,712	n/a	4.0	no data	Below Benchmark	3.5	-0.53	
		Violence - School Expulsions	2013-14	Social & Economic Factors	Rate	41,712	n/a	0.1	no data	Below Benchmark	0.0	-0.03	
HIV/AIDS/STDs	Core	STD - Chlamydia	2012	Health Outcomes	Rate	138,088	n/a	444.9	456.7	Below Benchmark	248.4	-196.51	
		STD - HIV Prevalence	2010	Health Outcomes	Rate	114,754	n/a	363.0	340.4	Below Benchmark	165.1	-197.9	
		STD - HIV Hospitalizations	2011	Health Outcomes	Rate	no data	n/a	2.0	no data	Below Benchmark	0.7	-1.27	
	Related	STD - No HIV Screening	2011-12	Clinical Care	Percentage	83,211	n/a	60.8%	62.8%	Below Benchmark	62.5%	1.65%	
Mental Health	Core	Mortality - Suicide	2010-12	Health Outcomes	Rate	136,484	<= 10.2	9.8	no data	Below Benchmark	12.7	2.93	
		Mental Health - Poor Mental Health Days	2006-12	Health Outcomes	Rate	104,042	n/a	3.6	3.5	Below Benchmark	4.0	0.4	
		Mental Health - Depression Among Medicare Beneficiaries	2012	Health Outcomes	Percentage	14,183	n/a	13.4%	15.5%	Below Benchmark	12.8%	-0.58%	
		Access to Mental Health Providers	2014	Clinical Care	Rate	144,030	n/a	157.0	134.1	Above Benchmark	247.2	90.17	
		Youth (age 12-18) Needing Emotional/Mental Health Care	2013-14	Health Outcomes	Percentage	no data	n/a	20.8%	no data	Below Benchmark	24.7%	3.90%	x
		Mental Health - Needing Mental Health Care	2013-14	Health Outcomes	Percentage	105,000	n/a	15.9%	no data	Below Benchmark	11.3%	-4.60%	

Health Indicators								Benchmarks		Needs Score			
Potential Health Needs	Core/ Related	Indicators	Data Source Year	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Desired Direction	Napa County	Difference from the State Value	Stastistically Unstable County Data
	Related	Lack of Social or Emotional Support	2006-12	Social & Economic Factors	Percentage	104,042	n/a	24.6%	20.7%	Below Benchmark	21.0%	-3.60%	
		Access to Mental Health Providers	2014	Clinical Care	Rate	144,030	n/a	157.0	134.1	Above Benchmark	247.2	90.17	
		Violence - Youth Intentional Injury	2011-13	Social & Economic Factors	Rate	15,181	n/a	738.7	no data	Below Benchmark	537.9	-200.77	
		Percent of 11th grade students who felt sad or hopeless almos everyday for 2 weeks or more so that they stopped doing	2011-2013, 2013-US	Health Outcomes	Percentage	no data	n/a	32.5%	31.7%	Below Benchmark	32.5%	0.00%	
Obesity/HEAL/ Diabetes	Core	Overweight (Adult)	2011-12	Health Outcomes	Percentage	93,030	n/a	35.9%	35.8%	Below Benchmark	37.0%	1.10%	
		Obesity (Adult)	2012	Health Outcomes	Percentage	103,831	n/a	22.3%	27.1%	Below Benchmark	24.0%	1.68%	
		Overweight (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.3%	no data	Below Benchmark	19.5%	0.21%	
		Obesity (Youth)	2013-14	Health Outcomes	Percentage	4,724	n/a	19.0%	no data	Below Benchmark	14.8%	-4.15%	
		Diabetes Prevalence	2012	Health Outcomes	Percentage	103,923	n/a	8.1%	9.1%	Below Benchmark	6.8%	-1.25%	
		Diabetes Hospitalizations	2011	Health Outcomes	Rate	no data	n/a	10.4	no data	Below Benchmark	7.4	-3.03	
	Related	Percent of adults who have diabetes (20+ years old)	2014, 2012-US	Health Outcomes	Percentage	no data	n/a	9.3%	12.3%	Below Benchmark	4.3%	-5.00%	
		Heart Disease Prevalence	2011-12	Health Outcomes	Percentage	102,000	n/a	6.3%	no data	Below Benchmark	9.9%	3.60%	
		Mortality - Ischaemic Heart Disease	2010-12	Health Outcomes	Rate	136,484	<= 100.8	163.2	no data	Below Benchmark	152.9	-10.24	
		Mortality - Stroke	2010-12	Health Outcomes	Rate	136,484	n/a	37.4	no data	Below Benchmark	38.0	0.65	
		Low Fruit/Vegetable Consumption (Adult)	2005-09	Health Behaviors	Percentage	101,137	n/a	71.5%	75.7%	Below Benchmark	64.7%	-6.80%	
		Low Fruit/Vegetable Consumption (Youth)	2011-12	Health Behaviors	Percentage	16,000	n/a	47.4%	no data	Below Benchmark	51.6%	4.20%	
		Fruit/Vegetable Expenditures	2014	Health Behaviors	Percentage	no data	n/a	14.1%	12.7%	Above Benchmark	suppressed		
		Soft Drink Expenditures	2014	Health Behaviors	Percentage	no data	n/a	3.6%	4.0%	Below Benchmark	suppressed		
		Food Environment - Fast Food Restaurants	2011	Physical Environment	Rate	136,484	n/a	74.5	72.0	Below Benchmark	63.0	-11.5	
		Food Environment - Grocery Stores	2011	Physical Environment	Rate	136,484	n/a	21.5	21.1	Above Benchmark	27.8	6.33	
		Food Environment - WIC-Authorized Food Stores	2011	Physical Environment	Rate	138,088	n/a	15.8	15.6	Above Benchmark	17.4	1.58	
		Food Security - Food Desert Population	2010	Social & Economic Factors	Percentage	136,484	n/a	14.3%	23.6%	Below Benchmark	13.0%	-1.35%	
		Physical Inactivity (Adult)	2012	Health Behaviors	Percentage	103,786	n/a	16.6%	22.6%	Below Benchmark	13.4%	-3.19%	
		Physical Inactivity (Youth)	2013-14	Health Behaviors	Percentage	4,724	n/a	35.9%	no data	Below Benchmark	31.1%	-4.78%	
		Park Access	2010	Physical Environment	Percentage	136,484	n/a	58.6%	no data	Above Benchmark	57.6%	-0.98%	
		Transit - Walkability	2012	Physical Environment	percentage	no data	n/a	1.7%	2.0%	Below Benchmark	no data		
		Recreation and Fitness Facility Access	2012	Physical Environment	Rate	136,484	n/a	8.7	9.4	Above Benchmark	12.5	3.81	
		Breastfeeding (Any)	2012	Health Behaviors	percentage	1,194	n/a	93.0%	no data	Above Benchmark	97.6%	4.58%	
		Breastfeeding (Exclusive)	2012	Health Behaviors	Percentage	1,194	n/a	64.8%	no data	Above Benchmark	87.3%	22.50%	
		Food Security - School Breakfast Program	2013	Social & Economic Factors	Rate	no data	n/a	3.9	4.2	Below Benchmark	no data		
		Economic Security - Commute Over 60 Minutes	2009-13	Social & Economic Factors	Percentage	61,338	n/a	10.1%	8.1%	Below Benchmark	9.0%	-1.10%	
		Food Security - Food Insecurity Rate	2012	Social & Economic Factors	Percentage	136,644	n/a	16.2%	15.9%	Below Benchmark	12.0%	-4.24%	
		Drinking Water Safety	2012-13	Physical Environment	Percentage	76,453	n/a	2.7%	10.3%	Below Benchmark	14.4%	11.73%	
		Commute to Work - Walking/Biking	2009-13	Health Behaviors	Percentage	64,876	n/a	3.8%	3.4%	Above Benchmark	5.1%	1.32%	
		Diabetes Management (Hemoglobin A1c Test)	2012	Clinical Care	Percentage	11,517	n/a	81.5%	84.6%	Above Benchmark	80.1%	-1.35%	
		Commute to Work - Alone in Car	2009-13	Health Behaviors	Percentage	64,876	n/a	73.2%	76.4%	Below Benchmark	76.1%	2.92%	
		Percent of children age 2-11 drinking one or more sugar sweetened beverages (other than soda) per day	2011-12	Health Behaviors	Percentage	no data	n/a	27.0%	no data	Below Benchmark	18.6%	-8.40%	
		Percent of 5th, 7th and 9th graders who are physically fit ** (ir the healthy fitness zone for aerobic capacity	2013-14 school year	Health Behaviors	Percentage	no data	n/a	64.1%	no data	Above Benchmark	68.9%	4.78%	
		Walking/Biking/Skating to School	2011-12	Health Behaviors	Percentage	27,778	n/a	43.0%	no data	Above Benchmark	36.0%	-7.00%	
Oral Health	Core	Poor Dental Health	2006-10	Health Outcomes	Percentage	102,821	n/a	11.3%	15.7%	Below Benchmark	7.6%	-3.72%	
		Dental Care - No Recent Exam (Adult)	2006-10	Clinical Care	Percentage	102,821	n/a	30.5%	30.2%	Below Benchmark	12.4%	-18.07%	
		Dental Care - No Recent Exam (Youth)	2013-14	Clinical Care	Percentage	18,000	n/a	18.5%	no data	Below Benchmark	42.6%	24.10%	x
		Absence of Dental Insurance Coverage	2009	Clinical Care	Percentage	96,000	n/a	40.9%	no data	Below Benchmark	43.7%	2.80%	
		Health Professional Shortage Area - Dental	2015, March	Clinical Care	Percentage	136,484	n/a	4.9%	32.0%	Below Benchmark	0.0%	-4.93%	
	Related	Soft Drink Expenditures	2014	Health Behaviors	Percentage	no data	n/a	3.6%	4.0%	Below Benchmark	suppressed		
		Drinking Water Safety	2012-13	Physical Environment	Percentage	76,453	n/a	2.7%	10.3%	Below Benchmark	14.4%	11.73%	
		Dental Care - Lack of Affordability (Youth)	2009	Clinical Care	Percentage	31,000	n/a	6.3%	no data	Below Benchmark	4.1%	-2.20%	
		Access to Dentists	2013	Clinical Care	Rate	140,326	n/a	7745.0%	6318.0%	Above Benchmark	7696.0%	-0.49	

Health Indicators								Benchmarks		Needs Score			
Potential Health Needs	**Core/ Related**	**Indicators**	**Data Source Year**	**MATCH Category**	**Measure Type**	**Population Denominator**	**HP 2020 Value**	**State Benchmark**	**National Benchmark**	**Desired Direction**	**Napa County**	**Difference from the State Value**	**Stastistically Unstable County Data**
Overall Health	**Core**	Poor General Health	2006-12	Health Outcomes	Percentage	104,042	n/a	18.4%	15.7%	Below Benchmark	16.7%	-1.70%	
		Mortality - Premature Death	2008-10	Health Outcomes	Rate	138,088	n/a	5594.0	6851.0	Below Benchmark	5308.0	-286	
		Pneumonia Vaccinations (Age 65+)	2006-12	Clinical Care	Percentage	20,336	n/a	63.4%	67.5%	Above Benchmark	68.7%	5.30%	
		Percent of adults age 65+ with a physical, mental or emotional disability	2014	Health Outcomes	Percentage	no data	n/a	51.0%	no data	Below Benchmark	53.0%	2.00%	
		Population with Any Disability	2009-13	Demographics	Percentage	135,843	n/a	10.1%	12.1%	Below Benchmark	10.8%	0.67%	
Pregnancy and Birth Outcomes	**Core**	Low Birth Weight	2011	Health Outcomes	Percentage	136,484	n/a	6.8%	no data	Below Benchmark	6.0%	-0.77%	
		Infant Mortality	2006-10	Health Outcomes	Rate	8,265	<= 6.0	5.0	6.5	Below Benchmark	5.4	0.4	
		Lack of Prenatal Care	2011	Clinical Care	Percentage	136,484	n/a	3.1%	no data	Below Benchmark	no data		
		Teen Births (Under Age 20)	2011	Social & Economic Factors	Rate	17,138	n/a	8.5	no data	Below Benchmark	6.0	-2.51	
	Related	Breastfeeding (Any)	2012	Health Behaviors	percentage	1,194	n/a	93.0%	no data	Above Benchmark	97.6%	4.58%	
		Breastfeeding (Exclusive)	2012	Health Behaviors	Percentage	1,194	n/a	64.8%	no data	Above Benchmark	87.3%	22.50%	
		Food Security - Food Insecurity Rate	2012	Social & Economic Factors	Percentage	136,644	n/a	16.2%	15.9%	Below Benchmark	12.0%	-4.24%	
Substance Abuse/Tobacco	**Core**	Tobacco Usage	2006-12	Health Behaviors	Percentage	104,042	n/a	12.8%	18.1%	Below Benchmark	8.6%	-4.20%	
		Tobacco Expenditures	2014	Health Behaviors	Percentage	no data	n/a	1.0%	1.6%	Below Benchmark	suppressed		
		Alcohol - Excessive Consumption	2006-12	Health Behaviors	Percentage	104,042	n/a	17.2%	16.9%	Below Benchmark	21.3%	4.10%	
		Alcohol - Expenditures	2014	Health Behaviors	Percentage	no data	n/a	12.9%	14.3%	Below Benchmark	suppressed		
	Related	Liquor Store Access	2012	Physical Environment	Rate	136,484	n/a	10.0	10.4	Below Benchmark	36.6	26.61	
		Percent of 11th grade students binge drinking at least once in month prior	2011-13, 2013-US	Health Behaviors	Percentage	no data	n/a	20.7%	24.6%	Below Benchmark	22.8%	2.10%	
		Percent of 11th grade students using cigarettes any time within last 30 days	2011-13, 2013-US	Health Behaviors	Percentage	no data	<= 21.0%	10.2%	21.1%	Below Benchmark	11.8%	1.60%	
		Percent of 11th grade students reporting marijuana use within the last 30 days	2011-13 , 2013-US	Health Behaviors	Percentage	no data	n/a	22.0%	25.5%	Below Benchmark	24.9%	2.90%	
Vaccine-Preventable Infectious Disease	**Core**	Pneumonia Vaccinations (Age 65+)	2006-12	Clinical Care	Percentage	20,336	n/a	63.4%	67.5%	Above Benchmark	68.7%	5.30%	
		Percent of kindergarteners with all required immunizations	2014-15	Clinical Care	Percentage	no data	>= 95.0%	90.4%	no data	Above Benchmark	93.7%	3.28%	
Violence/Injury Prevention	**Core**	Mortality - Homicide	2010-12	Health Outcomes	Rate	136,484	<= 5.5	5.2	no data	Below Benchmark	1.2	-3.98	
		Mortality - Suicide	2010-12	Health Outcomes	Rate	136,484	<= 10.2	9.8	no data	Below Benchmark	12.7	2.93	
		Mortality - Motor Vehicle Accident	2010-12	Health Outcomes	Rate	136,484	<= 12.4	5.2	no data	Below Benchmark	4.0	-1.14	
		Mortality - Pedestrian Accident	2010-12	Health Outcomes	Rate	136,484	<= 1.3	2.0	no data	Below Benchmark	1.1	-0.88	
		Violence - Youth Intentional Injury	2011-13	Social & Economic Factors	Rate	15,181	n/a	738.7	no data	Below Benchmark	537.9	-200.77	
		Violence - Assault (Injury)	2011-13	Social & Economic Factors	Rate	138,519	n/a	290.3	no data	Below Benchmark	193.2	-97.07	
		Violence - Domestic Violence	2011-13	Social & Economic Factors	Rate	61,326	n/a	9.5	no data	Below Benchmark	2.7	-6.78	
		Violence - Assault (Crime)	2010-12	Social & Economic Factors	Rate	137,980	n/a	249.4	246.9	Below Benchmark	308.5	59.1	
		Violence - Robbery (Crime)	2010-12	Social & Economic Factors	Rate	137,980	n/a	149.5	116.4	Below Benchmark	51.0	-98.53	
	Related	Violence - All Violent Crimes	2010-12	Social & Economic Factors	Rate	137,980	n/a	425.0	395.5	Below Benchmark	383.6	-41.37	
		Alcohol - Excessive Consumption	2006-12	Health Behaviors	Percentage	104,042	n/a	17.2%	16.9%	Below Benchmark	21.3%	4.10%	
		Alcohol - Expenditures	2014	Health Behaviors	Percentage	no data	n/a	12.9%	14.3%	Below Benchmark	suppressed		
		Liquor Store Access	2012	Physical Environment	Rate	136,484	n/a	10.0	10.4	Below Benchmark	36.6	26.61	
		Transit - Walkability	2012	Physical Environment	Percentage	no data	n/a	1.7%	2.0%	Below Benchmark	no data		
		Violence - Rape (Crime)	2010-12	Social & Economic Factors	Rate	137,980	n/a	21.0	27.3	Below Benchmark	22.5	1.47	
		Violence - School Suspensions	2013-14	Social & Economic Factors	Rate	41,712	n/a	4.0	no data	Below Benchmark	3.5	-0.53	
		Violence - School Expulsions	2013-14	Social & Economic Factors	Rate	41,712	n/a	0.1	no data	Below Benchmark	0.0	-0.03	
		Percentage of 11th grade students reporting current gang involvement	2012-13	Social & Economic Factors	Percentage	no data	n/a	7.5%	no data	Below Benchmark	8.1%	0.60%	
		Percent of 11th grade students reporting harassment on school property related to their sexual orientation	2011-2013	Social & Economic Factors	Percentage	no data	n/a	7.6%	no data	Below Benchmark	8.3%	0.70%	
		Substantiated allegations of child maltreatment per 1,000 children ages 0-17	2014, 2013- US	Social & Economic Factors	Rate/1,000	no data	<=8.5	9.0	9.1	Below Benchmark	8.1	-0.9	
		Unintentional injuries age-adjusted mortality rate per 100,000 population	2011-13, 2013-US	Health Outcomes	Rate	no data	<= 36.4	27.9	39.4	Below Benchmark	30.7	2.8	
Older Adult Health	**Core**	Alzheimer's disease age adjusted mortality rate	2001-13, 2013-US	Health Outcomes	Rate/100,000	no data	n/a	30.8	23.5	Below Benchmark	31.0	0.2	
		Percent People 65 years or Older In Poverty (100%FPL)	2009-13	Social & Economic Factors	Percentage	no data	n/a	9.9%	9.4%	Below Benchmark	6.8%	-3.02%	
		Percent of adults age 65+ with a physical, mental or emotional disability	2014	Health Outcomes	Percentage	no data	n/a	51.0%	no data	Below Benchmark	53.0%	2.00%	
		Elder Index (Single elder head of household), percentage above 100% FPL, but below the Elder Index	2011	Social & Economic Factors	Percentage	no data	n/a	30.9%	no data	Below Benchmark	33.4%	2.50%	
		Elder Index (Elder Couple), percentage above 100% FPL, but below the Elder Index	2011	Social & Economic Factors	Percentage	no data	n/a	20.7%	no data	Below Benchmark	13.1%	-7.60%	

Health Indicators									Benchmarks		Needs Score			
Potential Health Needs	Core/ Related	Indicators	Data Source Year	MATCH Category	Measure Type	Population Denominator	HP 2020 Value	State Benchmark	National Benchmark	Desired Direction	Napa County	Difference from the State Value	Stastistically Unstable County Data
		Pneumonia Vaccinations (Age 65+)	2006-12	Clinical Care	Percentage	20,336	n/a	63.4%	67.5%	Above Benchmark	68.7%	5.30%	

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Absence of Dental Insurance Coverage	Percent Adults Without Dental Insurance	Estimated Total Population Age 18+	University of California Center for Health Policy Research,California Health Interview Survey. 2009.
Access to Dentists	Dentists, Rate per 100,000 Pop.	Total Population, 2013	US Department of Health & Human Services,Health Resources and Services Administration,Area Health Resource File. 2013.
Access to Mental Health Providers	Mental Health Care Provider Rate (Per 100,000 Population)	Estimated Population	University of Wisconsin Population Health Institute,County Health Rankings. 2014.
Access to Primary Care	Primary Care Physicians, Rate per 100,000 Pop.	Total Population, 2012	US Department of Health & Human Services,Health Resources and Services Administration,Area Health Resource File. 2012.
Air Quality - Ozone (O3)	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Total Population	Centers for Disease Control and Prevention,National Environmental Public Health Tracking Network. 2008.
Air Quality - Particulate Matter 2.5	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Total Population	Centers for Disease Control and Prevention,National Environmental Public Health Tracking Network. 2008.
Alcohol - Excessive Consumption	Estimated Adults Drinking Excessively(Age-Adjusted Percentage)	Total Population Age 18+	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services,Health Indicators Warehouse. 2006-12.
Alcohol - Expenditures	Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures		Nielsen,Nielsen SiteReports. 2014.
Alzheimer's age adjusted mortality rate	Alzheimer's age adjusted mortality rate	Total Population	CDPH county health profiles/NVSS report, 2011-2013
Asthma - Hospitalizations	Age-Adjusted Discharge Rate (Per 10,000 Pop.)		California Office of Statewide Health Planning and Development,OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Asthma - Prevalence	Percent Adults with Asthma	Survey Population(Adults Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Breastfeeding (Any)	Percentage of Mothers Breastfeeding (Any)	Total In-Hospital Births	California Department of Public Health,CDPH - Breastfeeding Statistics. 2012.
Breastfeeding (Exclusive)	Percentage of Mothers Breastfeeding (Exclusively)	Total In-Hospital Births	California Department of Public Health,CDPH - Breastfeeding Statistics. 2012.
Cancer Incidence - Breast	Annual Breast Cancer Incidence Rate (Per 100,000 Pop.)	Female Population	National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles. 2007-11.
Cancer Incidence - Cervical	Annual Cervical Cancer Incidence Rate (Per 100,000 Pop.)	Female Population	National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles. 2007-11.
Cancer Incidence - Colon and Rectum	Annual Colon and Rectum Cancer Incidence Rate (Per 100,000 Pop.)	Total Population	National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles. 2007-11.
Cancer Incidence - Lung	Annual Lung Cancer Incidence Rate (Per 100,000 Pop.)	Total Population	National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles. 2007-11.
Cancer Incidence - Prostate	Annual Prostate Cancer Incidence Rate (Per 100,000 Pop.)	Male Population	National Institutes of Health,National Cancer Institute,Surveillance,Epidemiology,and End Results Program. State Cancer Profiles. 2007-11.
Cancer Screening - Mammogram	Percent Female Medicare Enrollees with Mammogram in Past 2 Year	Female Medicare Enrollees Age 67-69	Dartmouth College Institute for Health Policy & Clinical Practice,Dartmouth Atlas of Health Care. 2012.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Cancer Screening - Pap Test	Percent Adults Females Age 18+ with Regular Pap Test(Age-Adjusted)	Female Population Age 18+	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services,Health Indicators Warehouse. 2006-12.
Cancer Screening - Sigmoid/Colonoscopy	Percent Adults Screened for Colon Cancer (Age-Adjusted)	Total Population Age 50+	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services,Health Indicators Warehouse. 2006-12.
Change in Total Population	Percent Population Change, 2000-2010	Total Population, 2000 Census	US Census Bureau,Decennial Census. 2000 - 2010.
Children Eligible for Free/Reduced Price Lunch	Percent Students Eligible for Free or Reduced Price Lunch	Total Students	National Center for Education Statistics,NCES - Common Core of Data. 2013-14.
Climate & Health - Canopy Cover	Population Weighted Percentage of Report Area Covered by Tree Canopy	Total Population	Multi-Resolution Land Characteristics Consortium,National Land Cover Database 2011. Additional data analysis by CARES. 2011.
Climate & Health - Drought Severity	Percentage of Weeks in Drought (Any)		US,Drought,Monitor.,2012-14.
Climate & Health - Heat Index Days	Percentage of Weather Observations with High Heat Index Values:%	Total Weather Observations	National Oceanic and Atmospheric Administration,North America Land Data Assimilation System (NLDAS) . Accessed via CDC WONDER. Additional data analysis by CARES. 2014.
Climate & Health - Heat Stress Events	Heat-related Emergency Department Visits, Rate per 100,000 Population	Number of Heat-related Emergency Room Visits	California Department of Public Health,CDPH - Tracking. 2005-12.
Climate & Health - No Access to Air Conditioning	Percentage of Housing Units with No Air Conditioning	Total Occupied Housing Units (2010)	US Census Bureau,American Housing Survey. 2011, 2013.
Commute to Work - Alone in Car	Percentage of Workers Commuting by Car, Alone	Population Age 16+	US Census Bureau,American Community Survey. 2009-13.
Commute to Work - Walking/Biking	Percentage Walking or Biking to Work	Population Age 16+	US Census Bureau,American Community Survey. 2009-13.
Dental Care - Lack of Affordability (Youth)	Percent Population Age 5-17 Unable to Afford Dental Care	Estimated Total Population Age 5-17	University of California Center for Health Policy Research,California Health Interview Survey. 2009.
Dental Care - No Recent Exam (Adult)	Percent Adults Without Recent Dental Exam	Total Population(Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Dental Care - No Recent Exam (Youth)	Percent Youth Without Recent Dental Exam	Estimated Total Population Age 2-13	University of California Center for Health Policy Research,California Health Interview Survey. 2013-14.
Diabetes Hospitalizations	Age-Adjusted Discharge Rate (Per 10,000 Pop.)		California Office of Statewide Health Planning and Development,OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Diabetes Management (Hemoglobin A1c Test)	Percent Medicare Enrollees with Diabetes with Annual Exam	Total Medicare Enrollees	Dartmouth College Institute for Health Policy & Clinical Practice,Dartmouth Atlas of Health Care. 2012.
Diabetes Prevalence	Percent Adults with Diagnosed Diabetes(Age-Adjusted)	Total Population Age 20+	Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion. 2012.
Drinking Water Safety	Percentage of Population Potentially Exposed to Unsafe Drinking Water	Estimated Total Population	University of Wisconsin Population Health Institute,County Health Rankings. 2012-13.
Economic Security - Commute Over 60 Minutes	Percentage of Workers Commuting More than 60 Minutes	Population Age 16+ that Commutes to Work	US Census Bureau,American Community Survey. 2009-13.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Economic Security - Households with No Vehicle	Percentage of Households with No Motor Vehicle	Total Occupied Households	US Census Bureau,American Community Survey. 2009-13.
Economic Security - Unemployment Rate	Unemployment Rate	Labor Force	US Department of Labor,Bureau of Labor Statistics. 2015 - June.
Education - Head Start Program Facilities	Head Start Programs Rate (Per 10,000 Children Under Age 5)	Total Children Under Age 5	US Department of Health & Human Services,Administration for Children and Families. 2014.
Education - High School Graduation Rate	Cohort Graduation Rate	Cohort Size	California,Department,of,Education.,2013.
Education - Less than High School Diploma (or Equivalent)	Percent Population Age 25+ with No High School Diploma	Total Population Age 25+	US Census Bureau,American Community Survey. 2009-13.
Education - Reading Below Proficiency	Percentage of Grade 4 ELA Test Score Not Proficient	Total Students with Scores	California,Department,of,Education.,2012-13.
Education - School Enrollment Age 3-4	Percentage of Population Age 3-4 Enrolled in School	Population Age 3-4	US Census Bureau,American Community Survey. 2009-13.
Elder Index from UCLA center for Health Policy Research - economic security for older adults	Elder Index from UCLA center for Health Policy Research - economic security for older adults	Total Adults 65+	UCLA, http://healthpolicy.ucla.edu/programs/health-disparities/elder-health/Documents/Hidden%20Poor%20By%20County.pdf
Federally Qualified Health Centers	Federally Qualified Health Centers, Rate per 100,000 Population	Total Population	US Department of Health & Human Services,Center for Medicare & Medicaid Services,Provider of Services File. June 2014.
Female Population	Percent Female Population	Total Population	US Census Bureau,American Community Survey. 2009-13.
Food Environment - Fast Food Restaurants	Fast Food Restaurants, Rate (Per 100,000 Population)	Total Population	US Census Bureau,County Business Patterns. Additional data analysis by CARES. 2011.
Food Environment - Grocery Stores	Grocery Stores, Rate (Per 100,000 Population)	Total Population	US Census Bureau,County Business Patterns. Additional data analysis by CARES. 2011.
Food Environment - WIC-Authorized Food Stores	WIC-Authorized Food Stores, Rate (Per 100,000 Population)	Total Population (2011 Estimate)	US Department of Agriculture,Economic Research Service,USDA - Food Environment Atlas. 2011.
Food Security - Food Desert Population	Percent Population with Low Food Access	Total Population	US Department of Agriculture,Economic Research Service,USDA - Food Access Research Atlas. 2010.
Food Security - Food Insecurity Rate	Percentage of the Population with Food Insecurity	Total Population	Feeding,America.,2012.
Food Security - Population Receiving SNAP	Percent Population Receiving SNAP Benefits	Total Population	US Census Bureau,Small Area Income & Poverty Estimates. 2011.
Food Security - School Breakfast Program	Average Daily School Breakfast Program Participation Rate	Total Population	US Department of Agriculture,Food and Nutrition Service,USDA - Child Nutrition Program. 2013.
Fruit/Vegetable Expenditures	Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures		Nielsen,Nielsen SiteReports. 2014.
Health Professional Shortage Area - Dental	Percentage of Population Living in a HPSA	Total Area Population	US Department of Health & Human Services,Health Resources and Services Administration,Health Resources and Services Administration. March 2015.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Health Professional Shortage Area - Primary Care	Percentage of Population Living in a HPSA	Total Area Population	US Department of Health & Human Services,Health Resources and Services Administration,Health Resources and Services Administration. March 2015.
Heart Disease Prevalence	Percent Adults with Heart Disease	Estimated Total Population Age 18+	University of California Center for Health Policy Research,California Health Interview Survey. 2011-12.
High Blood Pressure - Unmanaged	Percent Adults with High Blood Pressure Not Taking Medication	Total Population(Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.
Hispanic Population	Percent Population Hispanic or Latino	Total Population	US Census Bureau,American Community Survey. 2009-13.
Housing - Assisted Housing	HUD-Assisted Units, Rate per 10,000 Housing Units	Total Housing Units (2010)	US,Department,of,Housing,and,Urban,Development.,2013.
Housing - Cost Burdened Households	Percentage of Households where Housing Costs Exceed 30% of Income	Total Households	US Census Bureau,American Community Survey. 2010-14.
Housing - Substandard Housing	Percent Occupied Housing Units with One or More Substandard Conditions	Total Occupied Housing Units	US Census Bureau,American Community Survey. 2009-13.
Housing - Vacant Housing	Vacant Housing Units, Percent	Total Housing Units	US Census Bureau,American Community Survey. 2009-13.
Income Inequality	Gini Index Value	Total Households	US Census Bureau,American Community Survey. 2009-13.
Infant Mortality	Infant Mortality Rate (Per 1,000 Births)	Total Births	Centers for Disease Control and Prevention,National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention,Wide-Ranging Online Data for Epidemiologic Research. 2006-10.
Insurance - Population Receiving Medicaid	Percent of Insured Population Receiving Medicaid	Total Population(For Whom Insurance Status is Determined)	US Census Bureau,American Community Survey. 2014.
Insurance - Uninsured Population	Percent Uninsured Population	Total Population (For Whom Insurance Status is Determined)	US Census Bureau,American Community Survey. 2010-14.
Lack of a Consistent Source of Primary Care	Percentage Without Regular Doctor	Estimated Total Population	University of California Center for Health Policy Research,California Health Interview Survey. 2011-12.
Lack of Prenatal Care	Percent Mothers with Late or No Prenatal Care	Total Population	California Department of Public Health,CDPH - Birth Profiles by ZIP Code. 2011.
Lack of Social or Emotional Support	Percent Adults Without Adequate Social / Emotional Support (Age-Adjusted)	Total Population Age 18+	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services,Health Indicators Warehouse. 2006-12.
Linguistically Isolated Households	Percent Linguistically Isolated Population	Total Population Age 5+	US Census Bureau,American Community Survey. 2009-13.
Liquor Store Access	Liquor Stores, Rate (Per 100,000 Population)	Total Population	US Census Bureau,County Business Patterns. Additional data analysis by CARES. 2012.
Low Birth Weight	Percent Low Birth Weight Births	Total Population	California Department of Public Health,CDPH - Birth Profiles by ZIP Code. 2011.
Low Fruit/Vegetable Consumption (Adult)	Percent Adults with Inadequate Fruit / Vegetable Consumption	Total Population(Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services,Health Indicators Warehouse. 2005-09.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Low Fruit/Vegetable Consumption (Youth)	Percent Population Age 2-13 with Inadequate Fruit/Vegetable Consumption	Estimated Total Population Age 2-13	University of California Center for Health Policy Research,California Health Interview Survey. 2011-12.
Male Population	Percent Male Population	Total Population	US Census Bureau,American Community Survey. 2009-13.
Median Age	Median Age	Total Population	US Census Bureau,American Community Survey. 2009-13.
Mental Health - Depression Among Medicare Beneficiaries	Percentage of Medicare Beneficiaries with Depression	Total Medicare Beneficiaries	Centers,for,Medicare,and,Medicaid,Services.,2012.
Mental Health - Needing Mental Health Care	Percentage with Poor Mental Health	Estimated Total Population Age 18+	University of California Center for Health Policy Research,California Health Interview Survey. 2013-14.
Mental Health - Poor Mental Health Days	Average Number of Mentally Unhealthy Days per Month	Total Population(Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. 2006-12.
Mortality - Cancer	Cancer, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Homicide	Homicide, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Ischaemic Heart Disease	Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Motor Vehicle Accident	Motor Vehicle Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Pedestrian Accident	Pedestrian Accident, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Premature Death	Years of Potential Life Lost, Rate per 100,000 Population	Total Population, 2008-2010 Average	University of Wisconsin Population Health Institute,County Health Rankings. Centers for Disease Control and Prevention,National Vital Statistics System. Accessed via CDC WONDER. 2008-10.
Mortality - Stroke	Stroke, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Mortality - Suicide	Suicide, Age-Adjusted Mortality Rate (per 100,000 Population)	Total Population	University of Missouri,Center for Applied Research and Environmental Systems. California Department of Public Health,CDPH - Death Public Use Data. 2010-12.
Obesity (Adult)	Percent Adults with BMI > 30.0 (Obese)	Total Population Age 20+	Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion. 2012.
Obesity (Youth)	Percent Obese	Student Population Tested	California Department of Education,FITNESSGRAM® Physical Fitness Testing. 2013-14.
Overweight (Adult)	Percent Adults Overweight	Survey Population(Adults Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Overweight (Youth)	Percent Overweight	Student Population Tested	California Department of Education,FITNESSGRAM® Physical Fitness Testing. 2013-14.
Park Access	Percent Population Within 1/2 Mile of a Park	Total Population, 2010 Census	US Census Bureau,Decennial Census. ESRI Map Gallery. 2010.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Percent living in overcrowded housing conditions (>1.5 persons/room)	Percent living in overcrowded housing conditions (>1.5 persons/room)	Total Population	ACS, 2009-2013, table number B25014
Percent of 11th grade students binge drinking at least once in the month prior	Percent of 11th grade students binge drinking at least once in the month prior	11th Grade Students	CHKS/YRBSS, 2011-2013, 2013-US, http://www.cdc.gov/healthyyouth/data/yrbs/results.htm
Percent of 11th grade students reporting driving after drinking (respondent or by friend)	Percent of 11th grade students reporting driving after drinking (respondent or by friend)	11th Grade Students	CHKS/YRBSS, (no other info given)
Percent of 11th grade students reporting harassment on school property related to their sexual orientation	Percent of 11th grade students reporting harassment on school property related to their sexual orientation	11th Grade Students	CHKS, 2011-2013
Percent of 11th grade students reporting marijuana use within the last 30 days	Percent of 11th grade students reporting marijuana use within the last 30 days	11th Grade Students	CHKS/YRBSS, 2011-2013, 2013-US, http://www.cdc.gov/healthyyouth/data/yrbs/results.htm
Percent of 11th grade students using cigarettes any time within last 30 days	Percent of 11th grade students using cigarettes any time within last 30 days	11th Grade Students	CHKS/YRBSS, 2011-2013, 2013-US, http://www.cdc.gov/healthyyouth/data/yrbs/results.htm
Percent of 11th grade students who felt sad or hopeless almost everyday for 2 weeks or more so that they stopped doing some usual activities	Percent of 11th grade students who felt sad or hopeless almost everyday for 2 weeks or more so that they stopped doing some usual activities	11th Grade Students	CHKS/YRBSS, 2011-2013, 2013-US, http://www.cdc.gov/healthyyouth/data/yrbs/results.htm
Percent of adults age 65+ with a physical, mental or emotional disability	Percent of adults age 65+ with a physical, mental or emotional disability	Total Adults 65+	CHIS, 2014
Percent of children age 2-11 drinking one or more sugar sweetened beverages per day	Percent of children age 2-11 drinking one or more sugar sweetened beverages per day	Total Youth 2-11	CHIS policy report
Percent of children ever diagnosed with asthma (ages 17 and below)	Percent of children ever diagnosed with asthma (ages 17 and below)	Total Youth 0-17	CHIS/NHIS
Percent of kindergarteners with all required immunizations	Percent of kindergarteners with all required immunizations	Kindergarten students	CDPH, 2014-15, kindergarten table
Percent People 65 years or Older In Poverty	Percent People 65 years or Older In Poverty	Total Adults 65+	ACS, 2009-2013, table number S1703
Percentage of 11th grade students reporting current gang involvement	Percentage of 11th grade students reporting current gang involvement	11th Grade Students	CHKS, 2011-2013
Pesticide Use - Pounds of Pesticides Applied	Pounds of Agricultural Pesticides Used in 2013	N/A	California Department of Pesticide Regulation (CDPR), Pesticide Use Reporting (PUR) Data. 2013.
Pesticide Use - Rank of Pesticide Use Among CA Counties			California Department of Pesticide Regulation (CDPR), Pesticide Use Reporting (PUR) Data. 2013.
Physical Inactivity (Adult)	Percent Population with no Leisure Time Physical Activity	Total Population Age 20+	Centers for Disease Control and Prevention,National Center for Chronic Disease Prevention and Health Promotion. 2012.
Physical Inactivity (Youth)	Percent Physically Inactive	Student Population Tested	California Department of Education,FITNESSGRAM® Physical Fitness Testing. 2013-14.
Pneumonia Vaccinations (Age 65+)	Percent Population Age 65+ with Pneumonia Vaccination (Age-Adjusted)	Total Population Age 65+	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services,Health Indicators Warehouse. 2006-12.
Poor Dental Health	Percent Adults with Poor Dental Health	Total Population(Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2006-10.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Poor General Health	Percent Adults with Poor or Fair Health (Age-Adjusted)	Total Population Age 18+	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services,Health Indicators Warehouse. 2006-12.
Population with Any Disability	Percent Population with a Disability	Total Population (For Whom Disability Status Is Determined)	US Census Bureau,American Community Survey. 2009-13.
Population with Limited English Proficiency	Percent Population Age 5+ with Limited English Proficiency	Total Population	US Census Bureau,American Community Survey. 2009-13.
Poverty - Children Below 100% FPL	Percent Population Under Age 18 in Poverty	Total Population	US Census Bureau,American Community Survey. 2010-14.
Poverty - Population Below 100% FPL	Percent Population in Poverty	Total Population	US Census Bureau,American Community Survey. 2010-14.
Poverty - Population Below 200% FPL	Percent Population with Income at or Below 200% FPL	Total Population	US Census Bureau,American Community Survey. 2010-14.
Preventable Hospital Events	Age-Adjusted Discharge Rate (Per 10,000 Pop.)		California Office of Statewide Health Planning and Development,OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
Prostate cancer age adjusted mortality rate	Prostate cancer age adjusted mortality rate	Total Population	CDPH county health profiles/NVSS report, 2011-2013
Recreation and Fitness Facility Access	Recreation and Fitness Facilities, Rate (Per 100,000 Population)	Total Population	US Census Bureau,County Business Patterns. Additional data analysis by CARES. 2012.
Soft Drink Expenditures	Soda Expenditures, Percentage of Total Food-At-Home Expenditures		Nielsen,Nielsen SiteReports. 2014.
STD - Chlamydia	Chlamydia Infection Rate (Per 100,000 Pop.)	Total Population	US Department of Health & Human Services,Health Indicators Warehouse. Centers for Disease Control and Prevention,National Center for HIV/AIDS,Viral Hepatitis,STD,and TB Prevention. 2012.
STD - HIV Hospitalizations	Age-Adjusted Discharge Rate (Per 10,000 Pop.)		California Office of Statewide Health Planning and Development,OSHPD Patient Discharge Data. Additional data analysis by CARES. 2011.
STD - HIV Prevalence	Population with HIV / AIDS, Rate (Per 100,000 Pop.)	Total Population	US Department of Health & Human Services,Health Indicators Warehouse. Centers for Disease Control and Prevention,National Center for HIV/AIDS,Viral Hepatitis,STD,and TB Prevention. 2010.
STD - No HIV Screening	Percent Adults Never Screened for HIV / AIDS	Survey Population(Smokers Age 18+)	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Additional data analysis by CARES. 2011-12.
Substantiated allegations of child maltreatment per 1,000 children ages 0-17	Substantiated allegations of child maltreatment per 1,000 children ages 0-17	Total Youth 0-17	UC Berkeley/child maltreatment 2013 publication from Children's Bureau, http://cssr.berkeley.edu/ucb_childwelfare/refRates.aspx
Teen Births (Under Age 20)	Teen Birth Rate (Per 1,000 Female Pop. Under Age 20)	Female PopulationUnder Age 20	California Department of Public Health,CDPH - Birth Profiles by ZIP Code. 2011.
Tobacco Expenditures	Cigarette Expenditures, Percentage of Total Household Expenditures		Nielsen,Nielsen SiteReports. 2014.
Tobacco Usage	Percent Population Smoking Cigarettes(Age-Adjusted)	Total Population Age 18+	Centers for Disease Control and Prevention,Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services,Health Indicators Warehouse. 2006-12.
Total Population	Population Density (Per Square Mile)	Total Population	US Census Bureau,American Community Survey. 2009-13.

Indicator Details

Indicator	Indicator Variable	Population Denominator	Data source
Transit - Public Transit within 0.5 Miles	Percentage of Population within Half Mile of Public Transit	Total Population	Environmental Protection Agency,EPA Smart Location Database. 2011.
Transit - Road Network Density	Total Road Network Density (Road Miles per Acre)	Total Area (Acres)	Environmental Protection Agency,EPA Smart Location Database. 2011.
Transit - Walkability	Percent Population Living in Car Dependent (Almost Exclusively) Cities		Walk,Score®.,2012.
Unintentional injuries age adjusted mortality rate	Unintentional injuries age adjusted mortality rate	Total Population	CDPH county health profiles/NVSS report, 2011-2013
Violence - All Violent Crimes	Violent Crime Rate (Per 100,000 Pop.)	Total Population	Federal Bureau of Investigation,FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Violence - Assault (Crime)	Assault Rate (Per 100,000 Pop.)	Total Population	Federal Bureau of Investigation,FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Violence - Assault (Injury)	Assault Injuries, Rate per 100,000 Population	Total Population	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2009-11.
Violence - Domestic Violence	Domestic Violence Injuries, Rate per 100,000 Population (Females Age 10+)	Females Age 10+	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2009-11.
Violence - Rape (Crime)	Rape Rate (Per 100,000 Pop.)	Total Population	Federal Bureau of Investigation,FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Violence - Robbery (Crime)	Robbery Rate (Per 100,000 Pop.)	Total Population	Federal Bureau of Investigation,FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2010-12.
Violence - School Expulsions	Expulsion Rate	Total Student Enrollment	California,Department,of,Education.,
Violence - School Suspensions	Suspension Rate	Total Student Enrollment	California,Department,of,Education.,
Violence - Youth Intentional Injury	Intentional Injuries, Rate per 100,000 Population (Youth Age 13 - 20)	Total Youth Age 13-20	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2009-11.
Walking/Biking/Skating to School	Percentage Walking/Skating/Biking to School	Estimated Total Population Age 5-17	University of California Center for Health Policy Research,California Health Interview Survey. 2011-12.

Napa County
Community Health Needs Assessment
Appendix C. Community Input Tracking Form

Data Collection Method	Title/Name	Number	Target Group(s) Represented* (interviewee or at least one participant in the focus group self-identified as a leader, member, or representative of the following populations)					Date Input Was Gathered
Meeting, focus group, interview, survey, written correspondence, etc.	**Respondent's title/role and name or focus group population**	**Number of participants**	**Health Department representative**	**Chronic Condition**	**Minority**	**Medically underserved**	**Low-income**	**Date of data collection**
Interview	Executive Director, First 5 Napa County	1						10/8/15
Interview	Executive Director, Up Valley Family Centers	1			X	X	X	10/5/15
Interview	Director, Napa County Health & Human Services	1	X	X	X	X	X	10/2/15
Interview	Program Director, South Napa Shelter	1					X	9/23/15
Interview	Mayor, American Canyon	1			X	X	X	10/7/15
Interview	Director, American Canyon Family Resource Center	1			X	X	X	10/6/15
Interview	Previous Executive Director, On the Move	1			X		X	9/17/15
Interview	Program Director, Napa Valley Hospice and Adult Day Services	1			X			10/5/15

Napa County
Community Health Needs Assessment
Appendix C. Community Input Tracking Form

Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health Department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
Interview	Lead Facilitator, Napa Valley Hospice and Adult Day Services	1						9/29/15
Interview	Executive Director, Napa Emergency Women's Services	1			X		X	10/16/15
Interview	Program Director, VOICES/On The Move	1			X	X	X	10/14/15
Interview	Director, Napa Valley Unified School District Student Services	1		X	X	X	X	10/2/15
Interview	CEO, Queen of the Valley	1		X	X	X	X	10/6/15
Interview	CEO, St. Helena Hospital Napa Valley	1		X	X	X	X	10/7/15
Interview	Physician In Charge, Kaiser Permanente Napa Solano	1		X	X	X	X	10/6/15
Interview	CEO, Clinic Ole Federally Qualified Health Center	1						9/21/15
Interview	Public Health Officer, Napa County Health & Human Services	1	X					11/4/15
Interview	Public Health Officer, California Health Workforce	1	X	X	X	X	X	10/20/15

Appendix C. Community Input Tracking Form

Meeting, focus group, interview, survey, written correspondence, etc.	Respondent's title/role and name or focus group population	Number of participants	Health Department representative	Chronic Condition	Minority	Medically underserved	Low-income	Date of data collection
Focus Group	Calistoga; Latino Population	10		X	X	X		10/13/15
Focus Group	Calistoga; Older Adult Population	13		X	X	X		10/13/15
Focus Group	County-wide; Youth Population	10		X	X	X		10/15/15
Focus Group	American Canyon; General Population	14		X	X	X		10/21/15

* Indicates self-identification of interviewees or focus group participants as a leader, member, or representative of each specified population. In some cases, individuals did not self-identify as a representative of any of the listed groups.

Napa County
Community Health Needs Assessment

Appendix D. Primary Data Collection Protocols
Napa County Key Informant Interview Protocol
FINAL

Introduction

Hello, my name is ____________ and I work for Harder+Company Community Research/ Raimi+Associates. We are working with Napa County Public Health and several Napa non-profit hospitals on a comprehensive community health assessment, including Kaiser Permanente, Queen of the Valley Medical Center, County of Napa, and St. Helena Hospital.

You have been identified as an individual with extensive and important knowledge of the *[Napa County Community / Specific subpopulation of Napa County]* that can help us with the CHNA -- to help ensure that we get a clear picture of health-related issues that impact our Napa County residents. We are very interested in having you share thoughts and ideas that go beyond access to medical care, taking into consideration social, economic, and environmental factors that impact health. Your input will inform the development of the CHNA as well as a community health implementation plan for all of Napa County

This interview will take about 30-45 minutes. Our discussion today will be incorporated into the Community Health Needs Assessment for Napa County. Everything we talk about today is confidential. That means that when I write up a report of what was said, I won't use your name or any other information to identify who you are. However, there is always a chance that someone is able to identify what you said.

Do you have any questions so far?

Before we start talking about the specifics, I want to make sure you know that, during this interview:
There is no right or wrong answer, just your ideas.
It's ok if you don't have an answer or opinion about a particular question. It is just as important for us to know that too. "I don't know" is an ok thing to say. And finally,
If at any time while we are talking you are not sure what I mean or have questions, do not hesitate to ask questions and let me know.

I would like to take notes and record during the interview so that I make sure that I get your statements exactly how you stated them.
Is it ok for me to take notes? Great! Just as a reminder, since I will be typing notes, there might be some short delays to make sure I am able to capture everything you say.
Is it ok for me to record our conversation?
Before we begin, do you have any questions?

Questions
a) Would you give me a brief description of your organization, and your role there?

b) Within Napa County, what geographic area do you primarily serve?

1. a) What are the *most important health needs* that have the greatest impact on overall health in Napa County?

b) What are the specific populations that are most adversely affected by the health problems you just mentioned?

c) The following were identified as priority health issues during the previous CHNA process in 2013:

1. Drug and Alcohol Abuse
2. Inactivity/lack of exercise
3. Unsafe roads/Sidewalk conditions
4. Mental health issues
5. Agricultural pesticides

Can you tell me how aware you are of these health issues? How do they impact overall health in Napa County? In what ways have these health issues changed in recent years?

d) What existing community assets and resources could be used to address these health issues and inequities [and the health issues you think are most important]?

2. a) What health behaviors do you think have the biggest influence on the issues we just discussed in your community?

   b) The following were identified as significant health behaviors during the previous CHNA process in 2013:

   a. Binge drinking (In 2009, 38% of adults in Napa reported binge drinking at least once in the past year)
   b. Tobacco use (13.8% of adults were current tobacco users)
   c. Child consumption of sugary beverages (41% of children between ages 2-11 were drinking 1 or more sugar sweetened beverages every day)
   d. Inadequate consumption of fruits and vegetables among children (55% of children in Napa County were eating the recommended amount of fruits and vegetables on a daily basis)
   e. Harassment among youth (In 2011-2012, 27% of 11th graders and 33% of 9th graders reported being harassed on school property during the previous 12 months)

   Can you tell me how aware you are of these health behaviors? How do they impact overall health in Napa County? In what ways have these health behaviors changed in recent years?

   c) What existing community assets and resources could be used to address these health issues and inequities [i.e. the health issues we just mentioned or those you identified earlier]?

3. a) Are you aware of social factors that influence on the issues we've discussed for your clients/your community? If so, what social issues have the largest influence on these health issues?

   b) Are you aware of economic factors that influence the issues we've discussed for your clients/your community? If so, what economic issues have the largest influence on these health issues?

c) The following were identified as socioeconomic conditions in Napa during the previous CHNA process in 2013:

1. Lack of health insurance (In 2011, an estimated 15.8% of Napa residents were uninsured)
2. Food insecurity (In 2009. 52.2% of households in Napa with incomes below 200% of the Federal Poverty Line reported being food insecure)
3. Lack of access to public transportation (In 2013, populations in the Northeastern region of the county did not have access to public transportation service)
4. Performance in school, especially among English Language Learners (45% of 3rd graders and 62% of 4th graders earned a proficient or advanced score in English Language Arts during 2011-2012 school year. Only 15% of English Language Learners earned a proficient or advanced score.)
5. High school dropout among Hispanics/Latinos, English Language Learners, Special Education students, and socioeconomically disadvantaged students (In 2010-2011, the Napa County high school dropout rate was 13.3%. This rate was higher among Hispanics/Latinos, English Language Learners, Special Education students, and socioeconomically disadvantaged students.)

Can you tell me how aware you are of these socioeconomic conditions? How do they impact overall health in Napa County? In what ways have these conditions changed in recent years?

d) What existing community resources could be used to address these health issues and inequities?

4. a) Are you aware of <u>environmental factors</u> that influence the issues we've discussed for your clients/your community? If so, which factors have the biggest influence on overall health in your community?

   b) The following were identified as environmental conditions in Napa during the previous CHNA process in 2013:

   1. Pollution (From 2007-2009, Napa County experienced an average annual ambient fine particulate matter of 8.5mg/m3, compared to CA 11.7 mg/m3. The mean number of unhealthy days of ozone exposure was 0.21 during 2007-2009.)
   2. Pesticide usage (In 2009, 1,542,059 pounds of pesticides were applied in Napa.)
   3. Adequate recreational facilities (Napa County had 13.2 recreational facilities per 100,000 people.)
   4. Access to grocery stores (Napa County had 27.8 grocery stores per 100,000 people.)

   Can you tell me how aware you are of these environmental factors? How do they impact overall health in Napa County? In what ways have these conditions changed?

   c) What existing community resources could be used to address these health issues and inequities?

5. What are the challenges Napa County faces in addressing the health needs you mentioned previously?

   a. Are there any current trends that may have an important impact on the health of Napa County residents?

b. Are there any challenges that may impact economic opportunities in the community? Access to health care services? Community engagement? Public safety?

6. a) Do you have suggestions for systems-level collaborations or changes that could help to address the inequities we just talked about?

   b) Looking across all sectors, who are some current or potential community partners that we have not yet engaged who could help to impact these issues?

We have a brief demographics question we would like to ask. These are strictly for tracking purposes and you do not have to answer these questions if you don't want to.

7. Do you identify as a leader, representative, or member of any of the following communities? Please select all that apply.

☐ Individuals with chronic conditions

☐ Minorities

☐ Medically underserved

☐ Low-income

Those are all the questions I have for you today. Do you have anything else you would like to add?

Thank you for taking the time to have this conversation! The information that you provided will be very helpful not only for the needs assessment but also in crafting actions to address those needs.

Napa County
Community Health Needs Assessment
Focus Group Protocol
FINAL

Hi everyone. My name is ________ and I will be facilitating today's group. This is __________ and he/she will be taking notes and may jump in with any additional questions throughout the group.

First, we want to thank you for agreeing to be a part of this discussion, which will last about 1-2 hours. Napa County healthcare workers really want to improve the health of your community, and many of those people are sitting at the table together to think about the best ways to do this. The information we gather today will be used as part of a collaborative needs assessment that will help Kaiser Permanente, Queen of the Valley, Adventist Health, and Napa County Public Health to work together to determine what they can do to improve health in Napa County. Additionally, as a part of the Affordable Care Act, the federal government requires nonprofit hospitals to conduct community health needs assessments every three years, and to use the results of these assessments to implement plans to improve community health. This assessment will also fulfill this requirement for the hospitals. Harder+Company and Raimi+Associates are the organizations leading the assessment for the nonprofit hospitals in your area.

In this health needs assessment, we want to be sure to bring in voices that are not always represented. One of the reasons we are having this focus group is because we are really interested in the needs of *[XX group across the county/The community in XX location]*. Please keep this lens in mind as we talk about your experience in your community.
Before we begin, I'd like to talk about a few guidelines for our discussion.

- There are no right or wrong answers.
- Every opinion counts. We will respect other's opinions. It is perfectly fine to have a different opinion than others in the group, and you are encouraged to share your opinion even if it is different.
- Everyone should have an equal chance to speak. Please speak one at a time and do not interrupt anyone else.
- Do not hesitate to ask questions if you are not sure what we mean by something.
- Because we have a limited amount of time and a lot to discuss, I may need to interrupt you to give everyone a chance to speak, or to get to all the questions.
- What's said here, stays here. Everything we discuss today is completely confidential. We will summarize what the group had to say, but will not tell anyone who said what. Your names will never be mentioned. We also ask that you not repeat what is said here outside this room.
- We'd also like to record our conversation. Our note taker will be taking notes so that we remember what people had to say, but we'd also like to record the conversation to ensure we have the most accurate information possible. Is that okay?

How do these guidelines sound to everyone? Do you have any questions before we begin?

Introductions/Background

1) Let's start by introducing ourselves. Please tell us very briefly your first name, the town/city you live in, and one thing that you are proud of about your community.

Quality of life in community

2) Briefly, please describe what it is like to live in your community.

3) From your perspective, what are the biggest health issues among [criteria of this FG, e.g. the Latino community in Calistoga]?

    3a. Of the health issues you've mentioned, which would you say are the most important or urgent to address? Why?

4) What do you think are some of the biggest reasons why these health issues occur in your community?

    4b. What things keep you and your family from being as healthy as they could be?

5) From your perspective, what health services are lacking for you and the people you know in your community?

5b) From your perspective, what health services are difficult to access for you and the people you know in your community?

- Follow up: What other challenges keep individuals from seeking help?

6) Has the Affordable Care Act [may also be known as Covered California, Obamacare] had any impact on you or the people you know in your community?

Community Assets, Barriers, and Gaps

7) Outside of healthcare, what resources exist in your community to help you and the people you know to live healthy lives?

7a. What are the barriers to accessing these resources?

7b. What resources are missing?

What is needed to improve health?

8) What do you think is [or who is] needed to improve your health or the health of the people you know in your community?

9) Is there anything else you would like to share with our team about the health of your community [that hasn't already been addressed]?

Please make sure to fill out the quick survey before you leave!
Thank you so much for your time!

Thank you for participating in today's discussion group. We would like to ask you a few questions to understand who attended our groups. This survey is VOLUNTARY which means that do not have to participate. It is anonymous- your answers will not be tied to your name or any other personal information and we will report answers of the group as a whole.

1. What race/ethnicity do you identify as? (Please select all that apply.)

- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Hispanic/Latino
- ☐ Native American
- ☐ Asian (if checked, please select a choice below):
  - o Cambodian
  - o Hmong
  - o Vietnamese
  - o Filipino
  - o Other: _______
  - o Chinese
  - o Pakistani
  - o Japanese
  - o Thai
  - o Korean
  - o Laotian
  - o East Indian
  - o Native Hawaiian or Pacific Islander

2. What is your current gender identity? (Check one that best describes your current gender identity.)

- ☐ Male
- ☐ Female
- ☐ Genderqueer / Gender non-conforming
- ☐ Trans man
- ☐ Trans woman
- ☐ Another gender identity (Fill in the blank.) _________________
- ☐ Declined to answer

3. Do you consider yourself to be…? (Check one that best describes your current sexual orientation.)

- ☐ Heterosexual or straight
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Queer
- ☐ Another identity (Fill in the blank.) _________________
- ☐ Declined to answer

4. Do you identify as a person with chronic conditions, or a leader or representative of individuals with chronic conditions?

- ☐ Yes
- ☐ No
- ☐ Declined to answer

5. What is your age group?

- ☐ 14-24
- ☐ 45-64
- ☐ 25-44
- ☐ 65+

6. What is the zip code where you live?

_____ _____ _____ _____ _____

NEXT PAGE →

7. Have you ever served in the U.S. armed forces?

- ☐ Yes
- ☐ No
- ☐ Declined to answer

8. An Advance Directive for Health Care is a document in which you can write down your health care choices and name a person you trust to speak for you about health care matters. Do you have an Advance Directive for Health Care?

☐ Yes ☐ No
☐ Don't know ☐ Declined to answer

9. What would you estimate your monthly household income is?

☐ $0 to $4,999	☐ $35,000 to $44,999
☐ $5,000 to $9,999	☐ $45,000 to $54,999
☐ $10,000 to $14,999	☐ $55,000 to $64,999
☐ $15,000 to $19,999	☐ $65,000 to $74,999
☐ $20,000 to $24,999	☐ $75,000 to $99,999
☐ $25,000 to $34,999	☐ $100,000 and Over

10. How many people, including you, live in your house (this includes everyone related to each other by blood, marriage or a marriage-like relationship including partners and foster children)?

____

Thank you for completing this survey!

Napa County
Community Health Needs Assessment
Appendix E. Prioritization Scoring Matrix

Instructions: For each health need, write down a score between 1 to 7 for each criterion (1 being the lowest and 7 being the highest score possible). For example, if an issue is nearly impossible to prevent, it could be assigned a 1 in "Prevention" but may receive a score of 6 in "Severity". You will then use the clickers to indicate your score for each health need and criterion. Once everyone scores each health need, the scores will be averaged and multiplied by the weighting value to determine an overall score for each health need.

Health Need	Severity	Disparities	Prevention	Co-Benefit
	2	**2**	**1**	**1**
Access to Primary and Oral Health Care				
Economic and Housing Insecurity				
Education				
Cancers				
Mental Health				
Substance Abuse				
Obesity and Diabetes				

Appendix F. Napa County Asset Inventory

Type	Organization	Address	Phone	Website	Services
Education - Alternative Education and Public Schools	St. Helena Unified School District	465 Main St., St. Helena, CA 94574	707-967-2708	http://sthelenaunified.org/	St. Helena Primary School, St. Helena Elementary School, Robert Louis Stevenson Middle School, St. Helena High School
	Napa Valley Unified School District	2425 Jefferson St., Napa, CA 94558	707-253-3715	http://www.nvusd.k12.ca.us/	Pueblo Vista Magnet School, Vichy Elementary School
	Calistoga Joint Unified School District	1520 Lake Street, Calistoga, CA 94515	707-942-4703	http://www.calistogaschools.org/	Calistoga Elementary School, Calistoga Junior/Senior High, Palisades High School
	UpValley Family Center, St. Helena	1440 Spring St., St. Helena, CA 94574	707-963-1919	http://upvalleyfamilycenters.org/	Promotoras Program, Lunch and Learn for Older Adults
	UpValley Family Center, Calistoga	1500 Cedar St., Calistoga CA 94515	707-942-6206	http://upvalleyfamilycenters.org/	Promotoras Program, Lunch and Learn for Older Adults
	Napa County Office of Education	2121 Imola Ave, Napa, CA 94559	707-253-6810	http://www.napacoe.org/	Community seminars about alcohol and drug abuse, Safe Routes to School
Youth Empowerment	Healthy Cooking with Kids	P.O. Box 183, Benicia, CA 94510	707-205-5572	http://www.healthycookingwithkids.net/	A part of the Nutrition Education and Obesity Prevention (NEOP) Program which is a U.S. Department of Agriculture and California Department of Public Health funded initiative aimed at combatinng obesity in low income California. In Napa County, HCK, Inc. is responsible for executing acitivties as a recipient of the NEOP Grant.
Older Adult Serivces	Rianda House	1475 Main St., St. Helena CA 94574	707-963-8555	http://riandahouse.org/	In the heart of St. Helena, Rianda House offers a one-stop shop approach to connect our community's senior population to the programs, services and resources needed to support independence and successful aging.
	Area Agency on Aging Napa and Solano	1443 Main St. #125, Napa, CA 94559	707-255-5328	http://www.aaans.org/	Area Agency on Aging (AAoA) servies Napa and Solano Counties. It is one of 33 similar programs in California. Their role is to plan, coordinate, and advocate for the development of local programst o meet the needs of older persons, persons with disabilities, and their caregivers.
Faith-based Institutions	Pacific Union College	1 Angwin Ave., Angwin, CA 94508	707-965-6311	https://www.puc.edu/	Pacific Union College is a private liberal arts college located in Napa Valley. They put on various amounts of athletic events throughout the year that benefit the community.
	The Haven Seventh-day Adventist Church	15 Woodland Rd., St. Helena, CA 94574	707-963-1497	http://www.thehavennapavalley.org/	The mission of The Haven is to experience our Lives Changing… Not by wht we do, but by how we acknowledge the power of the Holy Spirit working in our community.
Health and Safety -- Fire	Saint Helena Fire Department	1480 Main St., St. Helena, CA 94574	707-967-2880	http://www.ci.st-helena.ca.us/fire	It is the mission of the members of the St. Helena Fire Department to provide efficient cost effective emergency services including: fire protection, both prevention and suppression; public life safety education; emergency medican and rescue services; response to natural and man made disasters; and respond to incidents involving hazardous materials.
	Calistoga City Fire Department	1113 Washington St., Calistoga, CA 94515	707-942-2822	http://www.ci.calistoga.ca.us/city-hall/departments-services/fire-department	The mission of the Calistoga Fire Department is to provide those services to the residents and visitors of greater Calistoga which protects their lives, property and environment from medical emergencies, hazardous materials, incidents, and disasters
Health and Safety -- Public Health and Safety	St. Helena Police Department	1480 Main St., St. Helena, CA 94574	707-967-2850	http://www.ci.st-helena.ca.us/content/poli	The police department is committed to provided excellent service to the St. Helena community
	Napa County Health and Human Services	2751 Napa Valley Corporate Dr., Napa, CA 94558	707-253-4279	http://www.countyofnapa.org/hhsa/	HHS provides services that help better the greater whole of the community that includes: alcohol and drug services, comprehenseive services for older adults, child welfare services, mental health, public health, and self sufficiency services.
	Calistoga Police Department	1234 Washington St., Calistoga, CA 94515	707-942-2810	http://www.ci.calistoga.ca.us/city-hall/depa	The Calistoga Police Department is dedciated to maintaining a positive and productive relationship with all segments of the community with a goal of ensuring that Calistoga remains a safe and pleasant community for our residents and visitors alike.
Recreation, Sports, Leisure, Athletics	St. Helena Chamber of Commerce	657 Main St., St. Helena, CA 94574	707-963-4456	https://www.sthelena.com/chamber-of-cor	A useful resource for the community in all aspects. They are a member-based association of business people organized to enhance the local economy and the St. Helena brand for the direct and indirect benefit of its members and the community.
	Calistoga Chamber of Commerce	1133 Washington St., Calistoga, CA 94515	707-942-6333	http://visitcalistoga.com/	Calistoga's chamber of commerce is dedicated to being a resource for the community while maintaining it's history http://visitcalistoga.com/
	St. Helena Recreation Department	1360 Oak Ave., St. Helena, CA 94574	707-968-9222	http://www.ci.st-helena.ca.us/parks-recrea	The City of St. Helena Recreation Department's mission is to enrich resident lives through providing quality recreation programs and services and to provide safe and well-maintained facilities and parks, while anticipating the changing needs of the community. The department provides programs in aquatics, youth and adult sports, community classes and events, youth and teen programs, after-school and educational programs, and summer camps.

Appendix G.

2016 CHNA approval

This community health needs assessment was adopted on October 18, 2016 by the Adventist Health System/West Board of Directors. The final report was made widely available on December 31, 2016.

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Request a copy, provide comments or view electronic copies of current and previous community health needs assessments: https://www.adventisthealth.org/pages/about-us/community-health-needs-assessments.aspx