

IDENTIFYING PRIORITY HEALTH NEEDS



NAPA COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT

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

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November 2007

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EXECUTIVE SUMMARY

"I know seniors who go without food when it's time to pay the bills. I know young children who are going hungry because their parents have issues with alcohol and drugs that prevent them from adequately caring for their children."—Outreach Worker

Introduction

A community health needs assessment provides the foundation for policymakers, community organizations and advocates to more strategically plan services and make needed improvements; it also informs funders about directing investments toward areas and populations of highest need. In 2006-2007, a collaborative of the three hospital systems serving Napa County, County Public Health, Napa Valley Vintners/Auction Napa Valley and Community Health Clinic Ole, working with the consulting firm BARBARA AVED ASSOCIATES (BAA), gathered and reviewed existing demographic, health status and service data to produce the present needs assessment. Community input that validated and enriched the data was obtained in several ways: distribution of a community health questionnaire at health fairs and other locations, countywide focus groups and interviews with community leaders whose perspectives would help to inform the review. To paint a more inclusive picture, relevant assessments carried out by others, such as the *Napa County Mental Health Services Act Plan*, were reviewed and several are summarized in this report.

To make the study manageable, a decision was made to limit the scope to the factors most directly related to health status—and for which community benefits grantmaking would most likely be directed. Hence, concerns such as the environment and housing, while clearly impacting health and well-being, were not included in the review. While attention is drawn to groups with a disproportionate burden of poor health—e.g., low-income seniors, Latinos with higher risk of diabetes—this community health needs assessment provides an overview of the state of health-related needs in Napa County and benchmarks from which to gauge improvement.

Highlight of Findings

Demographics

- Mirroring California, Napa County's 2006 population of 134,326 is becoming increasingly diverse and will continue to become more so. About one-quarter of the overall population identifies as Hispanic or Latino, while among children age 0-5 the proportion is closer to half.

- While close to six in 10 county residents live in the City of Napa, American Canyon grew 34.5% between 2000 and 2004, and is projected to grow at a faster rate than other Napa County cities. Various community agencies are working to understand what individuals and families in this expanding community need.
- Napa County's senior population is rising at a faster rate than California as whole. Population projections through 2030 for older residents show an increase of 99% for the age group 65-80.
- One-quarter of the students in Napa County's total K-12 enrollment are reported to be English-learners, a higher proportion than the state average.

Socioeconomic Factors

- The Napa County population has a higher level of education than the state average. In 2002, 19.6% of persons aged 25+ had not completed high school (the standard measure for education attainment) compared to 23.2% of Californians who had not done so.
- While Napa is not considered a “poor” county relative to other counties, including those with large agricultural areas, about 10.6% of children and 6% of seniors age 65+—close to 11,000 individuals—live below the poverty level.
- Over 96% of the county's labor force is employed, a condition better than both California and the U.S. However, about one in five individuals work in jobs that do not offer employment-based health insurance—typically low-paying jobs in the service, retail and agricultural sectors—and still may not be eligible for some forms of coverage or other assistance that could help.
- When all age groups are included, 88% of Napa County residents have some type of health insurance. The Children's Health Initiative has helped to bridge the gap for uninsured children. *Having* coverage, however, does not guarantee *access* to care if the scope of benefits is limited, the co-payments may be too high, or there may be an inadequate number of providers in the area or providers may be unwilling to accept all forms of coverage, including Medi-Cal and Medicare.

Key Health Factors

Communities commonly measure their health against statewide averages and national objectives such as Healthy People 2010. Health status indicators include demographic and socioeconomic factors, death and disease rates, conditions related to births, oral health, mental health, safety, substance abuse and health prevention activities. Indicators where Napa County compares favorably or unfavorably are shown in the chart on the following page. Because data are collected and expressed in various ways (e.g., rates, percentages) that may require explanation, the actual statistics are displayed in Section II of this report. *It is important to note that areas where county levels of health are similar to state and national averages may still warrant more attention.*

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

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

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

Input from the Community

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

Unmet Health Needs

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

Community Health Questionnaire	Community Focus Groups	Key Informant Interviews
Chronic disease (diabetes, cancer, allergies)	Preventive health (obesity, diabetes) and wellness	Mental health issues (gaps in service, depression, social/cultural isolation)
Lifestyle related/preventive health (obesity, nutrition, exercise, wellness)	Lack of insurance, provider not accepting Medi-Cal/Medicare and other access issues	Lack of insurance, provider not accepting Medi-Cal/Medicare and other access issues
Mental health issues (depression, social/cultural isolation)	Mental health issues (depression, social/cultural isolation)	Dental services for children, adults, seniors
Lack of insurance, provider not accepting Medi-Cal/Medicare and other access issues	Drug and alcohol related	Lack of bicultural/bilingual health care workers
Drug and alcohol related	Transportation problems	Preventive health (obesity, exercise); need for health education/adoption of preventive lifestyle
Transportation problems	Unawareness of type/location/eligibility for services	Chronic disease management, diabetes
Unawareness of type/location/eligibility for services	Dental services for adults/seniors	Unawareness of type/location/eligibility for services

These barriers were “usually a problem or issue when seeking services” for the following percent of people who responded to the Community Health Questionnaire:

Finding reduced-cost health care services	58.2%
Finding an office or clinic open when I’m not working	54.4%
Finding someone who takes Medi-Cal or other insurance	47.3%
Finding a provider where someone can speak my language	43.4%
Finding childcare	43.2%
Finding transportation	41.3%

Suggested Strategies and Solutions

The community made many recommendations about where additional support was needed to improve health in Napa County; the most frequently suggested strategies and solutions are listed below in order of mention.

Community Health Questionnaire	Community Focus Groups	Key Informant Interviews
More affordable primary care; help people pay for care	Increase awareness of services	Mental health services
Support wellness center-type services/health education	Bilingual and culturally competent health workers	Comprehensive preventive health education
Resource information and referral	Subsidize health insurance for low-income adults	Dental services for low-income adults and seniors
Bilingual and culturally competent health workers	Preventive health education	Build a bilingual workforce
Support for mental health services	One-stop comprehensive primary care	Increase Clinic Ole's capacity
Strategies for more providers to take Medi-Cal	Flexible transportation options	Low-cost insurance product for adults
Dental services for low-income adults and seniors	Education and support for substance abuse	Support services for seniors (choreworkers, transportation)

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

Unique Characteristics about Napa County that Key Informants Believe Affect Health and Well-Being
Assets
<ul style="list-style-type: none"> ▪ Unusually high degree of collaboration among community organizations ▪ Minimal turf issues ▪ Existence of highly-regarded Clinic Ole as a critical safety net provider ▪ Presence of local, generous funders supportive of health ▪ Consistent desire among organizations to serve high-need groups (e.g., Latinos, seniors)
Challenges
<ul style="list-style-type: none"> ▪ High cost of living in the area ▪ Aura of wealth that camouflages poverty ▪ A high proportion of an aging population ▪ Relatively high numbers of agricultural workers, many with unique needs ▪ Inadequate public sector resources for health education/health promotion and chronic disease prevention ▪ Geographic barriers due to distance and spread between cities/towns

Health Resource Availability

Much of the infrastructure needed to provide primary care services appears to be in place in Napa County. A myriad of non profit organizations, including a comprehensive community health clinic widely recognized as being a major safety net provider, serve the neediest residents along with two non-profit hospitals and a public health system. An adequate number of primary care physicians and general dentists practices in the community. Health insurance is available for low-income children, at least in the short term. The gaps are most evident in the limitations to the infrastructure relative to the supply, distribution, flexibility or emphasis on the following: community-based mental health services, affordable health care for adults, providers in some specialty areas, willingness of physicians and dentists to take Medi-Cal and Denti-Cal, transportation options, bilingual healthcare workforce and comprehensive community-wide preventive health in all aspects of community life in Napa County.

Conclusions and Recommended Priorities

After evaluating all of the data collected from the needs assessment process, certain key “surprises” (assumptions not confirmed, unanticipated findings) emerged, including:

Positives

- High screening rates for some cancers
- Low rates of effects from pesticide use
- Degree to which seniors rated themselves as being in good health
- Community awareness about the value of prevention and healthy living

Challenges

- Extent to which depression exists
- Degree of underage alcohol use
- Extent of the growing trend toward childhood and adult obesity

Recommended Priorities

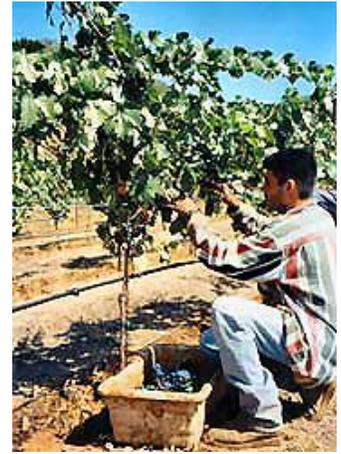
The Collaborative agreed that an important opportunity exists in Napa County for all health partners—regardless of their own organization’s mission and priorities—to focus on four priority areas.

- One of the most important is the area of “healthy living” and wellness to produce a long-term impact on health improvement; this requires a comprehensive approach that includes attention to nutrition, exercise, tobacco cessation and cancer screening.
- A second priority the Collaborative identified is the need for more community-based mental health services.

- Another priority area is the expansion of affordable dental services for low-income seniors and children.
- Finally, alcohol abuse and particularly underage drinking is an important priority area with opportunities for comprehensive, community-based interventions.

Recommended elements for grantmaking regarding all of these priority areas are described in the last section of the report. In a scenario with limited resources, the Collaborative believes that these unmet need areas should receive highest-priority consideration for focusing community investments.

Visions for future community support in all of these areas will require identifying suitable leadership, raising awareness of stakeholders (such as by sharing the findings from this needs assessment) and determining how to involve them, and agreeing in what areas and how each group will cooperate.



INTRODUCTION

“One of the biggest challenges for meeting the needs of the Latino community is being able to address the cultural [acculturation] differences in how this population views things.”—Health care provider

"Health" is a multi-dimensional concept. Individual health status can be rated along any of several dimensions, including presence or absence of life-threatening illness, risk factors for premature death, severity of disease and overall health. It may also be assessed by asking the person to report his or her overall perception of health. The health of an entire population is determined by aggregating data collected on individuals. Some commonly used measures of population health status are morbidity (incidence and prevalence of disease) and mortality (death rates). Judgments regarding the level of health of a particular population are usually made by comparing one population to another, or by studying the trends in a health indicator within a population over time.

Health status is closely related to a number of socioeconomic characteristics. Social and economic variables that have been shown to affect health include income, education, employment and even literacy, language and culture. "Health literacy" is a concept that links a person's level of literacy with their ability to act upon health information and, ultimately, to take control of their health. Individuals with poor health literacy—who tend to be poorly educated, immigrants, elderly or members of racial/ethnic minority groups—are at risk for unsafe care when important health care information is communicated using medical jargon and unclear language that exceed their literacy skills. These individuals can have problems reading materials such as prescription bottles, educational brochures, and nutrition labels and are more likely to have higher rates of complications than people who are more literate.¹

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

¹ Weiss BD, et al. *Health status of illiterate adults: relation between literacy and health status among persons with low literacy skills.* J Am Board Fam Pract 1992 May-June;5(3):257-64.

appropriately. One of the most important aspects of the community health needs assessment is obtaining information and views from community members themselves. This involves surveying a certain percentage of the community to find out which health problems are most prevalent and soliciting their ideas about strategies to address them. It also explores the factors that affect the design of programs and services to effectively address the identified health problems.

This report summarizes such a countywide health needs assessment undertaken in Napa County that included all of these methods and spanned approximately one year. The data in this report are not intended to be exhaustive, however, as various other reports and assessments of Napa County containing similar data—culled from the same publicly-available databases—are already available and used by different groups for specific purposes. For example, Children Now has just released a comprehensive county-level report on children's health, education and economic well-being available to the public.²

BACKGROUND

In 2006, a group of organizations, that over time became informally called the Napa County Health Collaborative (Appendix 1), began meeting and identifying existing county and comparison data. The objective was to collect useful information that could assist organizations, individually and collaboratively, that support health programs and services in Napa County in improving community health and maximizing resources. The data assessment was also intended to help the local hospitals meet SB 697 requirements. (Under this legislation, non-profit hospitals are required to conduct community needs assessments every three years, and develop and adopt a community benefits plan.)

In early 2007, BARBARA AVED ASSOCIATES (BAA), a Sacramento-based healthcare consulting firm, was retained to work with the Collaborative in collecting and analyzing needs-related data, seeking community input and identifying priority health needs for more strategic community investment. The consultant team included Barbara Aved, RN, PhD, MBA, whose expertise is community health, Larry S. Meyers, Ph.D., professor of psychology at California State University, Sacramento, and a researcher in the area of human services, and Anita Garcia-Fante, BA, a bicultural/ bilingual communications professional.

Purpose

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

- The unique characteristics of the community that contribute to or threaten health;
- The kinds of health problems (physical, mental, social) that members of the community are experiencing, and which are the highest needs;
- Which community members have the most urgent needs;

² *2007 California County Data Book*. Children Now. Oakland, CA. June 2007.

- What contributes to or causes these problems (including barriers);
- The resources (organizations, funding, community expertise, other strengths and assets) that are available to address these health problems, and the biggest gaps;
- How the highest-ranked needs can most effectively be met—identifying priorities for strategies and solutions for community investment.

Uses for the Needs Assessment

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

1. Providing documented decision-support for policymakers;
2. Presenting the community with an overview of the state of health-related needs and benchmarks from which to gauge progress;
3. Directing funding towards the highest-priority health needs in the community.

Limitations of the Published Data

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

Using existing published data (referred to as “secondary data”) requires collecting information from many sources. Data release varies among different data sources; new data are continually being released. Any report of this type will soon have certain indicators that are not the most up-to-date. Also, reporting periods can vary by calendar year, frequency and fiscal year; consistency varies, especially over time and among agencies and organizations; and data are not always collected in the format that is best suited to the purposes of the report.

This assessment relied on data that could be collected and analyzed to determine if and to what degree a problem or need existed. In some cases, data did not exist that directly applied to a certain need or condition; in other cases, no indicators were readily available to describe a potential need. The community input process provided some opportunity to identify such needs and ensured that they were considered in the priority-setting process.

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

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

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

Scope of the Assessment

While many factors, complex and interrelated, impact community health and well being, for pragmatic not philosophical reasons the Collaborative made the decision to limit the collection and presentation of secondary data to physical and mental health issues. The areas of environmental conditions affecting health (e.g., air, water and food quality) and housing were excluded in the analysis. Particular *emphasis* was paid, however, to low-income populations and seniors because of the known disproportionate needs in these two population groups.



PROCESS (METHODS)

“Collecting and using data provides a snapshot of community conditions at a particular point in time.”—A grants manager

DATA COLLECTION

The qualitative and quantitative assessment methods for this study included an “environmental scan” and the collection and analysis of primary and secondary data.³ Environmental scanning and needs assessment data provide the necessary information to inform decision makers and funders about the challenges they face in improving community health, and the priority areas where support is most needed.

SECONDARY DATA: COUNTY-LEVEL STATISTICS

Existing data were collected from available data sources including government agencies (California Department of Finance, Office of Statewide Health Planning and Development, California Department of Health Services) and other institutions. These data included demographics, health status indicators and service capacity/availability. Members of the Collaborative and the consultant gathered a wide variety of data that were thought to be useful and informative and after review determined those that are included in this report.

DOCUMENT REVIEW

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

³ *Secondary* data is defined as statistics and other data previously collected for another project and already published or reported to government agencies. An example of this would be rates of asthma. New data gathered to investigate and help solve a problem is called *primary* data. An example of this would be the percentage of focus group participants who ranked asthma as a top-10 health problem.

PRIMARY DATA: COMMUNITY INPUT PROCESS

Community Questionnaire

A questionnaire was developed in English and Spanish for the general public that inquired about most-important health needs and ideas for responsive solutions (Appendix 2). Certain questions that serve as markers for access to services were also included. The survey was distributed by members of the Collaborative to locations where the groups of interest would best be reached, such as health fairs, mobile home parks and family resource centers. The completed questionnaires were delivered to the consultant and the data were cleaned, coded and entered into an Excel spreadsheet and analyzed using SPSS Version 14.0.

Community Focus Groups

Three locations—Napa, Calistoga, and American Canyon—were chosen to ensure geographic representation and four community focus groups were conducted at sites intended to draw populations that typically gathered there. Key community-based organizations and housing complexes in those locations were identified by the Collaborative and asked to host a focus group. When those groups were already meeting for other purposes, the focus group was co-scheduled at their site to facilitate access and promote attendance. Although the participants constituted a convenience sample, there was the expectation that *in the aggregate* the groups would include the populations of highest interest.

To ensure that working people could attend, most of the meetings were held in the evening. One meeting was held in the morning to accommodate people whose children were in school who would otherwise need child care, and seniors or others who had difficulty driving at night or did not like to go out after dark. The groups were facilitated in English and Spanish with a bilingual/bicultural facilitator using a set of key questions (Appendix 3). The questions were generally open-ended; prompting with information or data was limited to reduce the potential for bias or leading of participants to any conclusions. Participants were not asked to “vote” or otherwise rank the items they identified as needs, problems or solutions.

Refreshments were served at the meetings and colorful gift bags containing toiletries and other practical items were offered in appreciation for participation. Agencies and organizations that sponsored the community meetings helped to publicize the meetings and promote attendance. A flyer written in English and Spanish was provided to the organization managers to post or distribute to residents (Appendix 4 contains a sample).

The focus group data were recorded on flip charts by the facilitator during the meetings then transferred to written summary formats where it was coded and analyzed.

Provider Focus Group

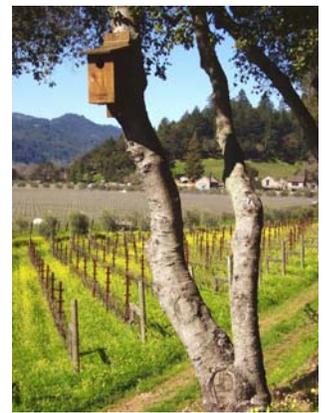
One focus group was held for healthcare professionals, including mostly community outreach workers, to gain their perspective about high-priority health needs, barriers to access and recommendations for community support. Invitations were open to all and the Collaborative members took responsibility for publicizing the meeting.

Key Informant Interviews

In-depth telephone interviews using a structured set of questions were conducted, primarily individually, with a representative group of 21 individuals whose perceptions and experience were intended to inform the assessment (Appendix 5). The interviews provided an informed perspective from those working "in the trenches," increased awareness about agencies and services, offered input about gaps and possible duplications in service, and solicited ideas about recommended strategies and solutions. The interviews also focused the needs assessment on particular issues of concern where individuals with particular expertise could confirm or dispute patterns in the data and identify data and other studies the Collaborative might not otherwise be aware of.

PRIORITY SETTING PROCESS

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



ASSESSMENT RESULTS

"Under the veneer of the beautiful homes and the wineries and eateries are the poor tucked into the trailer parks ." – Key Informant



Section I. Demographic and Socioeconomic Characteristics

COUNTY PROFILE

Napa County, located 50 miles northeast of the San Francisco Bay Area, is one of the most renowned premium wine-producing regions in the world in addition to producing other agricultural crops and supporting additional major businesses.

The Napa River flows north to south through the valley and is navigable from the city of Napa to the San Francisco Bay. Napa County is bordered by mountains on the north, east and west making it difficult to access the adjoining counties' population centers. Highways that pass into surrounding Lake, Sonoma, Yolo and portions of Solano counties are occasionally impassable in winter due to snow, ice or slides in heavy rain. Portions of the southern and southeastern borders of Napa County are non-mountainous allowing for easy access to the city of Vallejo in Solano County. However, the stretch from north to south county is at least 30 miles, presenting barriers to access for people with limited transportation options.

The Napa County proposed General Plan for the 25-year period through 2030 and the accompanying environmental impact report address some challenging and complex development issues. With growth in the Napa economy outpacing growth in housing for workers, the environmental modeling suggests traffic at key entrance and exit points will get worse (for example, traffic along Highway 29 near St. Helena, from Lodi Lane to Deer Park Road, is expected to deteriorate to failing levels of service). The modeling also suggests net loss of forest land and sensitive animal populations, increase in greenhouse gas emissions from auto traffic and more pressure on county water supplies.⁴

Approximately 57% of all county residents live in Napa; the remainder lives in smaller cities in rural surroundings. Highway 29 (about 15 miles from Interstate 80) is the main thoroughfare for the county. Generally, the county is divided into four regions:

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



Napa County

⁴ "General Plan: County's blueprint draws scrutiny" by David Ryan. Napa Valley Register, March 4, 2007.

According to California labor market data, about 36% of people who live in Napa County also work within the county (Table 1).

Table 1. County-to-County Commute Patterns

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

Source: U.S. Census Bureau, 2000.

Population Demographics

While the population size of Napa County was officially 134,326 residents in 2006, the population can swell to more than 200,000 with daytime work commuters and seasonal tourists; many people live in Solano County (primarily Vacaville and Fairfield) but work in Napa County. City/county population estimates with annual percent change between January 2006 and January 2007 show a positive growth for the county overall (Table 2). Between these two periods, Napa County had an overall 1.2% change in population. American Canyon had the highest percent change, and St. Helena had the lowest.

Table 2. Population with Annual Percent Change, 2006 and 2007 Estimates

Area	Total Population 2006 (Estimate)	Total Population 2007 (Estimate)	Percent Change
NAPA	134,326	135,969	1.2
AMERICAN CANYON	14,948	16,031	7.2
CALISTOGA	5,252	5,302	1.0
NAPA	76,639	76,997	0.5
ST HELENA	5,983	5,993	0.2
YOUNTVILLE	3,261	3,290	0.9
BALANCE OF COUNTY	28,243	28,356	0.4

Source: State of California, Department of Finance, *Population Estimates by City, May 2007*.

Population estimates beyond 2004 are displayed in Table 3 and show the continuing projected trend for considerable population growth in American Canyon. While the population of Napa County increased overall from 2000 to 2004, the city of American Canyon grew significantly at 34.5% during this period and is already the second-largest city in Napa County. Services for residents in this area are still being established—and various

community agencies are working to understand what individuals and families in this expanding community need.

Table 3. Population Estimates of Napa County Cities, 2001-2007 with 2000 Benchmark

City	4/1/2000	1/1/2001	1/1/2002	1/1/2003	1/1/2004	1/1/2005	1/1/2006	1/1/2007
American Canyon	9,774	10,078	11,293	12,377	13,169	14,269	14,948	16,031
Calistoga	5,190	5,224	5,240	5,256	5,197	5,209	5,252	5,302
Napa	72,585	73,674	74,270	75,000	75,997	76,160	76,639	76,997
St Helena	5,950	6,003	6,032	6,064	6,001	5,991	5,983	5,993
Yountville	3,297	3,278	3,300	3,289	3,267	3,251	3,261	3,290
Balance Of County	27,483	27,836	28,147	28,276	28,124	28,094	28,243	28,356
Incorporated	96,796	98,257	100,135	101,986	103,631	104,880	106,083	107,613
County Total	124,279	126,093	128,282	130,262	131,755	132,974	134,326	135,969

Source: State of California, Department of Finance, *Population Estimates by City, May 2007*.

Population by Age and Race/Ethnicity

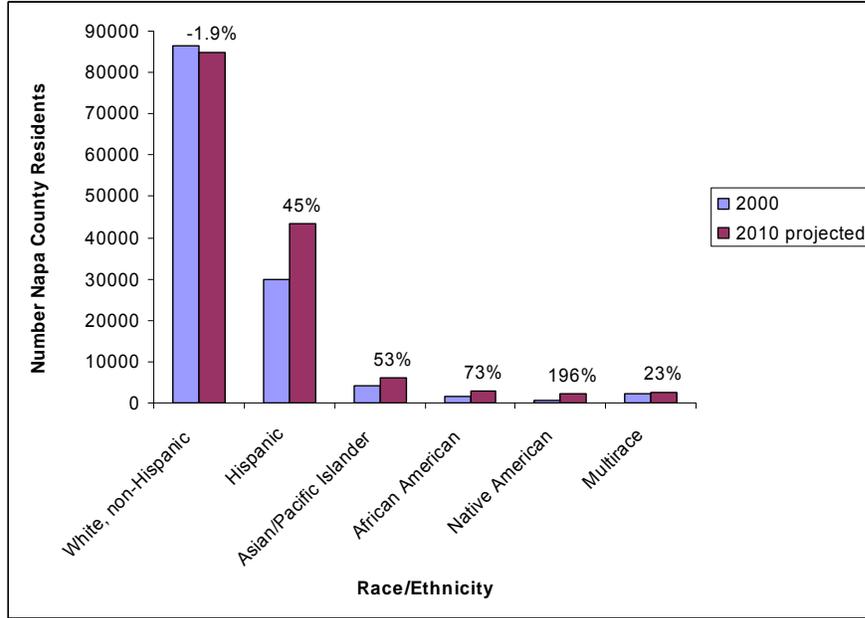
Mirroring California, Napa County is becoming increasingly diverse. Napa County population by age group and race/ethnicity based on the 2000 census and the 2010 projected population estimates are shown in Table 4. The projected percent changes in population are shown for each group in Figure 1 below. Non-Hispanic Whites make up 65% of the population while residents who identify as Hispanic/Latino comprised about 28% in 2004, an increase of 16% in four years. The majority of children aged 0-5 years in the county identify as Hispanic (48%) or White (44%).

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

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

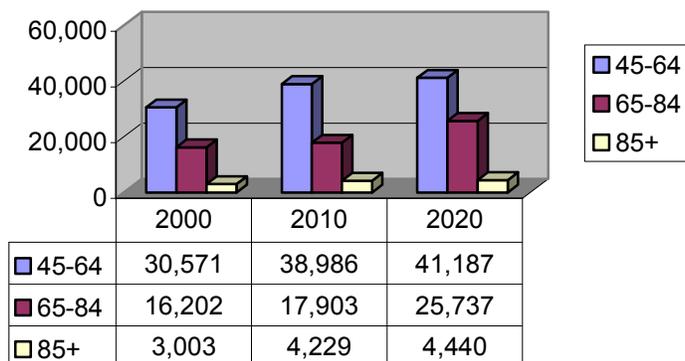
Source: State of California, Department of Finance, *Population Estimates with Race/Ethnic Detail, May 2007*.

Figure 1. Napa County Population Percent Change, 2000 and 2010 Projected



With 15% of all residents over the age of 65, Napa County has a higher proportion of older residents than California as a whole (11.3%). Yountville, largely due to the presence of the California Veteran’s Home, has a higher proportion of seniors living there followed by the cities of Calistoga and St. Helena.

Figure 2. Adult/Senior Population 2000-2020



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

Farmworker Population

With a peak agricultural labor force of approximately 6,000 farm workers (California Employment Development Department, 2005), approximately one of every 22 Napa County residents is a farmworker.

Anticipated Population Changes

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

Age Shifts

Napa County's senior population is rising at a faster rate than California as whole. The over-85 population is also growing at a significantly faster rate than the total county population. In Napa County, population projections through 2030 for older residents include:⁵

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

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

Cultural Shifts

Corresponding to the growth in population, Napa County's population is projected to become increasingly diverse in coming years. Some highlighted increases estimated for Napa County by 2030 include:⁶

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

⁵ Data excerpted from California Department of Finance, reported in *The Coming Wave: Solano and Napa Counties Brace for Elderly Population Boom*. Solano Community Foundation and United Way, report undated.

⁶ Ibid.

SOCIOECONOMIC FACTORS

Socioeconomic characteristics include measures that have been shown to affect health status, such as income, education and employment and the proportion of the population represented by various levels of these variables. There is considerable evidence that individuals with higher incomes have better health.⁷ Some of the ways in which poverty contributes to poor health are immediately obvious. Absolute deprivation leading to poor nutrition may lead to susceptibility to infection and chronic disease, and crowded housing may increase disease transmission. Higher incidences of unplanned or unwanted pregnancies, teen pregnancy, inadequate prenatal care, higher rates of low-birth-weight babies, infant deaths and low immunization rates are all associated with poverty along with a myriad of other adverse health outcomes.

Economic Well-Being

Self-sufficiency income is defined as the minimum income a household must earn in order to adequately meet the basic needs of the family without being obligated to use public or private assistance. The self-sufficiency income for a family of four living in Napa County was \$47,511 per year in 2003.⁸ Children in families in Napa County actually rank 7th best in the state in family economic well-being indicators of self-sufficiency and median family income (Table 5). While these data are favorable overall, they tend to mask the picture of poverty for the low-income. Although Napa County is not considered a “poor” county—and is better off economically than most agricultural counties in California—the substantial wealth of a disproportionate number of Napa Valley residents skews the economic indicators for a sizeable portion of the population.

Table 5. Family Economic Well-Being by County Ranking

Area	County Ranking	% at Self-Sufficiency	Median Family Income	Median Income as a % of Self-Sufficiency
Napa County	7	70%	\$61,410	160%
California	N/A	60%	\$56,332	128%

Source: U.S. Census Bureau. 2000 Summary File 3, *Poverty Status in 1999 by Age*, 2000.

Measures of Poverty

Poverty levels (“persons living under poverty”) are generally higher for California than for Napa County. One in ten (10.7%) Napa County children ages 0-17 in 2003 were estimated to live in families with incomes less than 200% of the official federal poverty level (Table 6).⁹ About 7.6% of seniors ages 65 and older also live below the poverty level. Overall, 7.8% of

⁷ Pritchett L, Summers L.H. Wealthier is healthier. *Journal of Human Resources* 31, 841-868, 1997.

⁸ US Bureau of the Census, Profile of Selected Economic Characteristics, 2000; Californian's for Economic Self Sufficiency and Equal Rights Advocates, The Self-Sufficiency Standard for California, 2000.

⁹ U.S. Census Bureau, *Small Area Income and Poverty Estimates*, 2005.

the total population of the county (10,036 persons in 2004), compared with 13.2% of Californians, lives in poverty.

Table 6. Persons Living Below Poverty Level, Napa County and California

Age Group	Napa County		State
	Number	Percent	Percent
All ages	10,036	7.8%	13.2%
All children under age 18	3,306	10.7%	18.7%
Children ages 5-17	2,339	10.5%	17.7%
Ages 65+	955	5.6%	7.6%

Source: U.S. Census Bureau. Small Area Income & Poverty Estimates. Estimates for California Counties 2004.

Although the need for affordable housing was not included in this assessment, Table 7 is provided to show an example of the difference in housing values in Napa County and the statewide average relative to affordability. The difference for St. Helena is particularly striking.

Table 7. Selected Sample of Housing Values

Estimated median house/condo value in 2005: \$603,550	
<i>Napa County</i>	 \$603,550
California:	 \$477,700
Estimated median house/condo value in 2005: \$1,090,000 (it was \$453,600 in 2000)	
<i>St. Helena</i>	 \$1,090,000
California:	 \$477,700

Source: http://www.city-data.com/county/Napa_County-CA.html

An additional indicator of low-income status is the number of school children eligible for free or reduced-cost school meals.¹⁰ Since 1997-98, the percentage of eligible children in the county has slowly risen. In 2006-07, 40.6% of all children enrolled in Napa County public schools received free or reduced meals.¹¹

¹⁰ Eligibility for free or reduced-price meals is set at 185% of the federal poverty level.

¹¹ California Department of Education.

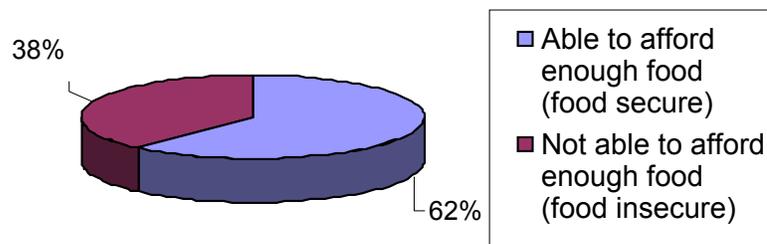
Table 8. Number and Percent of Students Receiving Free-Reduced Price Lunches, Selected Years

	2004-05	2005-06	2006-07
Calistoga Joint Unified	532 (60.4%)	542 (66.5%)	607 (74.1%)
Howell Mountain Elementary	36 (49.3%)	34 (43.6%)	44 (53.7%)
Napa Co. Office of Education	73 (34.0%)	116 (68.6%)	136 (74.7%)
Napa Valley Unified	6,559 (38.7%)	6,451 (37.7%)	6,642 (38.8%)
Pope Valley Union Elementary	10 (17.5%)	19 (33.3%)	19 (26.8%)
St. Helena Unified	602 (40.8%)	544 (39.6%)	513 (37.7%)
Napa County Total	7,812 (39.7%)	7,706 (39.3%)	7,961 (40.6%)
California State Total	3,127,202 (49.9%)	3,164,384 (51.1%)	3,123,038 (50.7%)

Source: California Department of Education

Not being able to afford enough food and dependence on public assistance for adequate nutrition are other important socioeconomic indicators of community health. Based on the results of the 2005 California Health Information Survey in Napa County, in which adults whose income is less than 200% of the Federal Poverty Level were asked about the ability to afford enough food, only six of 10 (61.6%) respondents were considered “food secure” (Figure 3). It was estimated that 500 persons were currently receiving food stamps in Napa County.

Figure 3. Food Security of Adults <200% of Poverty, 2005 CHIS



Employment

Work for most people is at the core for providing financial security, personal identity, and an opportunity to make a meaningful contribution to community life. Although it is difficult to quantify the impact of work alone on personal identity, self-esteem and social contact and recognition, the ability to have employment—and the workplace environment—can have a significant impact on an individual’s well-being. Napa County’s labor force is 54.4% of its population, a figure that has remained fairly steady since 2002. According to current labor

market data, 72,300 of Napa County's 75,000 labor force are employed, a condition better than both California and the U.S.¹²

Unemployment

Despite a low unemployment rate of 3.6% in 2007, many low-income individuals and families are employed in low-paying jobs in the service (such as hospitality), retail and agricultural sectors. Service and retail jobs account for about 44% of total employment, while agriculture accounts for approximately 8%.

Farm Workers

Agricultural workers are considered by many to be the backbone of Napa County's \$549 million agricultural economy. Of the 6,790 farmworkers employed in Napa County during 2005, the majority, 5,415 (80%), were hired directly by farm operators, including wine grape growers and vineyard management companies. The remaining 1,375 were employed by farm labor contractors. Nearly two-thirds (64%) of farmworkers report permanent resident status in Napa County, 18% live in the surrounding counties and 17% live farther away; and 2% are follow-the-crop migrants. Most (55%) report being hired by a Napa County employer for seven months or more according to an assessment by the California Institute for Rural Studies (Table 9).¹³

Table 9. Farmworkers Employed by Seasonal Employment Status, 2005

Employment Status	
Regular (7 months or more)	3,744 (55%)
Seasonal (3-6 months)	1,258 (19%)
Temporary (less than 3 months)	1,788 (26%)
Total	6,790 (100%)

Source: California Institute for Rural Studies. 2007.

Educational Attainment

Educational levels obtained by community residents can affect the local economy. In general, higher levels of education equate to the ability to earn higher wages, experience less unemployment and enjoy increased job stability. "Persons aged 25 and older with less than a high school education" is the socioeconomic measurement typically used for this indicator. Napa County population has a higher level of educational attainment than the state as a whole. In 2002, one in five (19.6%) persons aged 25+ in Napa County had not

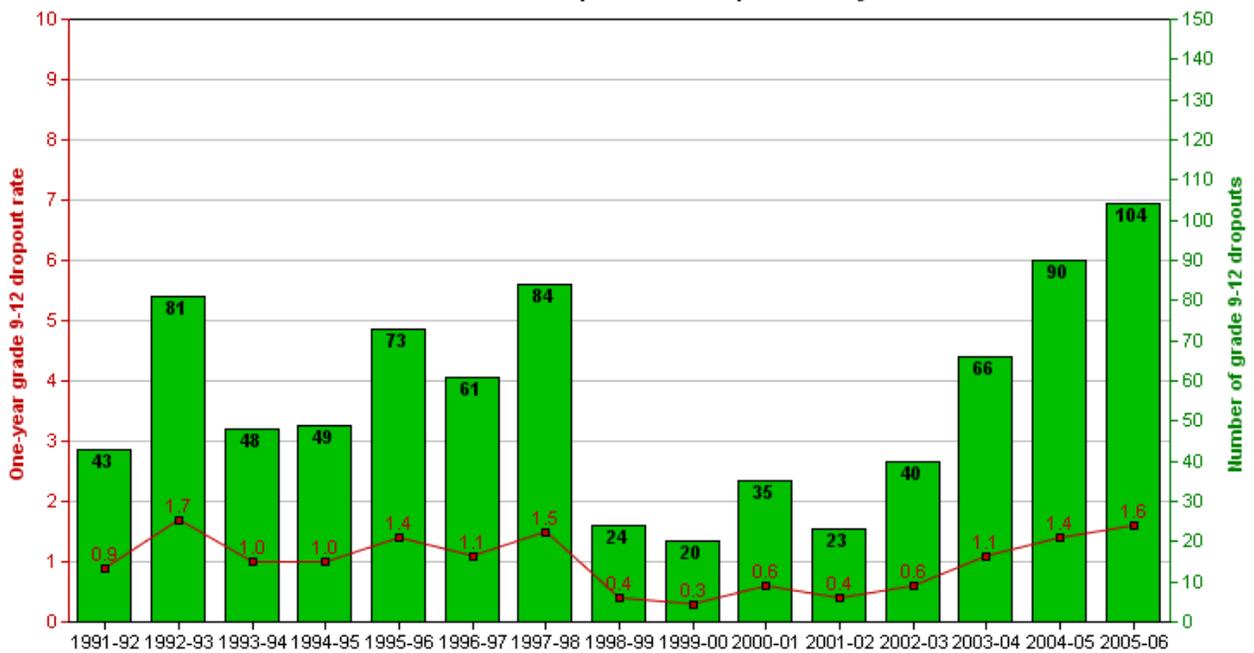
¹² California Economic Development Department. *Employment and Wages*, May 2007.

¹³ *An Assessment of the Demand for Farm Worker Housing in Napa County*, California Institute for Rural Studies, March 2007.

completed high school (for California, the figure is 23.2%). Low educational attainment—and particularly dropping out of school—increases the risk for school-age pregnancy; high levels of school engagement have been found to be associated with postponing pregnancy, for example.¹⁴ In 2002 in Napa County, approximately one in three babies was born to mothers with less than 12 years of education.

Research has also shown that young people who drop out of high school are more likely to use drugs/alcohol, be involved in criminal activity, and become teen parents. High school dropouts also have higher unemployment rates and are more likely to receive public assistance. The high school drop out rate in Napa County appears to be increasing (Figure 4), however enrollment data for small student populations may vary widely from year to year and it is important to use caution when interpreting trends and comparisons across student populations. Additionally, there is some disagreement over whether dropout rates accurately represent the number of students who leave high school without finishing, because there is no standardized method to track students who stop attending school.

Figure 4.
Grade 9-12 Dropouts in Napa County



¹⁴ The influence of high school dropout and school disengagement on the risk of school-age pregnancy. *Journal of Research on Adolescence* 8(2):187-220, 1998.

In general, dropout rates among Hispanic, African American and Native American students in Napa County are higher than the county rate (Table 10), although the county rates are lower than the state average.

Table 10. High School Dropouts and Rate Per 100 Students Enrolled in Grades 9-12

Ethnic Group	Total Enrolled			Total Drop (9-12)			4-Yr Derived Rate (9-12)		
	03/04	04/05	05/06	03/04	04/05	05/06	03/04	04/05	05/06
Amer Indian	121	119	102	2	3	0	7.0	10.7	0.0
Asian	111	131	116	0	0	3	0.0	0.0	8.7
Pacific Isld	11	27	21	0	0	0	0.0	0.0	0.0
Filipino	128	173	172	1	3	1	3.2	8.8	2.5
Hispanic	2085	2181	2243	40	41	67	9.3	8.1	14.1
African Amer	116	121	127	1	5	1	5.9	20.0	4.3
White	3581	3346	3239	21	37	29	2.3	4.5	3.5
Multi-Rate/No Resp	120	186	322	1	1	3	2.5	2.0	4.4
County Total	6273	6284	6342	66	90	104	4.4	6.0	6.9
State Total							12.9	12.6	14.8

Source: California Department of Education, California Basic Educational Demographics.

Non-English Speaking

Of Napa County’s total K-12 enrollment of 20,133, one-quarter (24.6%) of the students are reported to be English-Learners, similar to the state average. The percentages are highest in the early grades—approximately 43% of K-3 children in 2005-06. The Calistoga Joint Unified School District has the highest percentage of English-learners by a relatively wide margin (Table 11).

Table 11. Number and Percent of English-Learners by Napa County School District

	2004-05	2005-06	2006-07
Calistoga Joint Unified	446 (50.7 %)	367 (45.0 %)	359 (36.5 %)
St. Helena Unified	418 (28.7 %)	386 (28.1 %)	397 (28.6 %)
Napa Co. Office of Education	59 (27.4 %)	59 (34.7 %)	78 (39.6 %)
Napa County Total	4,962 (25.2 %)	4,971 (25.0 %)	4,908 (24.4 %)
Napa Valley Unified	4,016 (23.7 %)	4,129 (23.7 %)	4,047 (23.2 %)
Howell Mountain Elementary	14 (19.4 %)	17 (20.5 %)	14 (17.9 %)
Pope Valley Union Elementary	9 (15.8 %)	13 (22.4 %)	13 (19.4 %)
California State Total	1,591,525 (25.2%)	1,570,424 (24.9%)	1,568,661 (25.0%)

Source: California Department of Education

Of the various languages spoken in classrooms, by far the greatest proportion (more than (95%) of English learners speak Spanish.

Table 12. Languages of Napa County English Learner Students, 2005/06

	Number of Students	Percent of Enrollment
Spanish	4,746	23.8%
Filipino (Pilipino or Tagalog)	78	0.4%
Punjabi	30	0.2%
Japanese	17	0.1%
Arabic	14	0.1%
All Other	86	0.4%
Total	4,971	25.0%

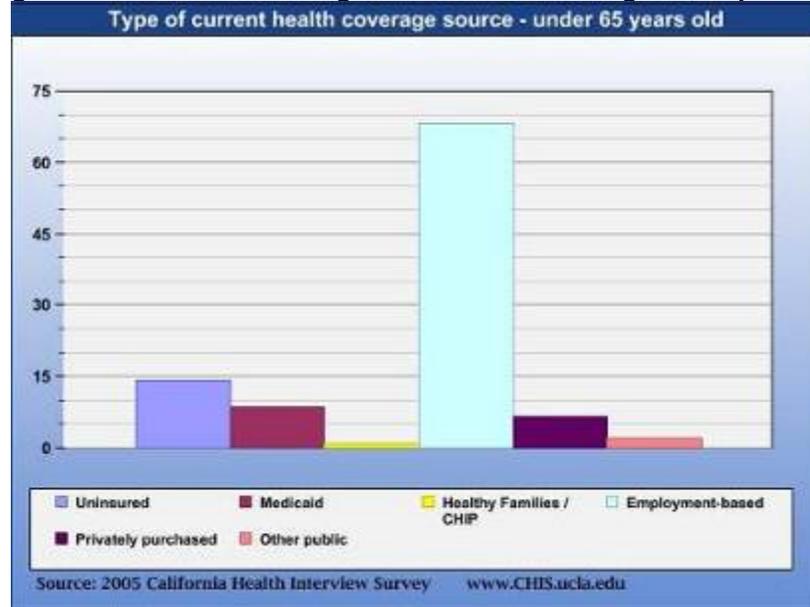
Source: California Department of Education, Educational Demographics Office, May 2007.

Health Insurance Coverage

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

In 2005, nearly 86% of Napa County adults age 18-64 responding to the California Health Interview Survey (CHIS) had some form of health insurance, leaving 14% without medical coverage (Figure 5). The covered proportion rises closer to 88% when all population age groups are included. *Having* coverage for care, however, does not guarantee *access* to care if there are an inadequate number of providers in the service area and/or providers are not willing to accept all forms of coverage, including Medi-Cal and Medicare. Approximately 8.5% of the non-senior adult population is also covered by Medi-Cal.

Figure 5. Insurance Coverage of Persons Under Age 65, Napa County, 2005



About 68% of Napa County residents reported in the CHIS has health benefits through their employer. This is the second-lowest rate of the nine greater Bay Area counties. Of those Napa County employees who were eligible, 12.1% did not accept health benefits from their employer, giving the county the highest refusal rate for employer-based benefits (Table 13). Slightly more than 10.5% worked for companies that did not offer health benefits at all. And, 6.4% reported depending on privately purchased insurance.

Table 13. Percent of Napa County Residents Relative to Employer-Based Health Benefits in 2003

Accepted health benefits	Eligible for benefits, but did not accept	Not eligible for benefits offered by employer	Employer did not offer health benefits
69.0%	12.1%	8.4%	10.5%

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

Medi-Cal

Medi-Cal pays the cost of medical care for children and their parents, the disabled, and elderly who have low incomes. Although a substantial portion of Medi-Cal recipients in California still receive health care services through the traditional fee-for-service delivery system, more than half receive their care through one of several managed care models. Napa is one of eight counties with a County Organized Health System (COHS). In this Medi-Cal managed care model, enrollment in a single county-run plan is mandatory for the

Medi-Cal population and occurs concurrently with enrollment in the Medi-Cal program.¹⁵ The Partnership HealthPlan of California, which began operations in May 1994, is a public/private organization that administers the COHS in Solano, Napa, and Yolo counties. According to some key informants in this needs assessment the HealthPlan has made Medi-Cal “more palatable for everyone,” although there is still an inadequate number of physicians signed up as providers. Table 14 below provides county Medi-Cal beneficiary enrollment information.

Table 14. Medi-Cal Beneficiary Enrollment in Napa County

	July 2001	July 2002	July 2003	July 2004
Total Medi-Cal Beneficiaries	9,572	11,183	11,989	11,987
Total Medi-Cal Beneficiaries enrolled in Medi-Cal Managed Care	8,011	8,917	9,705	9,879

With a total of 6.4% of its overall county population who have health insurance enrolled in Medi-Cal in 2005, Napa County has a small proportion of Medi-Cal recipients compared to other counties.

Seniors

Very few seniors in Napa County lack health insurance; most are covered by a combination of Medicare and a private supplemental plan or Medi-Cal (Table 15). Napa County seniors use a combination of Medicare and Medi-Cal much less frequently than seniors in the rest of the Bay Area counties, and are more likely to have private supplemental coverage in addition to their Medicare coverage.

Table 15. Type of Current Health Coverage in 2003 for People Age 65+

Medicare and Other	Medicare Only	Other Only
78.3%	4.8%*	10.4%*

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

* Represents statistically unstable results due to small sample size.

¹⁵ California HealthCare Foundation, Medi-Cal Delivery Models, March 2003.

Children

Although the estimate ranges widely because of the small sample size, data from the 2005 California Health Information Survey (CHIS) suggest 6.8% (with a range of 2.3% to 11.3%) of children ages 0-18 in Napa County, are uninsured all or part of the year (Table 16), i.e., a range of 736 to 3,616 uninsured children.

Table 16. Health Insurance Coverage of Children Ages 0-18, Napa County

	Napa County		California
	Estimate	Range of Estimate	
Percent uninsured all or part year	6.8%	(2.3-11.3)	10.7%
Percent insured all year, employment-based	72.5%	(63.7-81.2)	50.3%
Percent insured all year, Medi-Cal/Healthy Families	13.8%	(7.0-20.6)	31.2%
Percent insured all year, privately purchased and other	6.9%	1.9-11.8)	7.8%

Source: 2005 California Health Information Survey.

Besides Medi-Cal coverage for children, the state also offers the Healthy Families Program. It is a state and federally funded health insurance program that provides health, dental and vision coverage for uninsured children with family incomes above the level eligible for no-cost Medi-Cal and below 250% of federal income guidelines. Similar to Medi-Cal, eligibility is limited to children who are U.S. citizens, nationals or eligible qualified immigrants. As of June 2006, there were a total of 1,256 subscribers enrolled in Healthy Families in Napa County.¹⁶

Napa is one of the California counties taking a creative approach to guarantee that all low- to mid-income children have access to health coverage. In late 2005, Napa County implemented the Children's Health Initiative that enrolls eligible children in public insurance programs for which they are eligible including a new "Healthy Kids" program. Napa county's Healthy Kids program is funded largely through short-term private grants, some county government funds and members also pay part of their premiums. In November 2005, The Partnership HealthPlan of California was licensed to offer a Healthy Kids plan, which offers comprehensive health coverage to children 0 to 18 years of age who are ineligible for either Medi-Cal or Healthy Families because their family incomes exceed these programs' thresholds or they do not meet the citizenship requirements. Families with incomes up to 300% of the poverty level qualify for Healthy Kids coverage.

While estimates of the number of uninsured children in Napa County vary, according to the Children's Health Initiative (CHI) of Napa County, by June 2007 there were 2,200 fewer uninsured children in the county than when the CHI began in late 2005. The CHI's goal is to enroll all low-income uninsured children in Napa County who qualify for Medi-Cal, Healthy Families, or Healthy Kids by 2008. However, the successful program is beginning to face funding challenges that could limit enrollment in the Healthy Kids program.¹⁷

¹⁶ Healthy Families Program Current Enrollment Distribution by County and Health Plan, Managed Risk Medical Insurance Board, June 2006.

¹⁷ Personal communication with Mark Diel, CHI Executive Director, June 27, 2007.



Section II. Selected Health Status Indicators

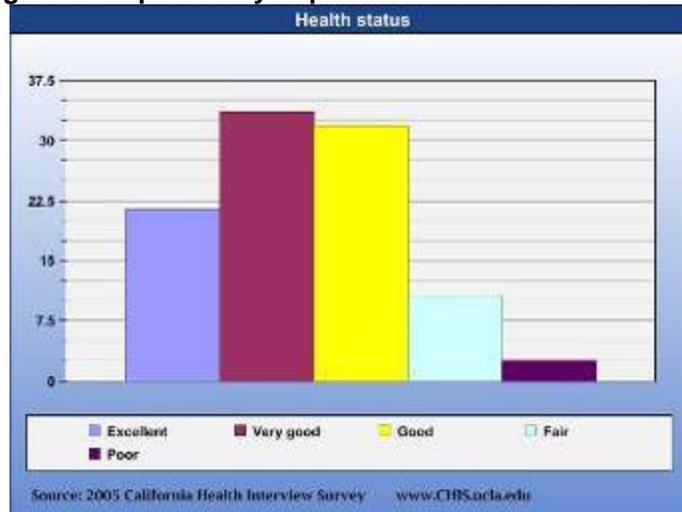
"Prevention always gets the short shrift; treatment gets all of the attention."—Key Informant Interview

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

SELF-RATED HEALTH STATUS

In population studies, self-rated health is generally regarded by researchers as a valid, commonly accepted measure of health status.¹⁸ Understanding the correlates of self-rated health may help health care professionals prioritize health promotion and disease prevention interventions to the needs of the population.¹⁹ One of five (21.5%) Napa County respondents to the 2005 California Health Information Survey rated their health status as "excellent" and 33.5% as "very good."

Figure 6. Napa County Population Self-Rated Health Status



¹⁸ Franks P, Gold MR, Fiscella K. Sociodemographics, self-rated health, and mortality in the US. *Soc Sci Med.* 2003;56:2505–2514.

¹⁹ Idler, EL., Benyamini, Y. (1997). Self-rated health and mortality: A review of twenty-seven community studies. *J Health Soc Behav*, 38, 21-37.

Although a slightly higher percentage of residents statewide rate themselves as being in excellent health, when the two categories of excellent and very good are combined, Napa County residents view themselves similarly to other Californians (Table 17). However, when the senior population (age 65+) is broken out of the county and statewide data, Napa County seniors rate their health more favorably overall than other California seniors: 81.2% considered their health to be excellent, very good or good in contrast to only 68.3% of California seniors who gave themselves such high ratings.

Table 17. Percent of Population Self-Rated Health Status, Napa County and California, 2005

	Napa County		California	
	All Ages	Seniors Age 65+	All Ages	Seniors Age 65+
Excellent	21.5	16.1	25.4	12.8
Very good	33.5	30.6	29.5	25.6
Good	31.8	34.5	28.8	29.9
Fair	10.7	14.1	13.0	22.2
Poor	2.5	4.7	3.3	9.6

Source: 2005 California Health Interview Survey

MORBIDITY (DISEASE AND ILLNESS)

Table 18 displays the incidence or cases of certain communicable diseases commonly reported as indicators for community health. The case rates shown in the table are per 100,000 population.

Table 18. Napa County Morbidity by Cause, 3-Year Average

County Rank Order	Health Status Indicator	2003-2005 Cases (Ave.)	Crude Case Rate	Crude Case Rate		National Objective
				Statewide	National ¹	
24	AIDS Incidence (Age 13+)	4	3.66*	12.56	16.4	1.00
34	Tuberculosis incidence	5	4.02*	8.32	4.9 ^a	1.00 ^b
15	Chlamydia incidence	174	131.07	336.86		
13	Gonorrhea incidence	22	16.32	82.29	114.0	19.00

Source: County Health Status Profiles 2007. California Department of Health Services, Sacramento, CA.

* Rate or percent unstable; relative standard error greater than or equal to 23%.

^a National rate is not comparable to California due to rate calculation methods.

^b Prevalence data were not available in all California counties to evaluate National Objective of >3% testing positive in the population 15-24 years of age.

Based on analysis of AIDS cases from 2002 to 2004,²⁰ Napa County ranked 25th in reported incidence of AIDS among California counties. Between March 1983 and June 2007, the county had a cumulative total of 228 AIDS cases; of these 228 cases, 137 (60%) are now deceased. There have been 47 HIV cases reported for Napa County since April 2006, when a new reporting system was put into place in California. Date of diagnosis for these cases ranges from prior to 1990 through June 2007. Table 19 shows the distribution of the reported HIV/AIDS cases by racial/ethnic groups, age and gender.

Table 19. Cumulative HIV/AIDS Cases Reported for Napa County as of June 30, 2007

	AIDS	HIV
<i>Race/Ethnic Group</i>		
African American	11 (5%)	<5 (N/A)
Asian/Pacific Islander	5 (2%)	<5 (N/A)
Caucasian	174 (76%)	31 (66%)
Hispanic	38 (17%)	10 (21%)
Native American	0 (0%)	0 (0%)
Unknown	0	<5 (N/A)
<i>Gender</i>		
Male	201 (88%)	36 (77%)
Female	27 (12%)	11 (23%)
<i>Age</i>		
0-19	7 (3%)	<5 (N/A)
20-29	33 (15%)	18 (38%)
30-39	83 (36%)	13 (28%)
40-49	66 (29%)	10 (21%)
Over 49	39 (17%)	5 (11%)
Total	228	47

Source: California Health Status Profiles, 2006.

Chlamydia, a bacterial disease, typically has no symptoms and people who are infected may unknowingly pass the disease to sexual partners. While treatable, Chlamydia can lead to infertility, and like gonorrhea and syphilis can have long-lasting consequences. Newborns can also contract Chlamydia from their infected mothers at the time of birth. Napa County's case rate (187.1 per 100,000 population in 2006) for Chlamydia is relatively low compared to California (Table 20). Because mandatory reporting of Chlamydia only recently came into effect, it is difficult to distinguish real increases in cases from increased reporting.

²⁰ California Health Status Profiles, 2006. California Department of Health Services.

Table 20. Chlamydia Case Rates Per 100,000 Population, 2002-2006

Area	2002	2003	2004	2005	2006
Napa County	87.3	101.4	110.3	184.2	187.1
California	211.4	323.4	338.1	349.2	363.5

Source: California Department of Health Services, STD Control Branch, 2006.

Napa County’s case rate (per 100,000 population) for tuberculosis is relatively low compared to California. Because the number of cases each year is small, it is difficult to detect trends over time. Like California and the rest of the nation, Napa has seen an overall decrease in cases since 1996. Just as in the rest of California, however, that decrease appears to have leveled off in recent years.

Table 21. Tuberculosis Case Rates Per 100,000 Population, 1996-2005

Area												Percent Change
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2005-06
Napa County	9.3	*	4.1	*	*	*	5.4	4.6	5.3	*	5.1**	*
California	13.5	12.5	11.7	10.8	9.7	9.6	9.0	9.0	8.2	7.9	7.4	-6.3

Source: California Department of Health Services. Report on Tuberculosis in California, 2005. March 2007

*Rates and rate changes not calculated where number of cases is less than 5.

**Provisional data.

MORTALITY (DEATH)

The leading causes of mortality (Table 22) display a broad picture of the causes of death in Napa County. The death rates shown are per 100,000 population. The crude death rate is the actual risk of dying. The age-adjusted rate is the hypothetical rate that the county would have if its population were distributed by age in the same proportions as the 2000 U.S. population.

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

County Rank Order	Health Status Indicator	2003-2005 Deaths (Avg)	Crude Death Rate	Age-Adjusted Death Rate	Age-Adjusted Death Rate		National Health Objective
					Statewide	National ¹	
27	All causes	1,256.7	946.6	750.5	716.7	800.8	^a
50	All cancers	317.7	239.3	197.6	165.1	185.8	158.6
53	Colorectal (colon) cancer	33.0	24.9	20.0	16.0	18.0	13.7
43	Lung cancer	82.7	62.3	51.9	41.5	53.2	43.3
28	Female breast cancer	19.7	29.6	22.5*	22.7	24.4	21.3
45	Prostate cancer	19.3	29.2	27.6	23.8	25.4	28.2 ^b
32	Diabetes	34.3	25.9	20.8	22.3	24.5	^b
56	Alzheimer's disease	73.0	55.0	39.1	22.1	21.8	^a
14	Coronary heart disease	216.7	163.2	124.6	162.6	160.0	162.0
48	Cerebrovascular disease (stroke)	110.7	83.4	62.0	51.7	50.0	50.0
41	Influenza/pneumonia	47.0	35.4	25.5	23.7	19.8	^a
23	Chronic lower respiratory disease	70.0	52.7	41.4	40.6	41.1	^a
37	Chronic liver disease and cirrhosis	18.7	14.1*	12.9*	10.8	9.0	3.2
19	Unintentional injuries	49.0	36.9	35.0	29.5	37.7	17.1
22	Motor vehicle crashes	19.7	14.8	14.8	11.7	14.7	8.0
21	Suicide	13.0	9.8*	9.6*	9.2	10.9	4.8
21	Homicide	3.7	2.8*	3.0*	6.7	5.9	2.8
11	Firearms-related	8.7	6.5*	6.3*	9.4	10.0	3.6
8	Drug-induced deaths	9.0	6.8*	6.7*	9.6	10.4	1.2

Source: County Health Status Profiles 2007. California Department of Health Services, Sacramento, CA.

* Death rate unstable, relative standard error is greater than or equal to 23%.

¹ 2004 mortality and morbidity.

^a Healthy People 2010 National Objective has not been established

^b National Objective is based on both underlying and contributing cause of death which requires use of multiple cause of death data files. California's data exclude multiple/contributing causes of death.

Diseases of the circulatory system—heart disease, stroke—are responsible for about 28% of total deaths, and all cancers (accounting for about 1 out of every 5 deaths) are the leading causes of death in Napa County. Hypertension (high blood pressure) is a major modifiable risk factor for heart disease and stroke and is a leading cause of death in California. The percentage of people with hypertension increases greatly with age, and men and women have about the same prevalence of hypertension. In 2003-2005, deaths from certain cancers and respiratory disease showed higher rates in Napa County than in California. Deaths due to coronary heart disease, however, were lower in the county than for the State for that same period of time; Napa County ranked 14th of 58 counties in mortality from heart disease.

Over 30% of cancer is estimated to be associated with poor nutrition, lack of physical activity and obesity; and another 30% with tobacco use.²¹ Cancers of the trachea, bronchus and lung lead all other types of cancer. Table 23 breaks out mortality data due to cancer by type of cancer and shows that Napa County's rates exceed the national health objective, and except for female breast cancer are higher than the statewide average as well. Napa County residents are about 25% more likely to die from lung (rate ratio=1.25) or colon cancer (rate ratio=1.25) than California residents as a whole, but the mortality rates for these cancers individually are not significantly different from the State rate.

Table 23. Deaths Due to Cancer by Type of Cancer, 2003-2005

Type	Napa County				California	National Objective
	2003-2005 Deaths (Average)	Crude Death Rate	Age-Adjusted Death Rate	Rank Order	Age-Adjusted Death Rate	
All cancers	318	239.3	197.6	50	165.1	158.6
Lung	83	62.3	51.9	38	41.5	43.3
Colorectal (colon)	33	24.9	20.0	53	16.0	13.7
Female breast	20	29.6	22.5	28	22.7	21.3

Source: County Health Status Profiles 2007. California Department of Health Services.

Chronic liver disease and cirrhosis is a cause of death primarily attributed to excessive alcohol consumption. For the three-year average 2002-2004, chronic liver disease and cirrhosis was the ninth leading cause of death in both California and Napa County.²² In 2003-2005, Napa County's age-adjusted death rate due to chronic liver disease and cirrhosis, 12.9, is substantially higher than the health objective (Healthy People 2010) for the nation, which is a rate not to exceed 3.0.

²¹ *California Cancer Facts and Figures, 2007*. California Cancer Registry, California Department of Health Services, and American Cancer Society.

²² *Health Data Summaries for California Counties 2006*. California Department of Health Services.

CHRONIC DISEASE AND OTHER CONDITIONS

Chronic diseases cost the nation's economy more than \$1 trillion a year in lost productivity and treatment costs and the amount could soar to \$6 trillion by mid-century according to new figures on the cost burden of chronic disease.²³ The researchers—who conducted a state-by-state analysis of seven common chronic diseases (e.g., cancer, diabetes, heart disease)—concluded that “investing in good health would add billions of dollars in economic growth in the coming decades.” California was in the top quartile of states with the lowest rates of chronic diseases.

Heart Disease

“Heart disease” refers to a variety of conditions including coronary artery disease, heart attack, heart failure, angina, and congenital heart defects. Smoking, being overweight or physically inactive, and having high cholesterol, high blood pressure, or diabetes are risk factors that can increase the chances of having heart disease. In addition, heart disease is a major cause of chronic illness. While *death* due to heart disease is lower in Napa County than California as a whole, the County's prevalence of heart disease is actually higher than the State's. According to 2001 State Department of Health Services data, about 7.8% of all Napa County adults had heart disease in that year, a rate that was slightly higher than the State rate of 7.2% of all California adults (Table 24). In response to the question asked in the California Health Interview Survey, “ever diagnosed with heart disease?” 9.5% and 7.0% of Napa County respondents answered “yes,” respectively, in 2003 and 2005, both higher than the California averages those years of 6.9% and 6.2%.

Table 24. Heart Disease Prevalence Among Adults, 2001

Area	Age-adjusted rate	Estimated Number
Napa County	7.8	8,900
California	7.2	1,726,400

Source: California Department of Health Services, Prevalence of Heart Disease in California Counties, 2001

Diabetes

Diabetes poses a significant public health challenge. It increases the risk of cardiovascular disease, and the direct complications—blindness, lower limb amputation and end-stage kidney failure—increase as the prevalence of diabetes increases.²⁴ Obesity is a major risk factor for the development of diabetic complications, including cardiovascular disease and

²³ DeVol R, et al. An Unhealthy America: The Economic Burden of Chronic Disease. Milken Institute. October 2, 2007.

²⁴ National Diabetes Fact Sheet, United States Department of Health and Human Services, p. 7-8.

stroke. The prevalence is more than twice as high among adults who are obese as it is among those who are overweight.²⁵

Diabetes is strongly related to social and economic factors. It is more than twice as common among adults who either did not attend or did not graduate from high school, compared to college graduates. The annual economic cost of diabetes in California is approximately \$12 billion from all sources—probably a conservative estimate because lost wages, productivity, nursing home care costs and non-prescription drugs are not included.²⁶ Each year there are over 300,000 diabetes-related hospitalizations in California, at an annual cost of \$3.4 billion.²⁷

In both Napa County and California, according to California Health Interview Survey (CHIS) data, the percentage of the population having diabetes increased from 2003 to 2005, and in 2005 Napa County had a higher proportion than the state average (Table 25). Neither the state nor the county achieved the Healthy People 2010 national health objective (Table 26). About 8,000 Napa County residents were estimated to have diabetes in 2005.

Table 25. Diabetes, Adults Age 18 and Over

Area	Has Diabetes		Does not Have Diabetes		Diagnosed Borderline or Pre-Diabetes	
	2003	2005	2003	2005	2003	2005
Napa County	5.1%	8.3%	94.5%	90.6%	*	1.1%**
California	6.6%	7.0%	92.6%	92.0%	0.8%	1.1%

Source: 2005 California Health Interview Survey.

*Estimate is less than 500 people.

**Statistically unstable.

Table 26. Prevalence Rates¹ of Diabetes in Adults, 2003

	Age-Adjusted Rate	Crude Rate
Healthy People 2010 Objective	2.5	--
Napa County*	4.3	5.1
California	6.6	6.5

Source: *Prevalence of Diabetes in California Counties, 2003*. California Department of Health Services.

¹Rate is per 100 county or State population.

*Age-adjusted rate is significantly different from age-adjusted State rate.

²⁵ California Health Interview Surveys, *Diabetes on the Rise in California*, Health Policy Brief, December 2005.

²⁶ Based on a study by the Lewin Group, Inc., for the American Diabetes Association. 2002 estimates of both the direct (cost of medical care and services) and indirect costs (costs of short-term and permanent disability and of premature death) attributable to diabetes.

²⁷ Diabetes in California Counties: Prevalence, Risk Factors and Resources, 2005, California Diabetes Program, California Department of Health Services.

Mirroring California, race/ethnic, age and gender differences exist for Napa County with regard to risk factors and diabetes prevalence (Table 27). With regard to gender, women generally fared better than men on physical activity and consumption of fresh produce but worse on factors related to weight. Overall by race/ethnicity, White residents had the lowest prevalence and risk factors except on consumption of fruit and vegetables where Latinos rated higher. A much higher percentage of Latinos than Whites were at risk regarding weight factors, however. Where there were sufficient numbers for statistical reliability, Asians fared better than Whites on weight issues and physical activity but had the least consumption of fresh produce of any group except Other. There was very little difference by age group on eating fruits and vegetables. Prevalence and risk related to weight was greatest for adults 46-64. And, seniors 65+ exercised the least of any age group.

Table 27. Napa County Diabetes Prevalence and Risk Factors

	Diabetes Prevalence		Overweight		Obese		Physical Inactivity ¹		Less-than-5-A-Day ²	
	#	%	#	%	#	%	#	%	#	%
Countywide	6987	7.7	49133	53.9	15782	17.3	65523	71.8	38504	42.2
Female	3665	8.3	27901	63.0	8518	19.2	30765	69.5	16615	37.5
Male	3323	7.1	21232	45.2	7264	15.5	34758	74.0	21889	46.6
Latino	1445	7.7	14386	77.0	5177	27.7	15296	81.9	6838	36.6
Asian	*	*	217	9.6	*	*	1363	60.1	1134	50.0
African Amer	*	*	625	69.0	*	*	906	100.0	425	46.9
White	4673	7.1	32573	49.2	9964	15.0	45917	69.3	28132	42.5
Other	309	9.8	1332	42.5	640	20.4	2041	65.1	1976	63.0
18-45	1663	3.6	24484	52.8	6608	14.3	30855	66.6	19411	41.9
46-64	2624	9.5	16535	60.1	6524	23.7	20705	75.2	11265	40.9
65+	2700	15.6	8114	46.7	2651	15.3	13962	80.4	7827	45.1

Source: Diabetes in California Counties: Prevalence, Risk Factors and Resources. California Diabetes Program Based on the 2001 CHIS, Center for Health Statistics, and Department of Finance population estimates.

¹Physical Inactivity is defined as less than 20 min. of vigorous exercise 3/week or 30 min. of moderate activity 5/week.

²Less-than-5-A-Day refers to the consumption of 4 or less fruits and vegetables per day.

*Insufficient number of observations to make a statistically reliable estimate.

Overweight and Obesity

Overweight and obesity, which are often caused by the interdependence of dietary factors and physical inactivity, are becoming epidemic in the population and are associated with an increased risk for a number of serious health conditions. The public health impact of overweight and obesity is substantial, both in terms of disease burden and cost. According to the Centers for Disease Control and Prevention (CDC), physical inactivity cost the United States nearly \$76.6 billion in direct medical costs in 2000. Obesity, a companion problem with physical inactivity, is also on the increase in the US. CDC estimated that in 1998

medical expenses attributable to being overweight or obese accounted for 9.1 percent of total U.S. medical expenditures and may have reached as high as \$78.5 billion.²⁸

On average, higher body weights are associated with higher death rates. In particular, overweight and obesity substantially increase the risk of morbidity from hypertension, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and endometrial, breast, cervical, ovarian, prostate and colon cancers.²⁹ Although the associations are still not understood, infants born to obese mothers are one-third more likely to suffer significant birth defects, including spina bifida, limb reductions and heart defects according to recent research on maternal obesity.³⁰ And, there is considerable variation in the prevalence of overweight and obesity by race and ethnicity. Among adults not diagnosed with diabetes, approximately one in four African Americans, Latinos and Native Americans and more than one in six Whites are obese, compared to one in 16 Asians.³¹

Although the Napa County prevalence of obesity is higher than the Healthy People 2010 benchmark of 15.0, it is lower than the State rate. The prevalence of healthy weight for the county is similar to the State (Table 28), but neither meet the Healthy People 2010 target of 60% of adults who are at a healthy weight.

Table 28. Prevalence of Obesity (BMI >30.0) and Healthy Weight Among Adults In California, 2001

Area	Age-Adjusted Rate ¹	Crude Rate ¹	Estimated Number
<i>Prevalence of Obesity (BMI >30.0)</i>			
Napa County	16.0	16.7	28,900
California	19.1	19.0	4,728,600
<i>Prevalence of Healthy Weight (BMI >18.5 and BMI <25.0)</i>			
Napa County	45.6	44.8	43,700
California	43.0	43.2	9,894,200

Source: California Department of Health Services. *Prevalence of Obesity and Healthy Weight in California Counties, 2001*.

¹Rate is per 100 county or State population.

The rapid increase in overweight among children and adolescents is generating widespread concern. Nationally, the percentage of overweight children and adolescents increased from the 1960s to 2002.³² Overweight and obesity are major risk factors for chronic diseases. For example, the risk of new-onset asthma is higher among children who are overweight.³³

²⁸ Reported in *Northwest Public Health*, Fall/Winter 2006.

²⁹ National Institutes of Health. *Clinical Guidelines of the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: the Evidence Report*. NIH publication No. 98-4083. September 1998.

³⁰ Waller DK, et. al. Pregnancy obesity as a risk factor for structural birth defects. *Archives of Pediatric and Adolescent Medicine*. 2007;161:745-750.

³¹ CHIS, *Diabetes on the Rise in California*.

³² Childhood overweight: What the research tells us. The Center for Health and Health Care in Schools. March 2005.

³³ Gilliland FD, Berhane K, et al. Obesity and the risk of newly diagnosed asthma in school-age children. *Am J Epidemiol*. 2003;158:406-415.

Among boys and young men, risk of overweight and overweight is a particular burden among Latinos, with 42.8% of Latinos ages 6-19 either at risk of overweight or overweight compared with 31.0% of non-Latino African American boys and adolescents and 29.2% of non-Latino White boys and adolescents. Among girls and young women, 40.1% of non-Latino African American young people are at risk of overweight or overweight, compared to 36.6% of Latino girls and young women and 27.0% of non-Latino White girls and young women.³⁴

Breastfeeding Rate

Interventions aimed at childhood obesity typically target school-age children, but prevention should start much earlier, as early as the day the child is born according to pediatric experts. Breast milk not only provides infants with all the nutrients they need and elements that promote growth and a healthy immune system, but is also recognized as the first step in the battle against childhood overweight.³⁵ Mothers who breastfeed exclusively (breast milk is the infant’s only food) are likely to breastfeed for a longer time—offering the best protection against overweight.

Statewide, about 83% of mothers choose to breastfeed their infants in the hospital; only 40.5% of these infants are exclusively breastfed. In Napa County, the percentages are 92.7% “any breastfeeding” and 71.2% “exclusively,” rates that are more favorable than state averages. Napa County is ranked 9th in the state for exclusive breastfeeding. In the county, unlike the state, there is almost no difference in the rates by ethnicity, all of which are higher than statewide ethnicity rates (Table 29). The Healthy People 2010 objective is for 75% of mothers to breastfeed in the early post-delivery period and 50% to still be breastfeeding when the baby is six months old.

Table 29. Percentage Exclusive Breastfeeding by Race/Ethnicity

Ethnicity	Napa County	State Average
Hispanic	70.4	29.0
Multi-race/Other	74.4	51.3
White	72.4	61.8
Total	71.2	40.5

Source: California WIC Association and UC Davis Lactation Center, 2004.

Asthma

Asthma is a serious public health problem and is responsible for millions of outpatient visits and hundreds of thousands of hospitalizations nationally. Costs for asthma hospitalizations are very high: the total charges for asthma hospitalizations in 2005 in California were \$763

³⁴ Hedley AA, Ogden CL, Johnson CL, Carroll MD, Curtin LR, Flegal KM. Prevalence of overweight and obesity among US children, adolescents, and adults, 1999-2002. *JAMA*. 2004;291(23):2847-2850.

³⁵ Owen CG, et al. Effect on infant feeding on the risk of obesity across the life course: A quantitative review of published evidence. *Pediatrics* 2005; 115:1367-1377.

million.³⁶ The National Health Interview Survey found that persons under age 18 have higher rates of asthma than any other age group.³⁷ About 14.8% of all children under age 18 in California and 15.4% in Napa County have ever been diagnosed with asthma. Nearly one half (45.5%) of all Napa County children and adolescents with asthma experienced an asthma attack in 2003 compared to about one third (36.3%) in California (Table 30). This suggests that a larger proportion of the county's children and adolescents than the state average may be at risk for serious illness and other complications associated with asthma, such as activity limitations and missed days of school.

Table 30. Lifetime Asthma,¹ Children and Adolescents

	Lifetime Asthma in California Children and Adolescents, 2003		Children and Adolescents in California with Lifetime Asthma Experiencing an Asthma Attack Within the Past Year, 2003	
	Rate ²	Estimated Number	Rate ²	Estimated Number
Napa County	15.4	5,000	45.5	2,000
California	14.8	1,404,000	36.3	510,000

Source: California Department of Health Services, *Asthma in Children and Adolescents in California Counties, 2003*.

¹Individuals with "lifetime asthma" have ever been told by a doctor that they have asthma.

²Rate is per 100 persons under age 18 with diagnosed asthma.

Table 31 shows the percent of Napa County residents of all ages who have ever been diagnosed with asthma and the percent with asthma diagnosis that reported in the 2005 California Health Interview Survey experiencing an episode or attack within the past 12 months. Adults age 18 and older have a slightly lower proportion of ever being diagnosed with asthma or having an asthma attack in the previous 12 months than children age 0-17. In both children and adults, being overweight is associated with higher asthma prevalence.³⁸

Table 31. Percent Ever Diagnosed with Asthma

Age Group	Percent Ever Diagnosed with Asthma	Population Estimate	Percent with Asthma Attack in Previous 12 Months	Population Estimate
0-17	11.5*	3,000	41.6*	1,000
18-64	10.3	8,000	34.7	3,000
65+	10.7	2,000	41.9*	1,000

Source: California Health Interview Survey, 2005.

* Estimate is statistically unstable

³⁶ Milet M, Tran S, Eatherton M, Flattery J, Kreutzer R. "The Burden of Asthma in California: A Surveillance Report." Richmond, CA: California Department of Health Services, Environmental Health Investigations Branch, June 2007.

³⁷ National Center for Health Statistics. "Asthma Prevalence, Health Care Use and Mortality." URL:

<http://www.cdc.gov/nchs/products/pubs/pubd/hestats/asthma/asthma.htm>

³⁸ Milet M, Tran S, Eatherton M, Flattery J, Kreutzer R. "The Burden of Asthma in California: A Surveillance Report." Richmond, CA: California Department of Health Services, Environmental Health Investigations Branch, June 2007.

When people manage their asthma properly and receive appropriate health care, they should not have to go to the emergency department (ED) because of their asthma. However, many people with asthma end up at the ED for treatment of asthma symptoms. In 2005, there were 518 asthma ED visits in Napa County that did not result in an inpatient hospitalization. This translates to a yearly age-adjusted Napa County rate of 39.3 ED visits per 10,000 residents, slightly higher than the California rate of 39.1. The County rate of asthma *hospitalizations*, however, is lower than the State rate.

MATERNAL HEALTH

Prenatal Care

Adequate and early initiation of prenatal care is associated with improved birth outcomes. The national objective for births to mothers with “adequate/adequate plus” care (which includes timing of entry into prenatal care) is 90%. Only one California county (Marin) met this objective in the last three-year reporting period. In Napa County, 73.5% of women received adequate prenatal care during 2003-2005, an increase of 5.3% from the 2000-2002 percentage of 69.8. In 2004, 87% of mothers statewide entered prenatal care in the first trimester as recommended.³⁹

Births

Approximately 1,658 babies were born in 2005 to women living in Napa County.* Birth projections for the county through 2010 show a slight but steady increase (Table 32). The increase in births is likely attributed to the county’s overall growth in population size. Similar to the majority of the state, the growth will be disproportionately higher among the Latino and certain Asian/Pacific Islander populations.

Table 32. Actual and Projected Births, 2000-2010

<i>Actual</i>	
2000	1,497
2001	1,565
2002	1,571
2003	1,676
2004	1,604
2005	1,658
2006	1,753 (preliminary)
<i>Projected</i>	
2007	1,730
2008	1,769
2009	1,810
2010	1,850

Source: State of California, Department of Finance, September 2006.
Napa County Public Health Division.

³⁹ Health Data Summaries for California Counties 2006. California Department of Health Services.

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

Based on Medi-Cal claims data from 2003, Medi-Cal pays for about one-third (35%) of the births to women from Napa County.

Adolescent Pregnancy

Napa County ranks 23 among California's 58 counties in births to adolescent mothers and its rate is more favorable than the state average (Table 33). While no national objective has been established for this indicator, the national target for *pregnancies* (as opposed to births) among adolescent females is 43 pregnancies per 1,000. Children of teen mothers are more likely to display poor health and social outcomes than those of older mothers, such as premature birth, low birth weight, higher rates of abuse and neglect, and more likely to go to foster care or do poorly in school.

Table 33. Births to Teen Mothers

Area	2003 Female Population 15-19 Yrs Old	2002-2004 Live Births (Ave.)	Age-Specific Birth Rate
Napa County	4,317	127.3	29.5
California	1,268,519	49,756	39.2

Infant Mortality

Infant mortality is used to compare the health and well-being of populations across and within countries. The infant mortality rate—the rate at which babies less than one year of age die—has continued to steadily decline in the U.S. and California over the past several decades. Nationally as well as statewide, however, African American infant death rates are significantly higher than both White non-Hispanic and Hispanic infants which are similar to one another. Because the number of infant deaths for most counties in California is too small for reliability, another trackable indicator for which the published data are reliable is the rate of low birth weight infants (less than 2500 grams at birth).

Low Infant Birth Weight

Low birth weight is a major public health problem, contributing substantially both to infant mortality and to childhood disabilities. The principal determinant of low birth weight is preterm delivery. Infant mortality rate and low birth weight correlate with the risk factors of poverty, unemployment and violent crime in the community. Neither Napa County's nor the statewide low birth weight rate met the national objective (Table 34) in 2004. Napa County ranks 15 among California's 58 counties in infants born at low birth weight.

Table 34. Low Birth Weight Infants

Area	2002-2004 Live Births (Ave.)			Healthy People 2010 Percent
	Live Births	Low Birthweight		
		Number	Percent	
Napa County	1,617	92	5.7	5.0
California	538,239	35,333	6.6	5.0

SUBSTANCE USE AND ABUSE

Adult Alcohol Use and Abuse

Alcohol abuse is a pattern of drinking that results in harm to one's health, interpersonal relationships or ability to work. Certain manifestations of alcohol abuse include failure to fulfill responsibilities at work, school or home; drinking in dangerous situations such as while driving; legal problems associated with alcohol use and continued drinking despite problems that are caused or worsened by drinking.⁴⁰ Alcohol abuse is associated with a number of acute and chronic health effects. *Chronic* health consequences of excessive drinking⁴¹ can include liver cirrhosis (damage to liver cells); pancreatitis (inflammation of the pancreas); various cancers, including cancer of the liver, mouth, throat, larynx (the voice box), and esophagus; high blood pressure; and psychological disorders. *Acute* health consequences of excessive drinking can include motor vehicle injuries, falls, domestic violence, rape, and child abuse.⁴²

Community-level indicators that serve as direct and indirect measures of alcohol and other drug use prevalence and related problems are collected, monitored and reported by the State. Selected indicators for Napa County are shown in Table 35 on the next page. Napa County rates for five of these indicators are higher than the statewide average, related to both adult and juvenile alcohol use.

⁴⁰ Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV), published by the American Psychiatric Association, Washington D.C., 1994. Reported at <http://www.cdc.gov/alcohol/faqs>.

⁴¹ For men, heavy drinking is typically defined as consuming an average of more than 2 drinks per day. For women, heavy drinking is typically defined as consuming an average of more than 1 drink per day. Note: There is no one definition of moderate drinking, but generally the term is used to describe low-risk or responsible drinking.

<http://www.cdc.gov/alcohol/faqs>.

⁴² U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

<http://www.cdc.gov/alcohol/faqs>.

Table 35. Community-Level Alcohol and Drug-Related Indicators

Indicator	Report Period	Napa	CA
Adult arrests for drug violations ¹	1999-2001 (3-Yr Ave Rate)	7.4*	10.3*
Adult arrests for driving under-the-influence ¹	2003-2005 (3-Yr Ave Rate)	84.9**	49.9**
Juvenile arrests for alcohol and drug offenses ¹	1999-2001 (3-Yr Ave Rate)	10.2*	9.1*
Alcohol-involved motor vehicle accidents ²	2003-2005 (3-Yr Ave Rate)	98.7***	60.3***
Adult alcohol and drug treatment admissions ³	2000-2002 (3-Yr Ave Rate)	4.1*	8.5*
Adolescent alcohol and drug treatment admissions ³	2000-2002 (3-Yr Ave Rate)	4.5*	1.8*
Hospital discharge, adult alcohol and drug disorder ³	1998-2000 (3-Yr Ave Rate)	460.2***	165.8***
Deaths due to alcohol and drug use ³	1998-2000 (3-Yr Ave Rate)	28.1***	26.5***

¹Source: CA Department of Justice, Criminal Justice Statistics Center. Statewide and County Profiles.

²Source: CA Highway Patrol, Statewide Integrated Traffic Records System (SWITRS).

³Source: CA Department of Alcohol and Drug Programs. Note: these numbers include tourists and non-residents as well.

* Rates are per 1,000 population; ** Rates are per 10,000 population; ***Rates are per 100,000 population.

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

According to the National Institute on Alcohol Abuse and Alcoholism binge drinking is defined as a pattern of alcohol consumption that brings the blood alcohol concentration level to 0.08% or above. This pattern of drinking usually corresponds to more than 4 drinks on a single occasion for men or more than 3 drinks on a single occasion for women, generally within about 2 hours.⁴³ Both alcohol use and binge drinking are more prevalent among Napa County adults than the statewide average (Table 36).

Table 36. Adult Alcohol Use and Binge Drinking Rates

	Any Alcohol Use 2001	Any Alcohol Use 2003	Any Binge Drinking 2001	Any Binge Drinking 2003
<i>Asked as "...within the last 30 days?"</i>				
Estimated Number	62,000	59,000	17,000	15,000
Estimated Population Age 18 and Over	91,000	94,000	91,000	94,000
Napa County Use and Binge Drinking	68.1%	63.3%	18.6%	16.1%
State Use and Binge Drinking Comparison	57.9%	57.4%	15.4%	15.1%

Source: California Health Interview Survey.

⁴³ National Institute of Alcohol Abuse and Alcoholism. NIAAA council approves definition of binge drinking. *NIAAA Newsletter* 2004;3:3.

Adolescent Alcohol and Drug Use and Abuse

Underage drinking and underage binge drinking are associated with higher risks of motor vehicle crashes, suicide, and sexually transmitted infections.^{44,45, 46} Underage alcohol use is more likely to kill young people than all illegal drugs combined. Youth who use alcohol are 1.5 times more likely to require ER care and 9.4 times more likely to drink and drive; they are also 2.5 times more likely to smoke.⁴⁷ An analysis of 2005 Youth Risk Behavior Survey data from four states found that liquor (e.g., bourbon, rum, scotch, vodka, or whiskey) was the most prevalent type of alcoholic beverage usually consumed by students in 9th-12th grade, followed by beer or malt liquor. Wine was the least popular drink by a wide margin. For the most part, the finding held true for both genders and across all racial groups.⁴⁸

Although the estimated rate of underage drinking and underage binge drinking reported in the California Health Interview Survey for Napa County youth age 13-20 is statistically unreliable because the ranges are so wide, the data suggest higher rates than the state average for use of alcohol, and similar rates to the state average for binge drinking (Table 37). The CHIS data do not distinguish type of alcoholic beverage. The national objective is no more than 29% of high school seniors using any alcohol.

Table 37. Underage Alcohol Use and Binge Drinking Rates

	Drank Any Alcohol		Engaged in Any Binge Drinking ¹	
	Asked as "...within the last 30 days?"			
	Yes	No	Yes	No
Napa County	59.4%* (23.0%-95.5%)	40.6%* (4.1%-40.6%)	10.0%* (0.5-19.6)	90.0% (80.4-99.5)
California	45.9%	54.1%	12.4%	87.6%

Source: 2005 California Health Interview Survey.

¹ Asked of those age 13-20 who ever had more than a few sips of alcohol. Male binge drinking in CHIS is five or more drinks on one occasion in past month; female binge drinking is four or more drinks.

*Estimate is statistically unstable.

⁴⁴ Zador PL, Krawchuk SA, Voas RB. Alcohol-related relative risk of driver fatalities and driver involvement in fatal crashes in relation to driver age and gender: An update using 1996 data. *J Stud Alcohol*. 2000;61:387-395.

⁴⁵ U.S. Department of Health and Human Services. Centers for Disease Control and Prevention: Youth Risk Behavior Surveillance – United States, 2005. *Morb Mortal Wkly Rep*. 2006;55:.

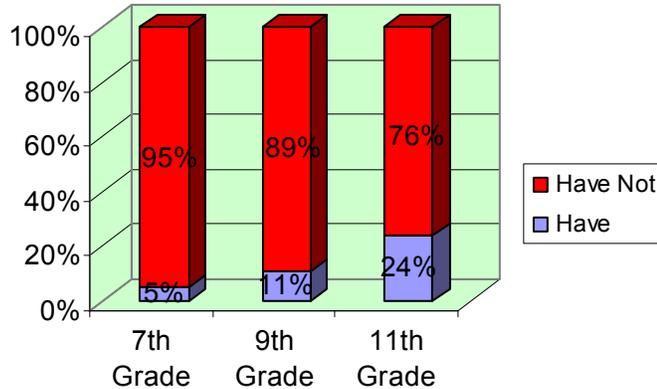
⁴⁶ Bailey SL, Pollock NK, Martin CS, et al.. Risky sexual behaviors among adolescents with alcohol use disorders. *J Adolesc Health*. 1999;25:179-181.

⁴⁷ National Household Survey on Drug Use and Health

⁴⁸ CDC. Youth Risk Behavior Surveillance—United States, 2005. *MMWR* 2006;55(No. SS-5).

The California Healthy Kids Survey (CHKS),⁴⁹ which collects data on students in grades 5, 7, 9 and 11 a minimum of every two years, offers another look at youth substance use. Approximately 1 in 10 (11%) 9th graders and 1 in 4 (24%) 11th graders reported binge drinking in the last 30 days in 2006 (Figure 7); the national objective is to reduce the proportion of high school seniors who report binge drinking of alcohol to 11%.

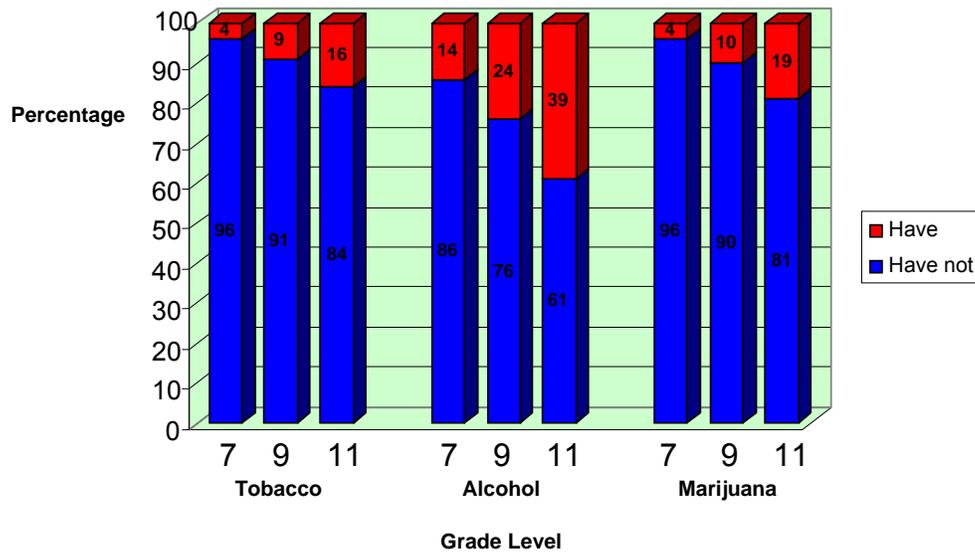
Figure 7. Binge Drinking in the Last 30 Days



A summary of other CHKS findings for Napa County is displayed in Figure 8. Only 4% of 7th graders reported using any tobacco or marijuana in the last 30 days, although 14% said they had used alcohol. Of the 9th graders, an equal percentage (9%) of reported any tobacco or marijuana use in the last 30 days, while one-quarter (24%) had used alcohol. Reported tobacco and marijuana use in the last 30 days among the 11th graders was 16% and 19%, respectively, and for alcohol use 39%.

⁴⁹ A minimum of 60% of parents must sign consents and students must complete a survey to ensure validity. Just under 60% of Napa Valley Unified School District parents did not consent for their students to complete the survey. St. Helena Unified had a very good participation. Calistoga Joint Unified School District was unable to get enough student participation to provide reliable data; Howell Mountain and Pope Valley have limited populations.

Figure 8. Napa County Drug Use by School Children by Grade Level



Source: California Healthy Kids Survey, Fall 2006.

The effects of alcohol ads are important with regard to both underage drinking and underage binge drinking. According to recent research, children as young as 11 and 12 years old who are exposed to alcohol marketing are more likely to use alcohol or plan to use it. Children with the highest levels of marketing exposure (e.g., at sporting events) were 50% more likely to drink and 36% more likely to intend to drink a year later compared to children with little exposure to alcohol ads.⁵⁰ Research has shown that delaying alcohol use decreases the likelihood that young people will drop out of school or participate in criminal activities.⁵¹

Other Adult Substance Use

Table 38 on the next page provides client information about the drug of choice for those Napa residents who receive substance abuse treatment from Napa County services. The data from these two programs include Project 90, which provides social model detoxification and residential substance abuse treatment services for adults in Napa County, and Alternatives for Better Living, which provides outpatient substance abuse treatment for youth and adults in Napa County. (Other treatment resources available in the county are private and probably represent much smaller numbers.) The majority of the clients served between January 2006 and July 2007 were White, male adults ages 25-44. Alcohol, followed closely by methamphetamine, was the most common drug of choice (Figure 9).

⁵⁰ Collins RL, Ellickson PL, McCaffrey D, Hambarsoomians K. Early Adolescent Exposure to Alcohol Advertising and its Relationship to Underage Drinking. *Journal of Adolescent Health*, April 2007;(40);6:527-534.

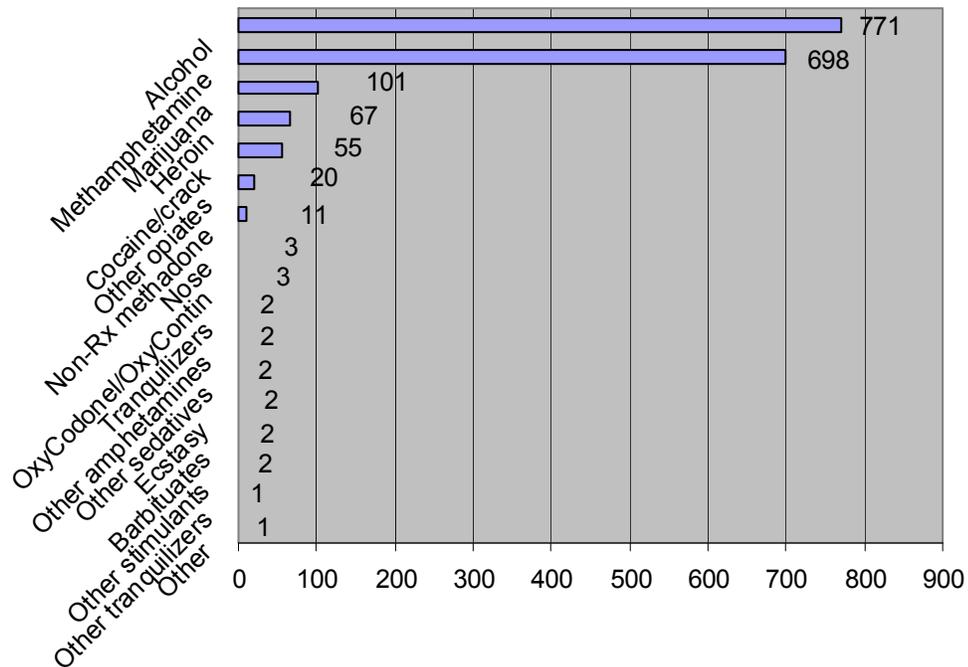
⁵¹ Elliott DS. Health Enhancing and Health-Compromising Lifestyles. *Promoting the Health of Adolescents*. Oxford University Press, New York. http://www.oup-usa.org/toc/tc_0195091884.html.

Table 38. Demographic Profile of Adult Clients Served for Substance Abuse, January 2006-July 2007

	Number	Percent
<i>Gender</i>		
Female	561	32.2%
Male	1,179	67.7%
Other	2	0.1%
Total Admissions	1,742	100.0%
<i>Age Group</i>		
18-24	231	13.3%
25-44	987	56.7%
45-55	435	25.0%
56-84	75	4.3%
>84	14	0.8%
<i>Race/Ethnicity</i>		
White	1,278	73.4%
Latino	342	19.6%
African American	60	3.4%
Native American	25	1.4%
Asian/Pacific	20	1.1%
Islander		
Other	17	1.0%

Source: Napa County Health and Human Services Agency/California Outcome Measurement System.

Figure 9. Drug of Choice of Adult Clients Served, January 2006 - July 2007



Adult Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Smoking causes at least 80% of all deaths from lung cancer, about 80% of all deaths from bronchitis and emphysema and approximately 17% of all deaths from heart disease; 30% of all cancer deaths can be attributed to smoking. Smoking rates among California adults declined steadily among both men and women from 1989 to 2005.⁵² However, according to the California Health Interview Survey (CHIS), in 2005 17.1% of California adults still smoked. A slightly higher proportion, 21.5%, of Napa County adults smoked in that year. Neither the State nor County meets the Healthy People 2010 objective of no more than 12% of adults age 18+ who smoke cigarettes. Decreasing the rate of smoking would lead to a demonstrable decrease in mortality from cancer alone, not to mention the additional decreases in mortality in heart disease and stroke. Based on CDC estimates, a 1% decrease in smoking would lead to about a 1% decrease in all-cause mortality in Napa County.

Perinatal Substance Abuse

Although California is recognized as a national leader in developing alcohol and other drug services for women, many counties, including Napa County, do not have the benefit of an adequate spectrum of comprehensive gender-specific and culturally appropriate screening, treatment and support services to address the needs of pregnant women involved with substance abuse. Applying statewide estimates of prevalence, approximately 189 infants were born substance-exposed in Napa County in 2005, or about 11.4% of all births that year.⁵³

ORAL HEALTH

Children

Oral health is an important component of overall health. Dental disease affects more school-age children than any other chronic health condition—next to the common cold, tooth decay is the most prevalent human disorder. Dental disease among children in California is an epidemic, five times more common in children than asthma. And it is an epidemic that is almost entirely (and inexpensively) preventable. According to the 2006 statewide Dental Health Foundation needs assessment, about one-third of low income children have untreated decay compared to about one-fifth of higher income children. Nearly 40% of children with no insurance have untreated decay compared with 21% of children with private insurance.⁵⁴ Additional findings from the DHF assessment include:

⁵² *California Cancer Facts and Figures, 2007*. California Cancer Registry, California Department of Health Services, and American Cancer Society.

⁵³ Vega W et al. *Profile of Alcohol and Drug Use During Pregnancy in California, Perinatal Exposure*. UC Berkeley and the Western Consortium for Public Health. Study conducted for the California Department of Alcohol and Drug Programs, September 1993.

⁵⁴ *Mommy it Hurts to Chew. The California Smile Survey An Oral Health Assessment of California's Kindergarten and 3rd Grade Children*. Dental Health Foundation, February 2006.

- 54% of kindergartners and 71% of 3rd grade children screened have a history of tooth decay (which means that they had at least one tooth that was either decayed or had been filled because of tooth decay).
- 26% of children have a need for dental care—22% need non-urgent or early dental care, while an additional **4% need urgent dental care** because of pain or infection.
- Latino and other minority children have more decay experience, more untreated tooth decay, and more urgent dental care needs than non-Latino white children. In addition to having more tooth decay, Latino children are less likely to have private dental insurance.

Children from poor families suffer twice as much dental disease as middle-class children and their disease is more likely to remain untreated. Applying the statewide assessment data above to poverty-level children age 0-19 in Napa County, at least 6,680 children have decay requiring treatment, an estimate that is probably conservative.

While it is difficult to accurately determine the number of these children that are receiving care, close to 8 in 10 children in Napa County are enrolled in some type of insurance program with dental coverage, and the same proportion reported visiting a dentist in the last year (Table 39). The proportion that used the oral health care system in the last year exceeds the national health target of 56%.

Table 39. Dental Health Indicators

Dental Health	Napa County	Statewide
Children with dental insurance	78%	79%
Children who visited a dentist last year	82%	80%

Source: 2007 California County Data Book, Children Now.

One important preventative measure is fluoridated drinking water. Fluoride, which naturally occurs in all water sources, has been proven to slow the rate of tooth decay by as much as 49% in baby teeth and 59% in permanent or adult teeth.⁵⁵ None of Napa County's cities are fluoridated.

Older Adults

Oral health is often an overlooked component of seniors' general health and well-being and can affect general health and quality of life in very direct ways, such as pain and suffering and difficulty in speaking, chewing and swallowing. The loss of self-esteem, which can intensify isolation and possibly lead to depression, is associated with the loss of teeth.⁵⁶

⁵⁵ Centers for Disease Control and Prevention. Public Health Service report on fluoride benefits and risks. *Journal of the American Medical Association* 1991; 266(8):1061–1067.

⁵⁶ Davis DM et al. The emotional effects of tooth loss: a preliminary quantitative study. *British Dental Journal*, 188(9):503-506, May 2000.

According to the 2003 California Health Interview Survey, only two-thirds (67%) of Napa County residents age 65+ reported visiting a dentist in the last year. One of the most important predictors of dental care utilization is having dental insurance. Applying the national estimate that 78% of adults age 65+ must pay dental care expenses out of pocket to Napa County, approximately 14,979 of Napa's seniors would be projected to have to cover the cost of their dental visits and treatment without the benefit of insurance coverage.

MENTAL HEALTH

Mental health problems are among the most important contributors to the burden of disease and disability nationwide. The effect of mental health disorders on health and productivity has long been underestimated. In a study calculating disease burden, using years of life lost to premature death and years lived with a disability of specified severity, mental illness including suicide ranked second in the burden of disease, in front of cancer, respiratory conditions like asthma, and alcoholism.⁵⁷ Devastating disorders such as schizophrenia, depression and bipolar disorder, Alzheimer's disease, the mental and behavioral disorders suffered by children, and a range of other mental disorders affect nearly one in five Americans in any year.⁵⁸ Projecting this estimate to Napa County's current population, up to 26,800 persons in the county could suffer from some level of mental disorder.

Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services.⁵⁹ While depression is under-detected at all ages, much more funding is available for treating younger people, for example. A key disparity often hinges on a person's financial status; formidable financial barriers block needed mental health care regardless of whether one has health insurance with inadequate mental health benefits or lack any insurance. Despite preventive interventions that have been shown to be effective in reducing risk factors for mental disorders and improving emotional development of children and adolescents (e.g., educational programs for young children, parent-education programs, and nurse home visits), a high proportion of young people in need of treatment, close to 70% according to one assessment, do not receive needed mental health services.^{60, 61}

Approximately 20% of older adults, who face challenges coping constructively with the physical limitations, cognitive changes, and various losses, such as bereavement, that frequently are associated with late life, are estimated to experience specific mental disorders that are not part of "normal" aging. Many in the senior population have to contend with difficulties remaining in their homes due to health and financial reasons, a dearth of

⁵⁷ Murray, C. J. L., & Lopez, A. D. (Eds.). (1996). *The global burden of disease. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Cambridge, MA: Harvard School of Public Health.

⁵⁸ *Mental Health: A Report of the Surgeon General*. December 1999. www.surgeongeneral.gov.

⁵⁹ Availability and utilization of services data from the Napa County Mental Health Division's 2006 *Mental Health Services Act Plan* is in the following section of this report, Section III.

⁶⁰ Stroul, B. A. (1993b). *Systems of care for children and adolescents with severe emotional disturbances: What are the results?* Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.

⁶¹ U.S. Office of Technology Assessment. (1986). *Children's mental health: Problems and services*. Washington, DC: U.S. Government Printing Office.

community-based affordable assisted living facilities, and difficulties accessing and retaining home health services. Although Napa County has a network of senior service providers and professionals, not all are available in every geographic area. Moreover, seniors frequently find that those services are hard to access, have different and sometimes confusing criteria for qualifying, have various cost structures, and are located in a variety of agencies and organizations. Family caregivers find it increasingly difficult to be aware of the range of services as well as to navigate the various programs needed to provide for the physical, mental health, and social needs of elder loved ones.

Detailed mental illness prevalence estimates are provided by the State to counties for planning purposes. The estimates in Table 40 below and continuing onto the next two pages were calculated by applying prediction weights, developed from previous nationally prominent survey studies, to California county population demographics. (Thus the rates should be understood as reasonable estimates of serious mental illness prevalence rates, rather than counts of actual individuals.) Although there are some limitations in using the data—for example, using only the household population since some of the mental health client population is in skilled nursing facilities, residential treatment facilities, or board and care homes that are not considered households—the prevalence estimates are useful for planning purposes, particularly for those with an income below 200 percent of the poverty level, since the public mental health system is intended to serve persons who have low resources.

Table 40. Estimate of Need for Mental Health Services for Napa County Serious Mental Illness for 2000

	Total Population (HH., Inst.& Group)			Household Population			Households <200% poverty		
	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Total Pop	8065	124279	6.49	7084	119046	5.95	2368	27908	8.48
Youth age 0-17*									
Youth	2141	29998	7.14	2107	29710	7.09	783	9000	8.70
Youth total	2141	29998	7.14	2107	29710	7.09	783	9000	8.70
Age	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
0-5	671	9198	7.29	667	9169	7.28	283	3271	8.65
6-11	736	10354	7.11	732	10326	7.09	264	3022	8.74
12-17	734	10446	7.02	707	10215	6.92	236	2707	8.72
Gender	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Male	1109	15503	7.15	1081	15259	7.09	396	4540	8.72
Female	1032	14495	7.12	1025	14451	7.09	387	4460	8.69
Ethnicity	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent

Table continues on next page

1.White-NH	1148	16829	6.82	1131	16671	6.79	299	3432	8.70
2.African Am-NH	32	406	7.95	31	390	7.85	12	140	8.60
3.Asian-NH	49	718	6.86	48	708	6.72	10	124	8.17
4.Pacific I-NH	5	51	8.86	3	42	7.51	1	8	9.25
5.Native-NH	11	149	7.21	10	145	7.02	3	39	8.08
6.Other-NH	6	84	7.24	6	82	7.06	2	23	9.00
7.Multi-NH	69	957	7.25	65	932	7.00	19	219	8.72
8.Hispanic	821	10804	7.60	813	10739	7.57	438	5016	8.72
Poverty level	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
1.Below 100%	331	3310	10.00	317	3169	10.00	317	3169	10.00
2.100%-199%	467	5832	8.00	467	5832	8.00	467	5832	8.00
3.200%-299%	375	5358	7.00	375	5358	7.00	0	0	0.00
4.300%+ pov	881	14678	6.00	881	14678	6.00	0	0	0.00
5.Undefined	87	820	10.65	67	674	10.00	0	0	0.00
Residence	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Household	2107	29710	7.09	2107	29710	7.09	783	9000	8.70
Institution	10	48	21.37	0	0	0.00	0	0	0.00
Group	24	240	9.93	0	0	0.00	0	0	0.00
Adults age 18 and older									
Adult total	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Adult total	5924	94281	6.28	4978	89336	5.57	1585	18908	8.38
Age	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
18-20	487	4843	10.05	357	3885	9.18	138	1231	11.17
21-24	434	5667	7.66	416	5537	7.52	223	2466	9.05
25-34	976	15562	6.27	866	15060	5.75	300	3707	8.10
35-44	1453	18884	7.70	1300	18284	7.11	387	3558	10.89
45-54	940	18392	5.11	844	18029	4.68	170	2172	7.83
55-64	586	11847	4.95	535	11462	4.66	144	1898	7.61
65+	1048	19086	5.49	661	17079	3.87	222	3876	5.72
Gender	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Male	2343	46513	5.04	1872	43683	4.29	517	8391	6.16
Female	3582	47768	7.50	3106	45654	6.80	1067	10517	10.15
Ethnicity	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
1.White-NH	4205	69103	6.09	3496	65400	5.34	918	10659	8.62
2.African Am-NH	113	1121	10.08	46	835	5.51	21	233	8.94
3.Asian-NH	171	2923	5.86	132	2646	4.98	34	464	7.27
4.Pacific I-NH	15	203	7.53	11	178	6.39	4	46	8.65
5.Native-NH	27	493	5.46	22	451	4.88	14	163	8.54
6.Other-NH	12	142	8.53	11	139	8.21	6	49	11.42
7.Multi-NH	117	1684	6.92	104	1616	6.43	30	285	10.49
8.Hispanic	1264	18612	6.79	1156	18072	6.40	558	7010	7.96
Marital status	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Married	2456	54391	4.51	2169	52844	4.11	517	8433	6.13
Sep/Wid/Div	1967	20183	9.74	1590	18737	8.49	580	4980	11.64

Table continues on next page

Single	1502	19707	7.62	1219	17755	6.86	488	5495	8.88
Education	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Grades 0-11	1744	19389	8.99	1413	18286	7.73	707	7469	9.46
HS graduate	3477	52597	6.61	2978	49743	5.99	795	9253	8.60
College grad	703	22295	3.15	588	21307	2.76	82	2187	3.77
Poverty level	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
1.Below 100%	724	6637	10.90	676	6183	10.94	676	6183	10.94
2.100%-199%	921	12927	7.12	908	12725	7.14	908	12725	7.14
3.200%-299%	795	14065	5.65	793	14007	5.66	0	0	0.00
4.300%+ pov	2608	56605	4.61	2601	56421	4.61	0	0	0.00
5.Undefined	876	4048	21.64	0	1	8.59	0	0	0.00
Residence	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Household	4978	89336	5.57	4978	89336	5.57	1585	18908	8.38
Institution	763	3006	25.39	0	0	0.00	0	0	0.00
Group quarters	183	1939	9.45	0	0	0.00	0	0	0.00

Source: California Department of Mental Health. Statistics and Data Analysis: Prevalence Rates of Mental Disorders, Updated (January 2006) and Detailed Prevalence Rates. www.dmh.ca.gov.

(*) Youth rates based on Serious Emotional Disturbance.

Serious mental illness (SMI): is a term defined by Federal regulations that generally applies to mental disorders that interfere with some area of social functioning.

Cases: Estimated number of mentally ill meeting the cell criteria

Household (HH): A household includes all of the people who occupy a housing unit.

Institutionalized population (Inst): The institutionalized population includes people under formally authorized, supervised care or custody in institutions at the time of enumeration.

Group quarters population (Group): the non-institutionalized population, which includes all people who live in group quarters other than institutions (such as college dormitories, military quarters, and group homes).

Suicide

Suicide exacts an enormous toll on its victims and the family and friends left behind. Suicide rates, which vary by age, gender and race/ethnicity, may underestimate the true rate of intentional self-harm. For example, the stigma attached to suicide may influence classification, and certain fatal events may arise from thoughts and actions similar to suicide (e.g., single-vehicle motor vehicle crashes, gang-related fights with weapons).⁶² For the three-year average 2003-2005, Napa County ranked more favorably on deaths from suicide with an age-adjusted rate of 9.6 than about two-thirds of the counties in California, though like the rest of the State did not achieve the Healthy People 2010 objective of no more than 4.8 for this indicator. The 1999-2001 (the last year for which these data were available) suicide rate for the <18 age group in Napa County was 1.1 compared to 0.9 in California.⁶³

⁶² California Department of Health Services, *County Health Status Profiles 2007*. (Note: The suicide rate is subject to a high degree of variability due to the small number of events used to calculate rates.)

⁶³ California Department of Health Services, Vital Statistics Section. 2004.

The elderly are the highest-risk population for suicide according to the Centers for Disease Control and Prevention, but few suicide prevention programs target them—a result, advocates say, of scarce funding and lack of concern for older adults. Although they comprised only 12% of the U.S. population 2004, people age 65 and older accounted for 16% of all suicide deaths that year.⁶⁴ As the baby boomer population ages, the number of suicides among the elderly may be expected to climb.

SAFETY ISSUES

Falls Among Seniors

Among people 65 years and older, falls are the leading cause of injury deaths and the most common cause of nonfatal injuries and hospital admissions for trauma. Serious injuries from falls include hip and other fractures, and head, neck and back injuries that require significant care. Falls that result in hospitalization also are likely to cause placement in costly and restrictive long-term care facilities, significantly reduced post-fall activity, depression, anxiety and isolation. Full recovery is unlikely for a significant percentage of these survivors.⁶⁵

Hospital discharge information is currently the best falls surveillance system in California (although the data are limited to only those falls that are serious enough to warrant a hospital admission). In 2004, there were 453 nonfatal hospitalized fall injuries among older (age 60+) Napa County residents; about two-thirds of these falls were by women. Napa County has a greater-than-average ratio of falls resulting in hospitalization when compared to hundreds of other cities. In 2004, the average cost of hospitalized stay for fall injuries among Napa County seniors was approximately \$41,000.⁶⁶ Cost data broken out by age group is displayed in Table 41.

Table 41. Average Cost of Hospitalized Stay Due to Fall Injuries Among Napa County Residents, 2004

Age Group	Number of Persons	Average Cost
60-64	27	\$49,074
65-69	38	\$60,735
70-74	39	\$31,688
75-79	55	\$35,437
80-84	116	\$39,503
85+	178	\$31,118

Source: 2004 California Patient Discharge Data, Office of Statewide Health Planning and Development and California Department of Health Services.

⁶⁴ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (WISQARS) www.cdc.gov/ncipc/wisqars.

⁶⁵ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2006). www.cdc.gov/ncipc/wisqars.

⁶⁶ California Department of Health Services, Epidemiology, Prevention and Injury Control Branch, Hospital Discharge Data, some data reported in Fall Trends by County June 6, 2006, Fall Prevention Center of Excellence, USC.

Domestic Violence

While it is difficult to gauge the extent of domestic or intimate partner violence in a community, particularly as it occurs most often behind closed doors, the number of law enforcement calls for assistance is used as the primary indicator. Another indicator is the percentage of domestic violence calls that involved weapons. Domestic violence continues to grow in numbers of reports to law enforcement. It is estimated that a large number of incidences go unreported, however. In Napa County, there were a total of 2,461 calls in the five-year period 2001-2005, 862 (35%) involving weapons (Table 42). In 1998, the most recent year for which domestic violence arrest data were available, 109 arrests for this purpose were reported.

Table 42. Total Number of Total Domestic Violence Calls and Calls Involving Weapons

Category	2001	2002	2003	2004	2005
Total calls	438	459	460	567	537
Calls involving weapons	172	181	172	149	188

Source: California Department of Justice, Office of Criminal and Justice Planning, reported in RAND California Community Statistics <http://ca.rand.org/cgi-bin/annual>.

Available data on the number of domestic violence calls for the City of Napa, which represent the largest number of calls in the county due to the city's population size, for a slightly earlier five-year period (Table 43), are broken out by type of violence and show that most are categorized as non-aggravated assaults.

Table 43. Number of Domestic Violence Calls by Type of Violence, City of Napa

Type of violence	1999	2000	2001	2002	2003
With firearm	3	2	3	5	3
With knife or cutting instrument	5	10	4	7	6
With other dangerous weapon	14	13	23	26	25
With hands, fists, feet, etc.	29	26	37	13	27
Simple assault, not aggravated	259	238	268	272	294

Source: City of Napa Police Department. Annual Report 2003.

Child Abuse

Child abuse is a serious problem with numerous long-term consequences. Children who experience maltreatment are at increased risk for adverse health effects and behaviors as adults—including smoking, alcoholism, drug abuse, eating disorders, severe obesity, depression, suicide, sexual promiscuity, and certain chronic diseases.⁶⁷ Napa County offers a full range of services for children who are or may be maltreated within their families. Over the last three years, the rate at which the Child Abuse Hotline has received child abuse referrals as compared to the general population have decreased as noted in Table 44.⁶⁸ Likewise, the rate of children per 1,000 where child abuse has been substantiated has also decreased.

Table 44. Emergency Child Abuse-Related Response Dispositions per 1,000 Population Under Age 18

Year	Total Child Population (Age 0 – 17o)	Children with Referrals	Incidence Per 1,000 Children	Children with Substantiations	Incidence per 1,000 Children	% of Referrals
2004	30,919	1,250	40.4	156	5.0	12.5
2005	30,972	1,207	39.0	145	4.7	12.0
2006	31,074	1,051	33.8	136	4.4	12.9

Source: California Department of Social Services, Statistical Services Bureau.

Elder Abuse

Elder abuse is a serious problem that is said to live in the shadows of most communities and go largely unreported. California Department of Social Services Adult Protective Services (APS) data show that the number of active cases statewide has been steadily increasing in recent years. Cases of self-neglect and neglect by caregivers are making up a larger proportion of total types of abuse and neglect than in the past. The majority (83%) of confirmed cases of self-neglect in the elder population are in three categories: physical care, health and safety standards, and medical care. It is not clear how much of the increase is due to the growth in the senior population, more awareness and reporting, and more actual occurrences. The most common confirmed cases of abuse perpetrated by others are financial and psychological/mental. Annual violent crimes committed against seniors for Napa County for the period 1990-1998 (the last year for which data are available) are displayed in Table 45. Annual data extrapolated for 1999-2000 showed that of the 7 total reported cases for elder abuse, 4 were found to be conclusive, 2 were inclusive and 1 was unfounded. APS reports that most (78%) cases that are found to be inconclusive upon investigation receive services nevertheless.

⁶⁷ Felitti V, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine* 1998;14(4):245–58.

⁶⁸ University of California Berkeley Center for Social Services Research website. <http://cssr.berkeley.edu/CWSCMSreports/Referrals/rates>

Table 45. Reported Violent Crimes Committed Against Senior Citizens, 1990-1998

Napa County	1990	1991	1992	1993	1994	1995	1996	1997	1998
	2	5	10	9	13	4	9	1	7

Source: California Department of Justice, Office of Criminal and Justice Planning, reported in RAND California Community Statistics <http://ca.rand.org/cgi-bin/annual>.

Exposure from the Physical Environment: Pesticides

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

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

Agricultural pesticides can either be applied by the property owner/operator or by a licensed Pest Control Operator (PCO). Many vineyards are managed by vineyard management companies and when these companies use pesticides they must be licensed PCOs. The most hazardous pesticides are designated as Restricted Materials in California and whether grower or PCO-applied required a Restricted Material Permit issued by the County Agricultural Commissioner for purchase and/or use.

In the wine grape industry, the most common pesticide applied is sulfur. Sulfur provides protection against powdery mildew. Sulfur dust is organic and considered relatively safe to use. All of EPA's toxicology data requirements for sulfur have been satisfied for a number of years. Sulfur is known to be of low toxicity, and poses very little if any risk to human health. Short-term studies show that sulfur is of very low acute oral toxicity and does not irritate the skin. However, sulfur can cause some eye irritation, dermal toxicity and inhalation hazards (it has been placed in Toxicity Category III for these effects).⁶⁹

People can be exposed to sulfur while mixing, loading or applying the pesticide, and while working among treated crops. Based on incidents of skin and eye irritation reported among field workers in California, EPA has determined that a hazard exists for workers reentering

⁶⁹ Pesticides and Toxic Substances, *Sulfur, R.E.D. Facts*, U.S. Environmental Protection Agency. May 1991. www.epa.gov

fields following foliar application of sulfur dust. Therefore, a 24-hour reentry interval and protective clothing requirements must be added to the labeling of all outdoor use sulfur products.⁷⁰

Pesticide-related illnesses have been tracked within the state of California for more than 50 years. The California Department of Pesticide Regulation, Pesticide Illness Surveillance Program (PISP), maintains a database of pesticide-related illnesses and injuries. Case reports are received from physicians and via workers' compensation records. The local County Agricultural Commissioner investigates circumstances of exposure. Medical records and investigative findings are then evaluated by DPR technical experts and entered into an illness registry. These data help validate the effectiveness of exposure mitigations and identify areas where improvements are needed. A total of 1,323 total cases were reported in California in 2005 as potentially related to pesticide exposure; of these, 811 had an intended use related to agriculture. Of the incidents specifically involving *field workers*, 9 systemic/respiratory illnesses were concluded to be possible and 1 definite/probable; 16 topical conditions were concluded to be possible and 2 definite/probable.

A summary of pesticide illness/injury incidents due to all causes in Napa County in 2005 reported as potentially related to pesticide exposure is shown in Table 46. For its size, the number of agriculture-related incidents in Napa County is relatively low.

Table 46. Summary of Illness/Injury Incidents Reported in Napa County as Potentially Related to Pesticide Exposure, 2005.

Relationship	Total Cases	Type of Exposure			Intended Use		
		Direct Contact	Drift	Residue	Other/Unknown	Agricultural	Non-Agricultural
Definite	2	2	0	0	0	1	1
Probable	1	0	1	0	0	0	1
Possible	3	0	0	0	3	3	0
Unlikely	2	0	0	1	1	1	1
Unavailable	1						

Source: California Department of Pesticide Regulation, Pesticide Illness and Surveillance Program, 2005.

⁷⁰ Ibid.

PREVENTIVE/PROTECTIVE HEALTH

Vaccination

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

The annual kindergarten assessment is conducted each fall to monitor compliance with the California School Immunization Law. Results from this assessment are used to measure immunization coverage among students entering kindergarten. (The annual Kindergarten Retrospective Survey (KRS), on the other hand, provides estimates of immunization coverage among kindergarten students *at various age checkpoints*; county-level data from the KRS are not available.) Napa County reported 94.4% of kindergarten entrants had all of their required immunizations at kindergarten entrance, a slightly higher percentage than the statewide average (Table 47).

Table 47. Selected Immunization Results from the 2006 Kindergarten Assessment

Element	Napa	California
<i>Admission status</i>		
Entrants with all required immunizations	94.4%	92.7%
Conditional entrants	4.1%	5.4%
Entrants with permanent medical exemptions	0.1%	0.2%
Entrants with personal belief exemptions	1.5%	1.4%
<i>Number of schools reporting</i>		
Public	63.8%	67.2%
Private	36.2%	32.8%

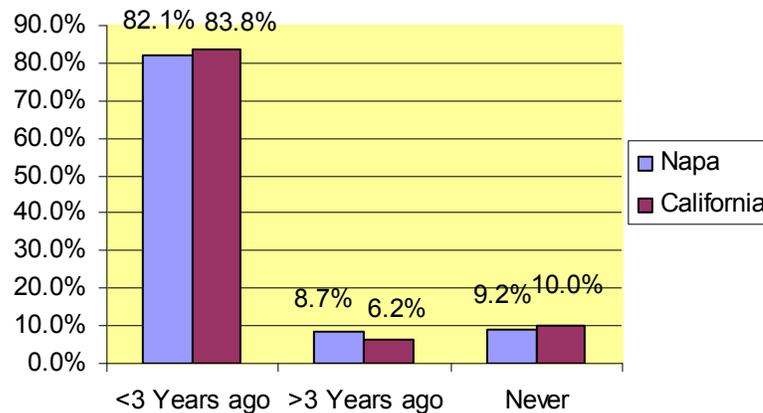
Health Screening for Cancer

Cancer is the second leading cause of death in the nation, and is also one of the most common chronic diseases. Critical health indicators commonly monitored for community health include cancer screening for cervical, breast, prostate and colorectal cancers. While it has always been difficult to get some people to go for cancer screening, it can be particularly challenging when financial barriers limit access or cultural beliefs influence utilization. In general, Napa County rates of cancer screening are more favorable than both state rates and national health objectives.

Cervical Cancer Screening

The Healthy People 2010 Objective is that at least 90% of women age 18 and older will have received a Pap test for cervical cancer during the past three years. The 2005 California Health Interview Survey (CHIS) asked about Pap test history. Eighty-two percent of women in Napa County reported having a Pap test within the last three years, 8.7% reported it had been more than three years since their last test, and 9.2% reported never having had a Pap test. The county's rates compare favorably with statewide averages (Figure 10), however neither meet the national health objective (Healthy People 2010) of 90% within the past three years and 97% ever having a Pap test.

Figure 10. Pap Test History



Because cervical cancer is a preventable disease, incidence of this cancer can be reduced through public health interventions, such as education on cervical cancer risk factors, especially HPV infection. Mortality could be reduced and virtually eliminated through regular screening and early detection of the disease through a Pap smear.

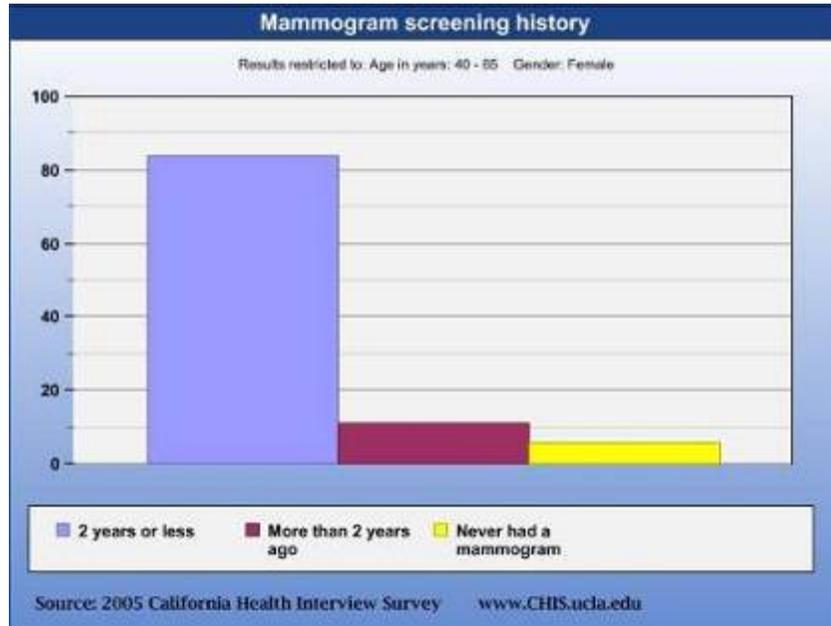
Breast Cancer Screening

Earlier detection for breast cancer through regular screenings can greatly increase survival rates of breast cancer because it identifies cancer when it is most treatable.⁷¹ At this time, mammography along with physical breast examination by a clinician is still the modality of choice for screening for early breast cancer. Napa County data from the 2005 CHIS show that 83.6% of women age 40-85 had a mammogram in the past two years (Figure 11),

⁷¹ "Effects of chemotherapy and hormonal therapy for early breast cancer on recurrence and 15-year survival: an overview of the randomised trials," early breast cancer trialists' collaborative group (EBCTCG), *The Lancet*, Vol 365, May 14, 2005, pp1687-1717

exceeding the national health objective (Healthy People 2010) of 70% and the proportion (61.9%) of California women who reported doing so.

Figure 11.



Colorectal Cancer Screening

Cancers of the colon and rectum account for 15% of cancer deaths and are second only to lung cancer as the leading cause of death in the U.S.⁷² Screening has been shown to have great effect on both cancer prevention and cancer survival rates,⁷³ but the challenge lies in making the test (colonoscopy/sigmoidoscopy) accessible to all adults at the appropriate age and schedule, and also in assuring that people actually follow through on recommendations to be screened. Survival from colon and rectal cancer is nearly 90% when the cancer is diagnosed before it has extended beyond the intestinal wall. In 2002, about 38% of colon and rectum cancers diagnosed in California were early-stage—compared to about 75% for prostate and 66% for breast cancer.⁷⁴

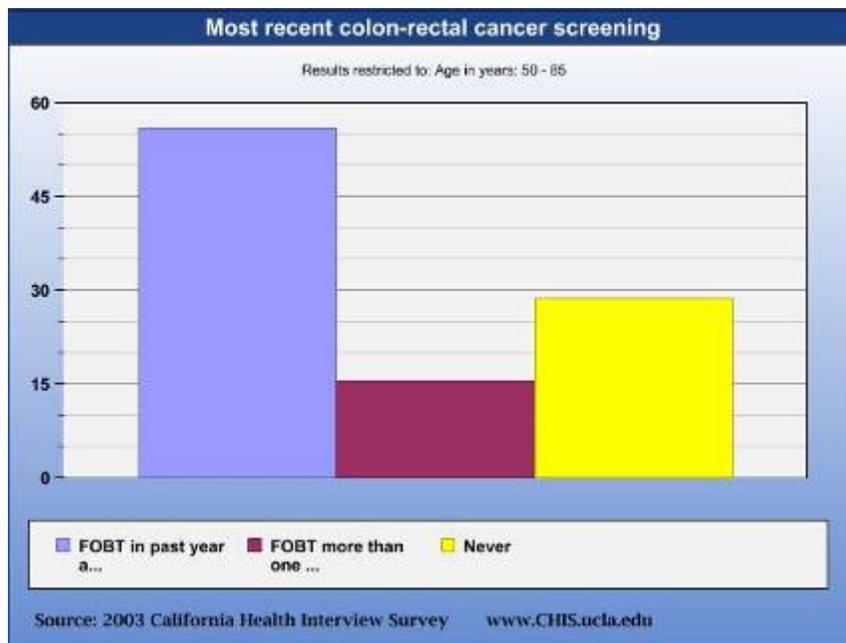
⁷² Parker SL, Tong T, Bolden S, Wingo PA. Cancer statistics, 1997. *CA Cancer J Clin* 1997;47:5-27.

⁷³ Read TE, Kodner IJ. Colorectal cancer: risk factors and recommendations for early detection. *Amer Fam Physician* June 1999;59(11):3083-88.

⁷⁴ *California Cancer Facts & Figures, 2007*. American Cancer Society, California Division and Public Health Institute, California Cancer Registry, September 2006.

When Napa County adults age 40 and older were asked about the most recent colorectal cancer screening in the 2003 California Health Interview Survey, more than one half (56%) said they had had such a test for this cancer within the past five years (only 38.4% of Californians reported doing so), exceeding the national health objective; 15.4% had had the test but it had been more than five years ago; and one quarter (28.6%) said they had never had such a test for this cancer (Figure 12). The national health target (Healthy People 2010) is to increase to 50% the proportion of adults age 50+ who have ever had a sigmoidoscopy; no Healthy People 2010 target has been set for the proportion of adults who should receive colonoscopy screenings.

Figure 12.



Note: Results in the bar graph are displayed for the following levels: FOBT fecal occult blood test in past year and/or colonoscopy/sigmoidoscopy in past 5 years; FOBT more than one year ago and/or colonoscopy/sigmoidoscopy more than 5 years ago; Never.

These apparently high colon cancer screening rates in Napa County belie a major disparity in screening, however. The CHIS findings cited above may not adequately represent low-income older adults, especially Latinos, who are less likely to have access to or be able to pay for these tests. Unlike cervical and breast cancers, there is no State- or federally-funded program to subsidize or cover colorectal cancer screening. If Napa County is similar to the rest of California, Latino adults age 50+ are about one-third less likely than Non-Latino Whites to have had a sigmoidoscopy/colonoscopy in the last five years.⁷⁵

⁷⁵ Ibid.



Section III. Health Resource Availability

“Having a ‘medical home’ with health insurance means a lot to make people feel hopeful that Napa [vs. Mexico] is their home.”—Director of a local agency

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

ACUTE CARE HOSPITALS⁷⁶

Hospital Utilization

In 2006, there were 349 available beds reported by the two Napa County acute care hospitals. The overall reported hospital occupancy rate in 2006 was approximately 71% at QVH and 46% at St. Helena (lower than the statewide average of 62%). Overall, there were 72,731 hospital patient days reported for this period.

Hospital Outpatient Visits

A total of 274,395 outpatient visits (2.05 per 1,000 population) was reported by the two hospitals in 2006. Except for 2002, the number has steadily risen each year since 2000.

⁷⁶ The source for the hospital utilization data reported in this section is *Perspectives in Healthcare, California and by County*. Office of Statewide Health Planning and Development, 2004.

Emergency Department Visits

The two hospitals with emergency departments (ED), Queen of the Valley Medical Center and St. Helena Hospital, reported a total of 31,153 visits to the ED in 2006 (an average of 4.4 visits per county resident), 25,395 and 5,758 visits to each ED, respectively (Table 48). Approximately 13% of QVH and 18% of St. Helena ED visits resulted in admission to the hospital in 2006, a figure that has remained fairly constant since 2000. Of the ED visits, on average approximately 2% were considered non urgent, 11% urgent, 36% moderate, 29% severe and 22% critical according to standard definitions used in hospital reporting.

Table 48. Emergency Department Visits, all Napa County Hospital EDs

	Visits	Visits per 1,000	Avg. % Visit Result in Admit
2000	28,390	223	15%
2001	35,010	271	15%
2002	24,960	194	13%
2003	24,509	187	13%
2004	24,411	184	15%
2005	31,448	235	16%
2006	31,153	229	16%

Source: Office of Statewide Health Planning and Development.

The 10 most common problems or symptoms which brought people to the emergency department in 2006 were somewhat similar between the two hospitals, although not in the same order of purpose for the visit (Table 49).

Table 49. Top 10 Reasons for Emergency Department Visits,* 2006

Queen of the Valley	St. Helena Hospital
1. Chest pain	1. Open wound of finger
2. Headache	2. Abdominal pain, unspecified
3. Open wound of finger	3. Sprain of ankle
4. Acute pharyngitis	4. Syncope and collapse
5. Otitis media	5. Sprain of neck
6. Bronchitis	6. Otitis media
7. Urinary tract infection	7. Follow-up exam neck
8. Fever	8. Chest pain
9. Acute upper respiratory infection	9. Urinary tract infection
10. Abdominal pain, unspecified	10. Contusion face/scalp/neck

Source: QVH and St. Helena Hospital

*Note: these are the top 10 visits, not the top 10 that led to admissions.

COMMUNITY-BASED AND SPECIALTY HEALTH CLINICS

Community Health Clinic Ole

Community Health Clinic Ole was founded in 1972 as the first clinic in Napa County to provide health care to local and migrant agricultural workers. According to community feedback obtained for this study, this non-profit organization is widely viewed as a vital asset for providing high quality safety net medical and dental services in Napa County. Clinic Ole is now a federally Qualified Health Center providing primary medical and dental care services in various locations in the county (Table 50). The organization is currently exploring options for opening a clinic in the rapidly-growing area of American Canyon. Days and hours of operation vary, and some sites offer services in the evening and on Saturdays.

Table 50. Clinic Ole Locations and Type of Services Provided (July 2007)

	Medical Services	Dental Services
St. Helena	x	
Calistoga	x	x
Napa	x	x
Napa Valley College Student Health	x	
Hope Center	x	
South Napa Shelter	X	

Source: Community Health Clinic Ole.

While accommodation at all Clinic Ole sites is made for drop-in patients (and appointment no-shows are back-filled with drop-ins), according to staff the waiting time for a non-urgent service can be 2-4 weeks depending on the location. Approximately 17 full-time equivalent licensed primary care providers, including dentists and licensed clinical social workers, are employed by the organization. Many of the staff is bilingual and bicultural. Adequate space is more of a problem than the supply of staff in limiting Clinic Ole's capacity to serve more clients.

In fiscal year (FY) 2006/07, Clinic Ole provided medical services to 14,007 clients; these services were provided at 40,119 visits (2.9 visits per client). Close to half (45%) of the patients are farmworkers and their family members. Nearly three-quarters (70%) are Latino and 55% prefer to speak Spanish.

Kaiser Permanente

Kaiser Permanente Medical Offices in Napa County provide services in the following departments: allergy, dermatology, eye care, internal medicine, optical sales, lab and radiology including mammography services, occupational health services, pediatrics, physical therapy, plastic surgery and women's health. Some services are by referral only.

Health education services offer classes, lend books and videos and health-related pamphlets.

Planned Parenthood

Planned Parenthood (PP) Shasta Diablo, which has clinic sites in a number of northern California counties, operates one clinic in Napa County, in the City of Napa, where it offers comprehensive reproductive health services. In 2006, a total of 3,635 low-income women and men made 5,378 clinic visits to the Napa PP clinic. The majority (91.5%) of the clients served were women and 26% were clients age 18 and under. Of the 44% of clients who are Latina, 30% are monolingual Spanish-speaking.

In addition to clinic services, PP offers health education through presentations at community programs. In 2006, 7,500 individuals, including parents of adolescents, received community health education services.

St. Helena Obstetrics and Gynecology

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

The Women's Center of St. Helena Hospital

The Women's Center offers programs and services designed to promote physical, emotional and psychosocial well-being, and educate in a way that encourages people to actively participate in their own health care. The Center provides mammography and bone density testing, and also has a health resource library and offers a variety of community health education events. Additionally, the Center houses the Heart-at-Risk program that provides health screenings in the community and at local businesses.

Napa Valley Women's HealthCare Center

Napa Valley Women's HealthCare Center (NVWHC), part of the Queen of the Valley Medical Center, provides a full range of obstetrical, including high-risk, and gynecological care that includes cancer prevention and detection, endocrinology evaluation, pre-pregnancy counseling, menstrual disorders, premenstrual syndrome (PMS) and menopause counseling and treatment. NVWHC offers both surgical and medical approaches to women's health. A number of procedures are performed in the office setting, such as diagnostic hysteroscopy, sonography, colposcopy, and cryosurgery. Additionally, the physicians specialize in minimally invasive surgery with many outpatient procedures and short hospital stays. The minimally invasive robotic surgery program is among the busiest in the United States, with same day or one day stays in the hospital.

Dental Services

Children's Mobile Dental Clinic

In 2003, children's oral health was identified as one of the most compelling health needs by pediatricians, schools, health and human services agencies and families in Napa County. At that time, Napa County ranked 58th out of California's counties in low-income children accessing dental care. The average utilization rate in California was 40% while in Napa the utilization rate was 26%. For children 0-5, Napa County's average utilization was only 13%.⁷⁷ In response to the overwhelming need, in 2004 Queen of the Valley Medical Center, in partnership with Sister Ann Community Dental Clinic, schools, resource centers and faith-based organizations implemented a Children's Mobile Dental Clinic. By June of 2007, the clinic had provided comprehensive dental services at five sites countywide to nearly 1,000 children ages 0 to 16 years, and averaged 200 visits per month. In addition to dental services, the mobile clinic provides access to health resources including insurance enrollment and health promotion and education for the entire family.

Sister Ann Community Dental Clinic

Sister Ann Community Dental Clinic⁷⁸ is the primary source of low fee and Medi-Cal subsidized dental care serving all age groups in Napa County.⁷⁹ In FY 2006/07, the clinic provided dental services to 5,335 users at 12,746 visits (1.33 visits/ patient). Dental services include cleaning, examination/X-rays, fluoride treatments, sealants, fillings, oral hygiene instruction, minor oral surgery, emergency dental care and dentures for seniors.

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

PHYSICIAN AND DENTIST SUPPLY

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

⁷⁷ California Dental Medi-Cal Information Management Report, State of California Denti-Cal Statistics, January 2003.

⁷⁸ Sister Ann was originally established in 1989 as Queen of the Valley Hospital Children's Dental Clinic. In 1991, a community-led effort to increase access to dental services resulted in the creation of the Napa Valley Community Dental Clinic. Ten months later, the clinic was renamed Sister Ann Community Dental Clinic to honor Sister Ann McGuinn who guided the effort to create it. And, in April 2007 Sister Ann Community Dental Clinic and Community Health Clinic Ole merged into one organization that allows Sister Ann Community Dental Clinic to continue its growth and expansion.

⁷⁹ Queen of the Valley Hospital mobile dental clinic serves only children ages 0-16. Approximately, 1000 children annually are served by this resource.

The adequacy of physician supply is generally evaluated based on the number of physicians per 100,000 civilian population, a useful benchmark for gauging adequacy. According to the Council on Graduate Medical Education (COGME), the national commission that publishes ranges for physician supply requirements, an appropriate range for *overall* physician supply is 145-185 patient-care physicians per 100,000 population.⁸⁰ With 320 non-federal, patient-care physicians active in Napa County in 2000, the county had 252 patient-care physicians per 100,000 population.⁸¹ Napa thus ranks high relative to the physician requirements estimated by COGME, exceeding the upper range of estimated requirements. As a comparison, the neighboring county of Solano ranks at the lowest end of the range requirements, while Sonoma ranks somewhat high (Table 51).

The COGME requirement estimates for *generalist* physicians (family practice, general practice, general internal medicine and general pediatrics) is 60-80 per 100,000 population, and for *specialists* it is 85-105 per 100,000 population. In 2000, Napa exceeded the upper ranges for both of those supply estimates, with 85 generalists per 100,000 population and 167 specialists per 100,000 population. Although Solano has a less adequate supply than either Sonoma and Napa counties, all three counties have generalist and specialist care physician ratios that are within or exceed the upper bound of COGME's estimated requirements.

Table 51. Active Patient-Care Physicians and Ratio to Population, Napa and Selected Comparison Counties

Area	Population In 2000	N of Pt. Care MDs	Ratio of Pt. Care MD:100K Pop.	N of Primary Care MDs	Ratio of Primary Care MD:100K Pop.	N of Specialists	Ratio of Specialists: 100K Pop.
Napa County	127,000	320	252	108	85	212	167
Sonoma County	450,100	985	219	394	88	591	131
Solano County	399,000	583	146	241	60	342	86
California	34,336,380	65,098	190	23,137	67	41,961	122

Totals = Active patient care physicians with Major Professional Activity of office-based (including locum tenens) and hospital staff; excludes residents, federal physicians, non-classified MPA, "other" MPA, inactive physicians and physicians with MPA in non-patient care activities.

Generalists = Family practice, general practice, internal medicine and pediatrics.

Specialists = Non-generalists, including unspecified specialty designations.

Sources: AMA Masterfile, 2000; CA Department of Finance, May 2000.

According to available data, 113 licensed dentists are in active practice in Napa County, the greatest majority (79%) located in the City of Napa (Table 52). Of these 113 dentists, 88 are considered general or primary care dentists. At 3.3 primary care dentists per 5,000

⁸⁰ Council on Graduate Medical Education, 1996; Council on Graduate Medical Education, 1995.

⁸¹ American Medical Association, 2000; California Department of Finance, 2000.

population, Napa County is considered to have a “medium” supply of general dentists according to the dentist-to-population ratios established by the American Dental Association.⁸² Only Sister Ann Dental Clinic, however, takes patients with Denti-Cal (the dental benefits program of the Medi-Cal program).

Table 52. Number of Dentists in Active Practice in Napa County by Type and Location

<i>Type of Dentistry</i>	City							<i>Total</i>
	Napa	Calistoga	St Hel	Yntville	Amer Canyon	Ruthfrd	Angwin	
General	67	2	10	1	4	1	3	88
Endodontics	3		1					4
Oral Surgery	5							5
Orthodontics	5		1					6
Pediatric	2							2
Periodontics	3							3
Prosthodontics	3		1					4
Public Health	1							1
<i>Total</i>	89	2	13	1	4	1	3	113

Source: California Dental Association Masterfile, Aril 2007.

PUBLIC HEALTH SERVICES

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

MENTAL HEALTH SERVICES

Napa County Mental Health Division, under contract with the California Department of Mental Health, arranges for or provides specialty mental health services to Medi-Cal beneficiaries. However, initial emergency services are available to anyone in crisis regardless of Medi-Cal status. Specialty mental health services are special health care services for eligible individuals who have a mental illness or emotional problem that a primary care physician cannot treat. These specialty services are provided through the Division's Mental Health Plan either directly by County staff or through contracts with

⁸² The ratios are estimates based on American Dental Association 1998 data and 1998 population projections. The primary care dentist-to-population range for a “medium” supply of dentists is 3:5,000 – 5:5,000. Napa County’s supply of general dentists is at the low end of this range.

community-based organizations. They are provided on an outreach basis, at on-site locations and in other locations in the community. A full range of emergency and continuing services are offered, including the following: homeless mentally ill outreach, psychiatric emergency response, psychiatric medications, child, adult and gero-psychiatric case management and outpatient therapy.

Napa County Mental Health carried out a needs assessment and community input process as part of its work in developing the *2007 Mental Health Services Act Plan*. Tables 53-55 reflect selected usage data from that assessment.

Mental health service usage in Napa County, at least in 2003-2004, was generally not proportionate to the population for several of the non-White race/ethnic groups. The service use disparity was greatest for Latinos, who are not typically accessing mental health services, data that was corroborated by Mental Health and community input. In part this may be due to a serious shortage of bilingual and bicultural mental health professionals in the county as elsewhere in California.

Table 53. Napa County General Population by Race/Ethnicity, Mental Health Service Use, 2003-04

Race/Ethnicity	% of Gen Pop	% of Napa County MH Service Use	Disparity
American Indian	1.0%	.8%	-.2%
Asian	3.5%	1.0%	-2.5%
African American	1.6%	2.6%	+1.0%
Hispanic	26.9%	13.0%	-13.9%
Multirace/Other	1.8%	2.2%	+.4%
Pacific Islander	0.2%	.8%	+.6%
White	65.0%	79.6%	+14.6%
Total	100.00%	100.00%	

Source: Napa County Community Services and Support Plan, Part II, 2007.

Older adults are the most significantly underserved age group for mental health usage in Napa County regardless of gender. (Older adults who are White, however, are overrepresented.) Female children age 0-15 are also underrepresented in usage of mental health services. About two male children are served for every female child. There are no differences in usage by gender for youth, and their rate of use, as with adults' rate of use, is in proportion to their percentage of the population. As with children and youth, while Latino adults represent about 27% of the general population, only about 3% of those using mental health services and supports are Latino.

Table 54. Napa County General Population by Age, Gender and Mental Health Service Use, 2003-04

Age Group and Gender	% of Gen Pop	% of Napa County MH Service Use	Disparity
0-15 Female	10%	7%	-3%
0-15 Male	11%	15%	+4%
16-25 Female	6%	10%	+4%
16-25 Male	7%	10%	+3%
26-59 Female	23%	26%	+3%
26-59 Male	23%	23%	0%
60+ Female	11%	5%	-6%
60+ Male	9%	4%	-5%
Total	100.00%	100.00%	

Source: Napa County Community Services and Support Plan, Part II, 2007.

While Table 55 indicates that mental health usage rates are lower than the percentage of total population in all major population areas other than Napa, the disparity is likely even higher. Opportunities for mental health services and supports from Napa County Mental Health are extremely limited in those areas. Individuals who require mental health services must typically travel to Napa.

Table 55. Napa County by Major Population Centers and Mental Health Service Use, 2003-04

City/Town	% of Major Population Areas	% of Napa County MH Service Use
Napa	75%	87%
Calistoga	5%	2%
St. Helena	6%	2%
American Canyon	14%	9%
Total	100.00%	100.00%

Source: Napa County Community Services and Support Plan, Part II, 2007.



Section IV. Other Related Assessments

"The amount and spectrum of passion in this Valley to develop and fund services is remarkable."—Director of a local agency

Previous related community-based studies and needs assessments helped to inform the present community health needs assessment. The following information and data is a summary of data sources the Health Collaborative reviewed when setting priorities.

FIRST 5 NAPA COUNTY

First 5 Napa County Children and Families Commission *2007 Community Plan* updated earlier plans and provides a brief overview of basic county geography and limited demographics related to children age 0-5. The Plan contains a brief description of needs and barriers related to each of its goal areas, including early childhood health. The Commission identified specific strategies to meet the identified needs and achieve the goal of improving access to care. The following is a sample of some of the strategies:

- Increase availability of home visits to all families of newborns.
- Provide assessment and support services for post-partum depression.
- Develop initiatives to address children's needs in the areas of oral health, nutrition and obesity.
- Improve access to affordable health insurance and health care linkages for uninsured families.
- Increase the use of prenatal care resources in the first trimester of pregnancy.
- Provide parent education focused on parent's role in providing and accessing preventive care for their children 0-5.

First 5 also works to promote the prevention, early identification and intervention in health and developmental issues with two Focused Funding Initiatives: the Infant-Parent Mental Health Project and the Children's Health Initiative.

MENTAL HEALTH SERVICES ACT PROGRAM PLAN

The Mental Health Services Act⁸³ (MHSA) Program Plan, approved by the Napa County Mental Health Board and the Mental Health Director, identifies the funding priorities for FY 2005-2008 that will guide the use of MHSA funds in Napa County. The Plan was developed after an eight-month community input and prioritization process, and provides funding for six broad components of new or expanded activities and services from this significant source of new funding:

1. Community Program Planning
2. Community Services and Supports (Systems of Care Services) for children, youth (including transitional aged), adults and older adults.
3. Capital Facilities and Technology
4. Education and Training Programs
5. Prevention and Early Intervention Programs
6. Innovative Programs

Over six hundred community members participated in some aspect of the community planning process. Of that number, about 37% were consumers and family members. In terms of ethnicity, an estimated 12% were Latinos.

Major Themes from Community Forums and Surveys

The following were the major issues and concerns identified by the community forum participants and surveys:

- Create a physical “presence” throughout the County of all community mental health services. Ideas included a mobile assessment team, a mobile crisis team, and locating mental health services alongside other health services.
- More bilingual/bicultural professionals and services and supports that reflect cultural competence.
- Outreach, education and mental health services and supports for the underserved Hispanic community, transitional aged youth and older adults.
- Education and information regarding mental health services for both individuals and families seeking mental health services and community “anti-stigma” education.
- Different approaches to providing treatment services (e.g., in-home for seniors, wraparound services for individuals with co-occurring disorders).
- More professionals who specialize in the psychiatric issues of older adults as well as expanded services and supports (for example, in-home).
- Expanded crisis services that include follow-up services, medication monitoring and service coordination.
- ‘Some place to be, some place to belong’ for adults with mental illness who want

⁸³ The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. To provide for an orderly implementation of MHSA, the California Department of Mental Health has planned for sequential phases of development for each of the components. Eventually all these components will be integrated into comprehensive plans with a continuum from prevention and early intervention to comprehensive, intensive interventions for those in need.

- to be a part of their community (for example, life skills, vocational services).
- A 'navigation' system for individuals and families who are new to the mental health system (for example, family-to-family mentors).
- Residential services for individuals with dual diagnoses.
- Transportation to mental health and related services and supports.
- Support groups for individuals with mental illness as well as their caregivers.

Recommendations for Programs or Strategies to Address Community Issues

The Stakeholder Work Groups used information from the community forums and surveys to develop programs or strategies in response to the identified community issues above. A sample of these by priority population includes:

Children

- A countywide, multi-ethnic program to provide education, training and follow-up services for parents and other caregivers in co-parenting, conflict resolution and support for both 'at-risk' children and children with significant mental illness.
- Recruit and train more mental health care professionals who specialize in treating children with significant mental illness and their families.
- A collaborative, comprehensive plan and implementation of countywide bilingual and bicultural community outreach, education, training and support designed to: (1) educate about early intervention; (2) reduce stigma and resistance regarding individuals with mental illness; (3) provide information about mental health services and supports.

Transitional-Aged Youth (TAY)

- Collaborative Public Education campaign (PEC) developed by community members, agency staff and youth. PEC will include youth developed materials that will utilize: flyers, PSA, e-mail/internet, classroom presentations, networks of churches, youth groups, sports groups, and other community groups.
- Develop a ride by request system to be able to transport TAY to different service delivery locations. Offer bus vouchers for TAY needing transportation assistance. Coordinate carpools amongst support group attendees.
- Educate TAY, parents, and caregivers about existing free and low cost services. Offer vouchers or a reduced rate (pay what you can) for individuals who qualify.
- Include depression screening and suicide prevention services in a public education campaign.

Adults

- Create capacity among public and private community mental health services and supports for serving bilingual and bicultural individuals, and provide mentoring and training for new staff in cultural competency and sensitivity.
- Recruit and train additional bilingual and bicultural staff.
- Use existing Latino services and supports and other community services.

- Recruit service providers in the Up Valley and American Canyon areas.
- Support a countywide program for individuals with dual diagnoses that is consumer-driven, bilingual/bicultural, and community-based.

Older Adults

- Identify and assess mentally ill seniors through screening in natural settings and refer for assessment with a uniform screening tool in primary medical care, shelters, hospitals, jails, homes or other settings.
- Provide wraparound services in the least restrictive environment.
- Develop capacity to identify quality care and support through a training program for gatekeepers such as senior center or shelter staff, police, bus drivers, utility workers to identify and refer those in need of referral and use of screening tools as appropriate.
- Increase the quantity of caregivers (professional and paraprofessional staff) able to provide quality culturally competent services to seniors with mental health problems.
- Provide education and support services to family members and others caring for seniors with mental health problems.

Latinos

- Conduct a countywide satisfaction survey of existing service offerings and gaps.
- Implement a coordinated plan (county system as well as community based organizations) to improve the uniformity of how information and resources are communicated to the Latino population.
- Motivate the community to be educated about their resources and benefits of using the services.
- Launch a fund development plan to build new or modify existing community service centers.
- Design program sites to be multi-service oriented with potential for generating revenue (space rental) to increase utilization and sustainability.
- Increase access to services for monolingual populations.
- Employ more bilingual and bicultural staff at all levels of service delivery.
- Sponsor family budget/money management training for families to support their child's education and pursuit of careers in mental health services.
- Provide integrated services to avoid the duplication of services.

The Community Services and Supports Program Workplan lists the program element (e.g., Project Access) and funds requested of the State by fund type (e.g., Outreach and Engagement) and age group (e.g., Transitional Age Youth), by amount (e.g., \$173,425), and by fiscal year (e.g., 2005-06) for each of the three fiscal years. Latinos, particularly the non-English speaking, are recognized as under-served and are a priority population in the Plan. Readers of the present needs assessment report who wish additional details about the MHSA Plan may view it at www.co.napa.ca.us, Health and Human Services.

ST. HELENA FAMILY RESOURCE CENTER BEHAVIORAL HEALTH ASSESSMENT

In 2006, a cross-section of 38 parents, students, principals, non-profit agency staff, therapists, physicians and law enforcement from St. Helena, Angwin and Lake Berryessa participated in structured and informal interviews. Latinos from housing complexes and church leaders participated in two focus groups. The purpose of this St. Helena Family Resource Center assessment was to examine perceptions of behavioral health (drugs and alcohol, depression and anxiety and domestic violence) issues and needs among the segments of the population studied.

Latina Women

Issues

- Lack of local resources: there are very few (and no sliding scale) bilingual counselors and therapists in St. Helena, and the County's resources are overstressed
- Distrust of community offerings, programs, classes unless someone they personally trust vouches for the activity
- Cultural difference between their role here and their old role in Mexico; often they and their husband don't speak English and have to rely on their children for information; they won't ask for help unless there is a crisis
- Social isolation caused by not being allowed to drive by their husbands, being left alone with the children; not having time with friends or time for themselves
- Depression caused by the above and psychological abuse by husbands who control them, resulting in low self esteem
- Inability to access available county services in a crisis, due to the lack of child care and transportation
- Lack of health insurance; don't know how to sign-up their eligible children

Suggestions

- Support groups – weekly in their living areas – reduced fee bilingual, bi-cultural counseling; couples counseling
- Education programs on parenting, health issues and healthy lifestyles; how to deal with teenagers, talk about sex/sexuality issues with their kids, empowerment, how to be more assertive, the laws regarding child abuse and minors and alcohol; help signing up for insurance
- An exercise class at Stonebridge and walking groups as the first steps toward self-esteem
- A volunteer pool of drivers/child care providers for emergencies; a fund for emergency taxi fares

Latino Men

Issues

- Economic; the expense of living in the area; lack of knowledge regarding budgeting, saving, opening bank accounts
- Cultural pride: will not ask for help until it's a crisis (after a DUI) and protectiveness, e.g. will not allow their children, especially daughters, to participate in school field trips and other activities
- The need to juggle/deal with a myriad of unfamiliar issues

- Inability to participate/volunteer in their children's schools: employers will not give them time off and their long working schedule

Suggestions

- Classes on money management, parenting (breakdown above), motivation and empowerment, vocational and job training
- Support groups for men/couples and affordable, bilingual counseling
- Local crisis services: housing

Farm Workers

Issues

- Isolation and loneliness (separated from families); alcohol, depression
- Lack of affordable housing
- Economic (see Latino issues)
- Cultural differences; unfamiliar terrain
- Lack of affordable, bilingual counseling

Suggestions

- Support groups/affordable bi-lingual counseling
- Transitional housing; rental assistance
- Motivational classes to help them better themselves, money management, vocational training
- Local crisis services

Latino Teens

Issues

- Social isolation; girls are protected
- Second and third generation don't fit in with new arrivals or old families unless they are athletes or scholars; those born here don't help new arrivals
- Parents rely on them to interface with community/school, which creates stress
- Lack of a range of activities, "things to do"

Suggestions

- Weekly support groups on different topics: eating disorders, obesity, physical abuse, etc.
- Exercise classes (yoga, hip hop, gymnastics)
- Community Center with arcade, bowling
- Revamp Teen Center with kids taking ownership

Latino Children

Issues

- Isolation; parents are protective and afraid to let their children attend programs, etc;
- Obesity/diabetes; don't play sports (protectiveness as well as transportation issues and uniform cost); don't get enough exercise; watch a lot of TV.

Suggestions

- More personal outreach to parents (from a Spanish speaking person they trust) regarding existing and new programs, scholarships, carpooling;
- More accessible sports programs

Latino Seniors

Issues

- Isolation; no activities; often left to baby-sit with children's children
- Often monolingual, no connection with community

Suggestions

- Activities like bingo; Spanish programs on specific nights at Rianda; Spanish movies at Cameo
- English classes

Caucasian Adults/Parents

Issues

- Community affluence creates pressure; parents often hold two jobs or have a long commute; culture of materialism; underlying poverty
- No time for kids or to pay attention to their issues; lip service that kids are important
- Don't know how to parent/say no to their kids
- Small community; pressure to conform; no anonymity; issues are kept hidden
- Culture based on alcohol; acceptance of minor's use of alcohol
- More drug issues than in Hispanic community
- Lack of health services, other than Clinic Ole, for low income Caucasians without insurance.

Suggestions:

- Parenting classes (at the school, other local venue like Up Valley Campus, and in Berryessa) beginning in elementary school; also classes on childhood obesity/diabetes, the law concerning minors and child abuse, alcohol and drug awareness (for kids and parents)
- Quick response therapy for crises; grief recovery/loss therapy (start with kids; include parents)
- More emphasis on family activities, relationships vs material things

Caucasian Children & Teens

Issues

- "There's nothing to do" leads to use of alcohol, sometimes drugs
- Isolation, peer pressure, academic pressure
- Sexuality issues
- Kids without resources (to pay for uniforms or transportation for sports) have fewer options

Suggestions:

- A place for high school kids to hang out with coffee, snacks, music, pinball, pool, bowling alley, arcade, internet
- More youth driven activities; encourage new leadership teacher next year at the high school to have students plan activities for their senior projects
- Revamp teen center programs with kids' involvement and buy-in; with a big, well publicized opening featuring a band
- Mandatory after-school activities (for targeted kids); programs for non-athletes and kids with non-involved parents.

- Transportation to Berryessa, Angwin, Pope Valley, Napa, American Canyon
- Walk-in support groups; issue of the day for girls; need an activity (a hook) to get boys there
- More peer mentoring; strengthen high school program with Challenge Day, field/bowling trips; other mentoring (by seniors)
- More family-based activities; more emphasis on relationships vs material things
- Preventive programs for all age youth; repeat 9th grade health/sexuality class in 11th grade; speakers and films for older kids
- Workshops addressing anxiety and stress for elementary students and parents
- Events celebrating both heritages to promote bi-cultural understanding

In addition, the assessment concluded that several characteristics of the St. Helena area that may cause behavior health issues came up repeatedly:

- The perceived and actual affluence of the “community”
- Social isolation often caused by the community’s small size
- The dearth of local social services
- The cultural differences between and among the two races (Caucasian and Latino)
- The inadequate transportation system.

LATINO HEALTH RESOURCE FAIR

In 2005 and again in 2006, Latino adults were surveyed at the Puertas Abiertas (“Open Doors”) Resource Fair asking what type of service or workshop would be most helpful. While health was a focus of interest, the survey was intended to be broad and open-ended. The top 10 survey responses to these assessments were as follows:

2005	2006
<ul style="list-style-type: none"> ▪ Dental ▪ Parenting ▪ Housing ▪ Counseling (child, family) ▪ Counseling (marital, adult) 	<ul style="list-style-type: none"> ▪ How to support child in school ▪ Immigration services ▪ Counseling (depression) ▪ Diabetes support group ▪ Prenatal classes

COMMUNITY HEALTH CLINIC OLE

In 2005, Clinic Ole prepared a summary of data from 413 health screenings conducted in 10 migrant worker facilities (192 additional screenings occurred during Binational Health Week.) Agricultural workers made up 89% of the total facility participants, about 9% of whom were women. Slightly more than half of the participants were currently living with their spouse, and nearly 60% were living with children in the house. The percentage of workers with health insurance was reported to be 42% (which increased from 25% in the prior year), ranging from 0% at the Calistoga facility to 88% at the Silver Oak screening.

Highlights of health status and health risk findings from the facility screenings, including a comparison with the 2005 results, include:

- Rate of cigarette smoking significantly decreased to 17%, possibly attributable to the agency's addition of an effective smoking cessation curriculum to the education component of the screening program.
- Moderate alcohol consumption dropped to 12%, heavy drinking dropped slightly to 6% and reported drug use remained at 4%.
- Men who reported sexual contact with prostitutes decreased to 6% (not correlated with county housing versus vineyard management companies); three-quarter of men reported "always" using a condom with these sexual encounters. About 15% reported having more than 3 sexual partners in the last 5 years, a possible decline from the prior year assessment.
- All measures of dental health (absence of pain, teeth cleaning, regular brushing, flossing) improved, possibly reflecting consistent, multi-year messages about preventive dental care and the availability of dental treatment which are included in the educational component of the screenings.
- Percentages of reported foot and back pain (34%-40%) and allergic rhinitis (27%-35%) remained steady between the two periods, while work-related rash dropped from 20% to 11%.
- Three percent of men, compared with 1% in the prior year, screened positive for tuberculosis, but none of the men had active TB on chest x-ray.
- The prevalence of reported depression was generally the same as the prior year, about 15% (4% stated they had severe depression); the agency noted possible sample bias in the unreliability of this estimate as men who were not screened may not share the characteristics of those who were screened.
- While different methods for measuring overweight and obesity, including Body Mass Index (BMI), were difficult to apply to physically active, muscular men, the agency estimated that in general about half of the men had body fat levels that required counseling on dietary changes and cardiovascular risk. Elevated cholesterol levels were found in 42% of the workers and non-fasting elevated blood sugar remained the same at 13%.
- The demographics of the participants screened during the Binational Health Week event were different from the vineyard management company screenings (for example, men made up 36% of participants at the event compared to 91% at the facilities) but some of the health status findings were similar. Individuals screened at the Binational Health Week had some measures that were better than the agricultural workers: better indicators of dental health (lower dental pain, regular brushing and use of floss, regular teeth cleaning), lower rates of smoking and alcohol consumption, lower reported sexual

risk factors, and lower rates of rash related to exposure at work. In other measured areas, the event participants were worse than agricultural workers: higher prevalence of back or foot pain, higher rate of seasonal allergies and asthma and a higher rate of symptoms of depression.

NAPA COUNTY MCH FIVE-YEAR COMMUNITY HEALTH NEEDS ASSESSMENT

The *Napa County Maternal Child and Adolescent Health (MCAH) Five-Year Community Health Needs Assessment* (dated June 2004) identified priority MCAH problems/needs to be addressed through 2010. With the help of a representative planning group, data related to common MCAH-related indicators were reviewed and the following goals were selected through a justification and priority ranking process:

1. Increase the number of Napa County children with health insurance and who successfully access health care.
2. Reduce the number of children with childhood obesity.
3. Increase identification of children demonstrating infant-parent mental health problems and increase access to needed mental health services.

The Needs Assessment includes a description of MCAH programs; the MCAH indicators that were selected for review and their rationale for selection; the quantitative and qualitative data that were reviewed and how they were collected; and the rationale for *not* addressing certain problems/issues in light of the data review (e.g., better-than-state-average status, adequate resources already exist). The appendices contain a list of Napa County medical providers who accept clients for certain MCAH-related programs (e.g., CHDP, Medi-Cal), although the information may not be up to date.

SENIORS NEEDS ASSESSMENT

In 2004, a needs assessment of seniors in Napa County was conducted by the Healthy Aging Population Initiative, a subcommittee of the Napa Valley Coalition of Nonprofit Agencies. The purpose of the assessment was to develop a more accurate profile of the senior community, understand needs and issues of importance, and inform the development of strategies and programs for seniors. These assessment findings from surveying 539 seniors (age 60+) and a variety of service providers regarding health-related issues included the following:

- About 16% of seniors reported their health as excellent, 48% as good, 29% as fair and 5% as poor; poorer seniors generally rated their health lower than non-poverty seniors.
- Nearly 92% of seniors reported having a primary care physician (PCP); only 3% reported not visiting a physician in the past year. Those without a PCP by race/ethnicity were Hispanic (27%), White (58%), and African American (7.6%).

- One-third had visited the hospital emergency department in the past 12 months; 27% had gone 1 or 2 times. Use of the ER (as well as being hospitalized) appeared to correlate with being low income.
- Nearly 1 in 5 (19%) reported having diabetes (Hispanics at twice the proportion of non-Hispanic Whites).
- While most (89%) felt they had someone to call in an emergency and would have someone to care for them if they were sick a short period of time, only 60% felt they had a friend or relative that could help if they were sick for a longer period of time.
- Slightly over half walked or did some similar physical exercise, 27% daily and 31% 2-5 times a week. 13% reported doing no physical activity in the past week.
- While half reported they never drank alcohol about 10% said they used it daily and 40% occasionally (twice as many males as females used alcohol daily).
- One in five cited mental health or depression as being a problem for them; 29% identified feelings of loneliness and isolation.
- Seniors identified as the most important services: emergency response (77%); transportation to services (73%); low-cost dental care (73%); senior centers/group activities (72%); meals on wheels (72%); senior housing (67%); and help paying for medications (66%).
- A large proportion of seniors indicated a lack of knowledge about the services and their availability (“not knowing how to use” was the most common reason cited for not using services; the second most common barrier was lack of transportation).
- Service providers corroborated senior-identified health needs and listed mental and emotional health services, help with medications, affordable housing and transportation as critical gaps affecting their clients.
- In addition to better coordination, the providers suggested the following in priority order to improve current services: more publicity and outreach; support for accessing services; follow-up and case management; caregiver education; cultural/linguistic competence; and qualified staff.

Dental Task Force

In 2006, the Health Aging Dental Task Force, a subcommittee of the Healthy Aging Planning Initiative, distributed a survey about dental health issues in English and Spanish to seniors at various locations in the community. A total of 221 surveys were analyzed. The seniors were low- to low-moderate income: 15% had private insurance; 46% had no insurance; and 39% were covered by Medi-Cal/SSI. Highlights of the assessment results included:

- A significant proportion (44%) of lower income older adults did not have a regular dentist that they saw annually. Cost was the most challenging barrier to dental care, while transportation issues prevented access.
- Despite the fact that Medi-Cal covers some dental services, of the three income groups, the Medi-Cal respondents were the least likely to have a regular dentist and reported the highest incidence of damaged teeth (31%) and painful or loose teeth (22%).
- A higher proportion of the Spanish-speaking respondents reported not having a regular source of dental care than English speakers.
- Between one-quarter and one-third of all respondents identified current unmet needs for extractions, crown and bridges.
- Difficulties in accessing dental care were even more pronounced for Spanish speakers who were less likely than English speakers to have a dentist and for whom the cost was an even greater barrier. Additional challenges for this group included transportation and the need to have someone accompany them to interpret. Gum disease was also more of an issue for Spanish speakers.

QUEEN OF THE VALLEY HOSPITAL HEALTH SURVEY

In 2007, Queen of the Valley Hospital participated with eight St. Joseph's Health System facilities in a system-wide behavioral health survey. Telephone interviews were conducted in the service area of each hospital. The QVH data, based on a total of 311 adult respondents (with a 37% response rate), were weighted for differences in age, race, gender and income so that the results could be applied to Napa County. Although the sample was small, Table 56 on the next page shows the findings are generally consistent with published health data reported to state and federal agencies and other telephone surveys such as CHIS. In the QVH survey, a higher number of individuals report having diabetes than the national health objective for this benchmark; the percentage of adults and children who are considered obese also exceeds the national target. On the other hand, the proportion of Napa County respondents meeting daily fruit and vegetable requirements (45.2%) is about double the national goal (23.2%) for this health behavior.

Table 56. Selected Health Behavior/Health Status of Residents in QVH Service Area

Behavior/Status	%	2010 Target	National
Proportion of adults meeting physical activity guidelines ¹	43.2%	50.0%	48.1%
Proportion of respondents meeting fruit and vegetable requirement ²	45.2%	N/A	23.2%
Prevalence of children overweight or at risk of being overweight	23.4%	10.0%	33.6%
Proportion of obese adults	25.4%	15.0%	25.1%
Proportion of adults with ongoing source of care	88.0%	96.0%	84.0%
Diabetes prevalence	10.1%	2.5%	7.5%
Proportion of age 65+ who have received flu shot in past year	69.9%	90%	69.6%
Prevalence of major depression	7.8%	N/A	6.7%
Mental health perception of "fair" or "poor"	11.5%	N/A	N/A
Proportion of depressed adults who have sought help	46.7%	50.0%	N/A

Source: St. Joseph Health System Health Behavior Survey, April 2007.

¹ ≥20 minutes of vigorous activity ≥3 days per week or ≥30 minutes of moderate activity ≥ 5 days per week.

² 2 fruits, 3 vegetables.



Section V. Local Perspectives about Needs and Solutions

“Having great health insurance doesn’t ensure you get into care if a doctor won’t see you.”—Outreach Worker

COMMUNITY QUESTIONNAIRE

Characteristics of the Sample

Three hundred and sixty six (366) individuals from the general public returned a survey called the Healthy Community Questionnaire. As intended, the characteristics of the respondents largely reflect the profile of the persons receiving services or attending events (e.g., health fairs) at the sites where the questionnaire was distributed; this sample is referred to as a “convenience sample.” Because the sample is not representative of all individuals who live in Napa County, caution should be used in interpreting the results.

The majority of the community respondents were female (70.2%), Latino (61.7%) and adults in the age group 21-64 years. Latinos, Asians and African Americans were over-represented for their relative populations in Napa County. Although not intended, seniors as an age group were under-represented as were men (Table 57 on the next page). While the sample is not representative of residents of Napa County, many groups of high interest for community health improvements were reached with the questionnaire.

Table 57. Characteristics of the Community Questionnaire Respondents

Characteristic	Responses	
	N	Percent
Gender		
Female	257	70.2%
Male	97	26.5%
Missing	12	3.3%
Total	366	100.0%
	Responses	
Ethnicity	N	Percent
Hispanic/Latino	226	61.7%
White	68	18.6%
Asian	48	13.1%
African American	15	4.1%
Mixed	7	1.9%
Missing	2	.5%
Total	366	100.0%
	Responses	
Age	N	Percent
Under 21	19	5.2%
21-64	308	84.2%
65+	29	7.9%
Missing	10	2.7%
Total	366	100.0%

Over half (50.3%) of the surveys were completed at a site in Napa, and 42.3% at a site in American Canyon. The remainder came from Calistoga (6.3%) and St. Helena (1.1%). There was roughly a 60/40 split between surveys that were completed in Spanish and those that were completed in English (Table 58).

Table 58. City Location and Language of Community Questionnaire Respondents

City	Responses	
	N	Percent
Napa	184	50.3%
American Canyon	155	42.3%
Calistoga	23	6.3%
St Helena	4	1.1%
Total	366	100.0%
	Responses	
Language	N	Percent
Spanish	207	56.6%
English	157	42.9%
Missing	2	.5%
Total	366	100.0%

Self-rated health status is commonly asked in surveys and questionnaires as a good predictor of population health status. And, recent dental visit is asked as it is a reflection of awareness and concern for one’s health and, as a proxy measure for access, the financial resources available for a preventive health service. The majority (56.8%) of the respondents rated their overall health favorably, 42.1% as “good” and 14.7% as “excellent. About 40%, however, rated their health as “fair” (34.1%) or “poor” (5.5%) (Table 59). It should be noted that the individuals who completed the community survey in this assessment process were not representative of Napa County, and so their responses cannot be compared to findings in representative community health surveys for Napa County such as the California Health Information Survey. In the CHIS survey, for example, a larger proportion of the respondents rated their health as excellent and good.

Nearly three-quarters (74%) of the needs assessment survey respondents reported having had a dental check-up in the last 1-2 years, a higher proportion than Napa County residents who responded to the CHIS survey. While this is a positive finding, as explained above the two populations are not comparable.

Table 59. Selected Health Indicators of Community Questionnaire Respondents

Self-Reported Health Status	Responses	
	N	Percent
Excellent	54	14.7%
Good	154	42.1%
Fair	125	34.1%
Poor	20	5.5%
Missing	13	3.6%
Total	366	100.0%
Last Dental Check-up	Responses	
	N	Percent
1 Year	223	61.0%
1-2 Years	47	12.8%
2+ Years	74	20.2%
Missing	22	6.0%
Total	366	100.0%

Identified Health Needs/Problems

Respondents were asked to identify the “top 5” health problems/needs they believe affect people in Napa County. Table 60 provides the list they identified. A total of 328 (90%) individuals answered this question, though not all of them chose to list five items. Since each individual could report more than one health problem/need, the number of responses, 815, is greater than the number of individuals who completed the questionnaire.

Table 60. Top Health Problems/Needs in Napa County Identified in the Community Questionnaire

Health Problem/Need	Responses	
	N	Percent
Chronic disease/chronic disease management	164	20.1%
Lifestyle choices/taking responsibility	137	16.8%
Mental health - lack of service/people's mental state	119	14.6%
Access to medical services due to no health insurance	82	10.1%
Providers don't accept Medi-Cal	52	6.4%
Drug and alcohol related	36	4.4%
Lack of transportation options	29	3.6%
Access to medical services – reasons not specified	24	2.9%
Health education	23	2.8%
Housing – inadequate, unaffordable, poor condition	17	2.1%
Violence related (e.g., domestic, child abuse, homicide...)	11	1.3%
Vision (e.g., eye exams)	11	1.3%
Lack of Spanish-speaking nurses, doctors, dentists, etc.	10	1.2%
Lack of affordable childcare	8	1.1%
More resource information	7	0.9%
Dental care – lack of dentists, dental specialists, etc.	6	0.7%
Social isolation	4	0.5%
Teen pregnancy	2	0.2%
Lack of specialty medical providers	1	0.1%
Other	70	8.5%
Total	815	100.0%

Chronic diseases/chronic disease management represented a majority of the responses at 20.1%. Of these responses, about 17% concerned allergies, 19% identified cancer (usually not naming a specific type) and 60% indicated that diabetes was a concern.

Nearly 17% of the responses were in the domain of healthy behaviors/lifestyle choices and taking personal responsibility which included the issues of obesity, nutrition, exercise and wellness. And, 14.6% of the responses concerned a mental/emotional health issue, including both mental health conditions and inadequacies of mental health services. Problems reported with response rates lower than 10% include drug and alcohol related problems, transportation and housing. A little over 1.2% of the responses indicated concerns about language difficulties (“needing someone to speak Spanish”).

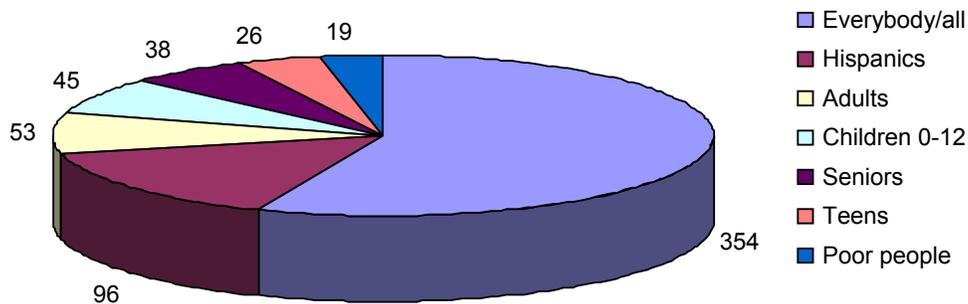
In total, 19.9% of the responses indicated some type of concern related to access to health care services. About 10% of these responses indicated that access was a problem due to a lack of health insurance, 6.4% of the responses specified it was due to providers not accepting Medi-Cal and 2.9% identified additional access issues without providing much specificity (e.g., “can’t go to the doctor,” “problems with appointments”).

The category of “Other” included problems and needs not addressed by the remaining concerns in the table. Examples included more activities for children such as after-school programs, sexually transmitted diseases including AIDS/HIV, “woman services,” sports and related activities and better roads.

Groups Perceived to be Most Affected by Health Problems

Overall, 277 individuals listed a group they believed was most affected by the health problems and unmet needs in Napa County. Since each individual could report more than one group, the number of responses, 651, is greater than the number of individuals who completed the questionnaire. The majority of the responses indicated that the health problems and needs of Napa County have an affect on all individuals (54.4%). Hispanics received a moderate amount of responses (14.7%) indicating they are affected by the health problems and needs of Napa County. Only 8.1% of the responses indicated that adults are affected. Less than 7% of the responses indicated that children under the age of 12 are affected by the health problems. The age groups of seniors and teens received even fewer responses. Figure 13 provides a graphical representation of the groups considered most affected by the health problems and needs of Napa County.

Figure 13. Groups Affected the Most by Health Problems/Needs in Napa County



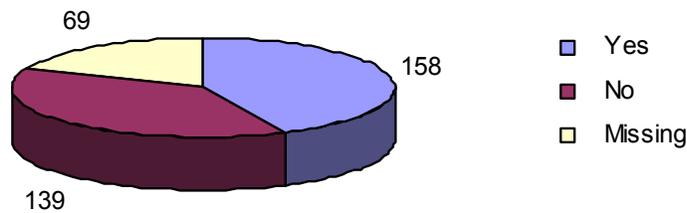
Access-Related Problems When in Need of Health Care

Question 2 of the survey asked individuals if any of the six listed problems were “usually a problem or issue” when they or their family needed health care. The problems listed were “childcare, transportation, finding a place where they speak my language, finding someone who takes my insurance (including Medi-Cal), finding somewhere that offers reduced-cost or free care, and finding an office or clinic that is open when I’m not working.” The responses to each problem are provided in Table 61 and Figures 14 through 19.

Table 61. Problems Usually Experienced When in Need of Health Care

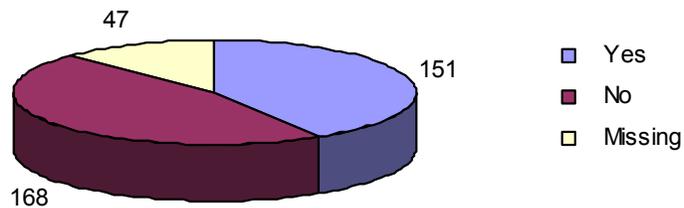
Problem		Responses	
		N	Percent
<i>Childcare</i>	Yes	158	43.2%
	No	139	38.0%
	Missing	69	18.8%
	Total	366	100.0%
<i>Transportation</i>	Yes	151	41.3%
	No	168	45.9%
	Missing	47	12.8%
	Total	366	100.0%
<i>Language – Finding a place where they speak my language</i>	Yes	159	43.4%
	No	152	41.6%
	Missing	55	15.0%
	Total	366	100.0%
<i>Insurance – Finding someone who takes my insurance (including Medi-Cal)</i>	Yes	173	47.3%
	No	134	36.6%
	Missing	59	16.1%
	Total	366	100.0%
<i>Cost – Finding somewhere that offers reduced-cost or free care</i>	Yes	213	58.2%
	No	103	28.1%
	Missing	50	13.7%
	Total	366	100.0%
<i>Hours – Finding an office or clinic that is open when I’m not working</i>	Yes	199	54.4%
	No	115	31.4%
	Missing	52	14.2%
	Total	366	100.0%

Figure 14. Is Childcare Usually a Problem When in Need of Health Care?



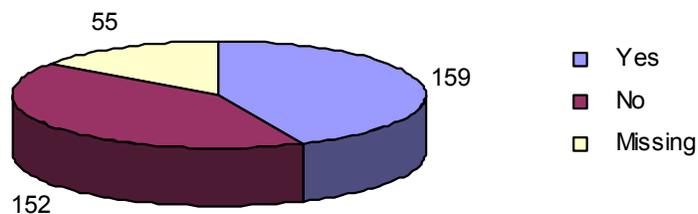
A little over 40% of the people indicated that childcare was usually a problem when they or their family was in need of health care. Thirty-eight percent (38.0%) of the people indicated that childcare was usually not a problem, and 18.9% did not provide a response.

Figure 15. Is Transportation Usually a Problem When in Need of Health Care?



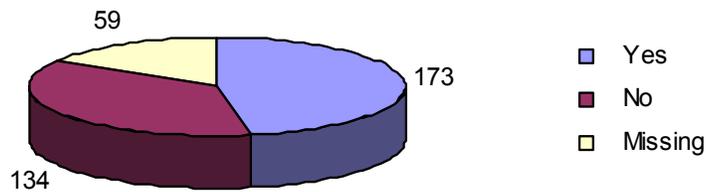
Transportation was usually a problem for 41.3% of the people when they or their family was in need of healthcare. However, slightly more people (45.9%) reported that transportation was not usually a problem and 12.8% did not provide a response.

Figure 16. Language as a Problem When in Need of Health Care



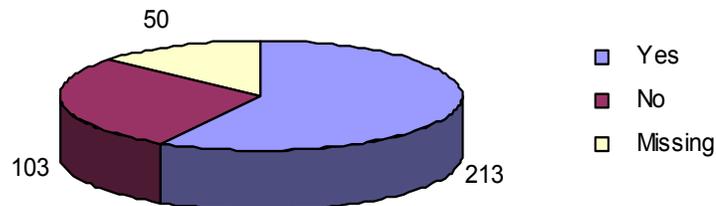
Slightly more than 43% of the people reported that finding a place where staff spoke their language was usually a problem when they or their family was in need of healthcare. However, almost 42% reported that language was not usually a problem and 15.0% did not provide a response to this question.

Figure 17. Is Finding Someone to Take Your Insurance Usually a Problem When in Need of Health Care?



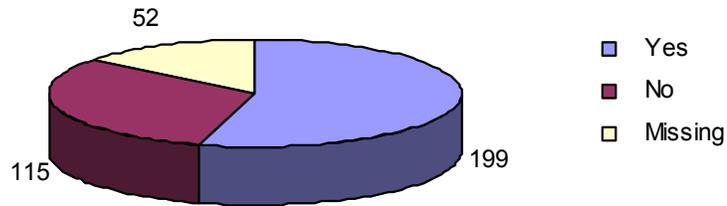
The largest set of the respondents (47.3%) indicated that finding a provider who takes their insurance (including Medi-Cal) is usually a problem when they or their family are in need of health care. Approximately 37% indicated that their insurance type was not usually a problem and 16.1 % of the people did not provide a response.

Figure 18. Is Finding a Free or Reduced-Cost Provider Usually a Problem When in Need of Health Care?



A majority of the respondents (58.2%) indicated that finding a place that offers reduced-cost or free care is usually a problem when they or their family are in need of health care. However, approximately 28% indicated that cost was usually not a problem and 16.1% of the people did not provide a response.

Figure 19. Are Hours of Operation Usually a Problem When in Need of Health Care?



A majority of the respondents (54.4%) indicated that finding an office or clinic that is open when they are not working is usually a problem when they or their family were in need of health care. Approximately 31% indicated that office or clinic hours of operation were not usually a problem and 14.2 % of the people did not provide a response to this question.

The survey question also allowed individuals to describe other problems that usually occur when they or their family were in need of health care. The list of “other” problems and issues as respondents stated them is shown in Table 62 on the next page.

Table 62. Other Things that are Usually a Problem When Needing Health Care

Problem/Issue	N
High medical costs	3
Cultural differences	2
Dental insurance	2
Lower-cost dentistry	2
Medical insurance	2
Work schedule interference	2
After school care	1
Appointment availability	1
Availability of therapy/counseling	1
Childcare availability	1
Costly supplemental insurance	1
Counselors for teenagers	1
Dentistry	1
Dentists, more insurance	1
Disease centers	1
Doctors lose test results	1
Expensive emergency care	1
Finding good care	1
Friendly help in clinics	1
Help our kids out of gangs	1
High co-pay costs	1
Insurance cost	1
Lack of low-cost providers	1
More help acquiring insurance	1
More help for the undocumented	1
More help for those without insurance	1
More help with prescriptions	1
More medical options	1
More business/office clinics	1
No access to health insurance	1
No resources in American Canyon	1
Poor treatment by office staff	1
Self-esteem	1
Seniors with difficulty paying insur. premiums after retirement	1
Setting appointments	1
Single dental/medical/vision center	1
More availability for those with healthy families	1
Transportation	1

Ideas to Help Improve the Health of People in Napa County

Question 3 of the survey asked individuals to provide ideas to improve the health of people in Napa County. Of the 366 individuals who returned the survey, only 239 (65%) people provided a response to this question. Since individuals could list more than one idea, the 268 responses were spread across the 239 individuals who answered the question. Some suggestions were more clearly related to unmet health needs and could be coded as such; other comments were recorded as “other” and both are detailed in Table 63 below.

Table 63. Ideas Suggested in Community Questionnaire to Improve Health in Napa County

Ideas	Responses	
	N	Percent
<i>Ideas coded for data analysis</i>		
More affordable health care; Help people pay for care	86	32.1
Support wellness center-type services/health education	56	20.1
Resource information and referral services	27	10.2
Cultural competence, bilingual services	12	4.5
Support for mental-health related services	10	3.7
More providers to take Medi-Cal	7	2.6
Dental care, especially for adults and seniors	6	2.2
Educate parents about health/taking care of children	5	1.9
Mobile health clinics	5	1.9
Increase childcare availability	3	1.1
Provide transportation	3	1.1
24-hour clinics	3	1.1
Eliminate pesticides	3	1.1
More frequent health fairs	2	0.7
Help enroll/sign up for eligible programs	2	0.7
Ambulances	2	0.7
Alternative medicine/therapy	2	0.7
Get women into prenatal care earlier	2	0.7
Sex education programs	1	0.4
<i>Ideas coded as “other”</i>		
Citizenship	1	0.4
Classes on violence	1	0.4
Clinics offering more services	1	0.4
Community building	1	0.4
Complete sidewalks, trails, bike paths	1	0.4
Continue to invest in water	1	0.4
Educational activities	1	0.4
Fluoride in H2O system	1	0.4
Getting to sleep on time	1	0.4
Glasses for children	1	0.4
Health education in schools	1	0.4
Help for those without papers	1	0.4
Help losing weight	1	0.4

Table continues on next page

Less air pollution	1	0.4
Less discrimination toward immigrants	1	0.4
In-school medical care	1	0.4
Less smoking	1	0.4
More attention to obesity	1	0.4
More community activities	1	0.4
More health professionals in the area	1	0.4
National health care programs (no HMOs)	1	0.4
Organic farmers market	1	0.4
Outreach groups	1	0.4
Provide services after work hours	1	0.4
Quality of drinking water	1	0.4
School/community liaisons	1	0.4
Stronger politicians	1	0.4
Support for diabetics	1	0.4
Too much racism in our community	1	0.4
Use ER's for emergencies – not clinic check up	1	0.4
Less smoking	1	0.4
More attention to obesity	1	0.4
More community activities	1	0.4
More health professionals in the area	1	0.4
Total	268	100.0%

About one-third (32.1%) of the ideas provided were concerned with helping people pay for care to improve the health of people in Napa County. Twenty percent of the responses indicated that support for affordable wellness services and wellness center facilities as well as health education would improve the health of people in Napa County. Ten percent suggested information resources to help people know what services were available and where they were located. Other ideas that received moderate responses are improved cultural competence (including interpreters and bilingual staff), and support for mental-health related service. The following ideas represent less than 2% of the responses: have more providers accept Medi-Cal, educate parents, increase childcare availability, provide transportation, help enroll for eligible programs, earlier prenatal care, and sex education programs.

Cross Tabulations with Problems/Needs of Napa County

Cross tabulations were performed of survey Question 1 (top unmet needs/problems identified) and the demographic data to focus on one problem at a time and examine the characteristics of the respondents citing that problem. These analyses are displayed in Tables 64 through 68 below.

The majority of respondents to the community questionnaire were Hispanic. To avoid presenting data based on small numbers, respondents identifying themselves as Asian, African American, Mixed, or White have been grouped into one category (Non-Hispanic). It is important to note that the responses to the questionnaire are not considered to be representative of Napa County's population as a whole.

Among Hispanics surveyed, chronic disease was the most frequently identified problem or need, followed by lifestyle/responsibility, other problems/needs, mental health and access (no insurance). Non-Hispanic respondents most frequently listed other types of problems or needs as areas of concern, with smaller percentages indicating that chronic disease, lifestyle/responsibility, and access (no insurance) were health problems or needs (Table 64).

Table 64. Ethnicity by Health Problem/Need of Napa County

Health Problem/Need		Race/Ethnicity	
		Hispanic/Latino	Non-Hispanic
Chronic disease	Count	139	24
	%	61.5%	17.4%
Lifestyle/responsibility	Count	105	22
	%	46.5%	15.9%
Mental health	Count	89	13
	%	39.4%	9.4%
Access-no insurance	Count	51	31
	%	22.6%	22.5%
Accept Medi-Cal	Count	38	14
	%	16.8%	10.1%
Drug/alcohol related	Count	31	5
	%	13.7%	3.6%
Transportation options	Count	10	19
	%	4.4%	13.8%
Access-except insurance	Count	15	9
	%	6.6%	6.5%
Housing	Count	1	16
	%	0.4%	11.6%
Other	Count	85	45
	%	37.6%	32.6%
Total Number Respondents		226	138

The majority of respondents to the community questionnaire were 21 to 64 years old (Table 65). Data from respondents in the under 21 and over 65 age categories should be interpreted with caution due to the small number of responses. It is important to note that the responses to the questionnaire are not considered to be representative of Napa County's population as a whole. Chronic disease and lifestyle/responsibility issues were the most frequently identified problems or needs among the 19 respondents under age 21 and the 308 respondents age 21 to 64. Mental health was also cited as an area of need by approximately 33% of 21 to 64 year olds surveyed. Respondents over age 65 most often identified transportation and housing issues as a problem or need.

Table 65. Age Category of Individuals by Health Problem/Need of Napa County

Health Problem/Need		Age Category		
		Under 21	21-64	65+
Chronic disease	Count	11	149	2
	%	57.9%	48.4%	6.9%
Lifestyle/responsibility	Count	10	114	1
	%	52.6%	37.0%	3.5%
Mental health	Count	2	100	1
	%	10.5%	32.5%	3.45%
Access - no insurance	Count	2	74	5
	%	10.5%	24.0%	17.2%
Acceptance of Medi-Cal	Count	3	48	0
	%	15.8%	15.6%	0.0%
Drug/alcohol related	Count	0	33	1
	%	0.0%	10.7%	3.5%
Transportation options	Count	0	17	10
	%	0.0%	5.5%	34.5%
Access - <i>except</i> insurance	Count	1	19	1
	%	5.3%	6.2%	3.5%
Housing	Count	0	8	9
	%	0.0%	2.6%	31.0%
Other	Count	4	120	5
	%	21.1%	39.0%	17.2%
Total Number Respondents		19	308	29

The majority of respondents to the community questionnaire were from the City of Napa and American Canyon. Responses from St. Helena and Calistoga residents have been grouped together due to the small number of respondents from these two cities. It is important to note that the responses to the questionnaire are not considered to be representative of Napa County's population as a whole. Chronic disease, lifestyle/responsibility, other problems/needs, and access to insurance were the most frequently identified problems or needs among respondents from the City of Napa and American Canyon. Mental health was also frequently identified as a health problem/need among City of Napa respondents (46%). Access (no insurance) was the most frequently identified health need or problem among St. Helena/Calistoga residents, but this should be interpreted with caution due to the small number of respondents from these cities.

Table 66. City of Residence by Health Problem/Need of Napa County

Health Problem/Need		City of Residence		
		Napa	American Canyon	St. Helena and Calistoga
Chronic disease	Count	125	37	2
	%	67.9%	23.9%	7.4%
Lifestyle/responsibility	Count	92	34	1
	%	50.0%	21.9%	3.7%
Mental health	Count	85	17	1
	%	46.2%	11.0%	3.7%
Access - no insurance	Count	39	35	8
	%	21.2%	22.6%	29.6%
Acceptance of Medi-Cal	Count	33	17	2
	%	17.9%	11.0%	7.4%
Drug/alcohol related	Count	28	7	1
	%	15.2%	4.5%	3.7%
Transportation options	Count	7	17	5
	%	3.8%	11.0%	18.5%
Access - <i>except</i> insurance	Count	6	17	1
	%	3.3%	11.0%	3.7%
Housing	Count	13	4	0
	%	7.1%	2.6%	0.0%
Other	Count	70	57	5
	%	38.0%	36.8%	18.5%
Total Number Respondents		184	155	27

The majority of survey respondents indicated that they had had a dental check-up within the last year. It is important to note that the responses to the questionnaire are not considered to be representative of Napa County's population as a whole. Chronic disease, other problems/needs, lifestyle/responsibility, mental health, and access to insurance were the most frequently identified health problems or needs across all categories of respondents by years since last dental check-up.

Table 67. Last Dental Check-up by Health Problem/Need of Napa County

Health Problem/Need		Last Dental Check-up		
		< 1 Year	1-2 Years	2+ Years
Chronic disease	Count	98	27	31
	%	44.0%	57.5%	41.9%
Lifestyle/responsibility	Count	73	22	24
	%	32.7%	46.8%	32.4%
Mental health	Count	69	9	20
	%	30.9%	19.2%	27.0%
Access - no insurance	Count	44	13	21
	%	19.7%	27.7%	28.4%
Acceptance of Medi-Cal	Count	34	4	11
	%	15.3%	8.5%	14.9%
Drug/alcohol related	Count	26	3	7
	%	11.7%	6.4%	9.5%
Transportation options	Count	11	4	11
	%	4.9%	8.5%	14.9%
Access - <i>except</i> insurance	Count	11	4	8
	%	4.9%	8.5%	10.8%
Housing	Count	6	1	9
	%	2.7%	2.1%	12.2%
Other	Count	90	13	25
	%	40.4%	27.7%	33.8%
Total Number Respondents		223	47	74

The majority of respondents to the community health questionnaire indicated that they were in good or fair health. It is important to note that the responses to the questionnaire are not considered to be representative of Napa County's population as a whole. Chronic disease, other problems/needs, lifestyle/responsibility, mental health, and access to insurance were the most frequently identified health problems or needs in all categories of health status.

Table 68. General Health of Individuals by Health Problem/Need of Napa County

Health Problem/Need		General Health				Total
		Excellent	Good	Fair	Poor	
Chronic disease	Count	17	61	69	11	158
	%	10.8%	38.6%	43.7%	7.0%	
Other	Count	22	50	49	9	130
	%	16.9%	38.5%	37.7%	6.9%	
Lifestyle/responsibility	Count	15	48	51	9	123
	%	12.2%	39.0%	41.5%	7.3%	
Mental health	Count	10	38	42	7	97
	%	10.3%	39.2%	43.3%	7.2%	
Access - no insurance	Count	9	42	25	5	81
	%	11.1%	51.9%	30.9%	6.2%	
Accept Medi-Cal	Count	8	25	15	1	49
	%	16.3%	51.0%	30.6%	2.0%	
Drug/alcohol related	Count	5	15	13	3	36
	%	13.9%	41.7%	36.1%	8.3%	
Transportation options	Count	2	14	11	2	29
	%	6.9%	48.3%	37.9%	6.9%	
Access - <i>except</i> insurance	Count	3	15	5	0	23
	%	13.0%	65.2%	21.7%	.0%	
Housing	Count	0	9	5	3	17
	%	.0%	52.9%	29.4%	17.6%	

Overall Summary of Cross Tabs

A majority of the respondents to the community questionnaire mentioning chronic disease, lifestyle and responsibility, mental health, access due to no health insurance, accept Medi-Cal, and drug and alcohol issues as a health problem rated their general health as good or fair, had a dental check-up in the last year, were female, Hispanic, between 21 and 64 years of age, and were residents of Napa County.

Those citing transportation, access due to reasons except health insurance, and housing showed a somewhat different pattern than the pattern described above. For transportation, respondents were equally divided on having had a dental check-up during the last year and having had one over 2 years, tended to be both White and Hispanic, and tended to be from American Canyon.

Those citing access due to reasons except health insurance indicated that their health was good and tended to be from American Canyon. Those citing housing indicated that their health was good, had a dental check-up more than 2 years ago, were White, and were about equally divided between the age categories of 21 to 64 and over 65.

COMMUNITY AND PROVIDER FOCUS GROUPS

Characteristics of the Sample

A total of 88 individuals attended one of the community focus groups, 74 oriented to the general public and 14 to individuals working in healthcare. (The numbering of the groups in Table 69 relates to the findings presented in subsequent tables.) Two of the focus groups were held with residents in low-income apartment complexes. The majority of the consumer participants were Latino—many with limited or no English-speaking ability—with the remainder predominantly White, non-Latino. Women and men were generally represented in equal numbers, and while the participants were typically 30-50 years of age, two groups also had a mixture of seniors and young adults (mostly young parents). The health professions group, which drew from across the county, was disproportionately female and composed of outreach workers.

Table 69. Focus Group Characteristics and Participation

City/Site	Characteristics	Primary Language	Participants	
<i>Community (General Public) Groups</i>				
1	American Canyon, Family Resource Center	Mix of gender and racial/ethnic, adults/seniors	English and Spanish	17
2	Calistoga, La Pradera apartment complex	Mix of gender, mostly Latinos, adults/seniors	Spanish	9
3	Napa Latino Parent Group	Mix of gender, mostly Latinos, mostly young parents/adults	English and Spanish	36
4	St. Helena, Stonebridge apartment complex	Mostly women, mostly Latinos, mostly adults,	Spanish	12
	<i>Subtotal</i>			<i>74</i>
<i>Health Professionals Group</i>				
5	Napa	Mostly female, mostly outreach workers	English	14
<i>Total</i>				<i>88</i>

Most-Commonly Identified Health Needs/Problems

Table 70 displays the health problems or unmet/under-met needs that focus group participants identified as being “most important to the people in Napa County.” The participants were not asked to prioritize or rank order the needs once they were identified. It will be clear from these data that although the facilitator did not limit the participants in identifying needs but attempted to draw them out and occasionally prompt them with additional questions, some groups focused on fewer problems and issues than other groups.

Mental/Emotional Health

While the need for more counseling services—as well as culturally and linguistically appropriate—for couples and families was the mental health service most often described as being needed, the actual mental health issue discussed was depression. The likeliest attributing factor was said to be social isolation for reasons in the following order of mention: parents' inability to speak English and interact with/relate to their children who are learning English/becoming more a part of U.S. society; undocumented immigrants who don't feel safe returning to Mexico (related to INS-related issues) to see their families or believe they'll never see them again and feel “stuck” here; elderly people living alone and/or not being able to socialize because of transportation and personal issues.

Substance Abuse

When alcohol and drug-related issues were identified they were generally directed to concerns of drug use by youth in schools (e.g., being hooked at an early age from older students selling to younger students) and gangs. The impact of alcohol abuse on the community, especially with regard to teenagers, was also described as a priority health concern. Some participants thought the schools were not vigilant enough in protecting children and law enforcement officials were not focusing on the main problems (“they are too busy writing traffic tickets”).

Access to Dental Services

Many participants expressed concerns about the cost of dental care and shared that they neglected taking their families to a dentist due to lack of coverage. The availability of community resources was acknowledged but it was noted that some of the services were limited in scope, eligibility and availability of appointments.

Home Health Care

The lack of in-home services for seniors was mentioned early on by one of the focus groups. Caregiving is expensive whether it involves a family member quitting a job to care for an elderly relative or paying someone to come into the home; many seniors without the ability to find affordable care may be trying to live independently and care for themselves but suffering ill health and detrimental isolation as a consequence, according to the participants.

Barriers

To identify barriers, participants were asked what “stood in the way” of seeking or obtaining needed services. While they are often interconnected, factors related to both the health care system and to individuals' personal barriers affect and may act as barriers to use of health services and adoption of preventive health practices. Functions of the healthcare system such as not enough providers taking Medi-Cal or lack of interpreter services are examples of system or structural barriers. Personal factors that serve as barriers—which tend to be a little less concrete—include beliefs and attitudes about illness and treatment

and fear of economic loss. Access to health care may also be impeded by a lack of personal resources, the absence of a personal support system, or a lack of knowledge. Both types of barriers put people at risk for not getting the amount, type, quality and timeliness of the services they need. And, in many cases the barriers are interrelated.

System Barriers

The system or provider-related barriers that were mentioned included:

- Long waiting time to receive an appointment
- Long waiting time during the visit (affecting transportation options and child care arrangements)
- Provider insensitivity to type of client, e.g., because of ethnic group, low-income, English learner, substance user, single mother, (viewed as perceived bigotry or general rudeness)
- Limitations on scope of services offered/type of insurance accepted
- Restrictive office policies (e.g., “if you’re 5 minutes late they make you re-schedule”)
- Limited transportation options (“it’s available but only goes within the city limits”)

Personal Factors as Barriers

The personal or consumer-related barriers that were discussed included:

- The inability to get time off from work (fears about job security, economic loss)
- Not having the money to pay for child care (“I have to bring along all my kids when I go to the doctor”) as the reason for not seeking care or missing or being late for appointments.
- Fear about enrolling oneself or one’s child for health coverage or other benefits they or their child were eligible for. These comments were usually made in the context of anxiety about immigrants being in the country without proper documentation. And, to a somewhat lesser extent about seniors who might be perceived as “less independent” if they asked for help.
- Lack of awareness of available services, lack of information or only superficial knowledge about where services were located, what the eligibility criteria were and how to access them.
- The need to feel comfortable in an environment where the provider would “understand my particular needs.”

Recommended Strategies/Solutions

Participants were asked to make suggestions about the kind of “top-most” programs or services they would like to see added, expanded or improved in Napa County if they “could make a wish,” or “had won the Lottery” and could spend money for this purpose. While most recommendations tied back to the identified needs, some did not. Table 71 on the next page lists the ideas and recommendations from each focus group that participants believed should be considered by funders. The “x’s” that are bolded signify that the item particularly resonated with the group (for example when others gave a resounding “yes, that’s right,” indicating their agreement with the recommendation being made).

Table 71. Strategies Focus Group Members Believe Should Receive More Support (Funding)

Strategy/Solution	Focus Group #				
	1	2	3	4	5
▪ Support ways to increase awareness of services : type/location/availability		x	X	X	x
▪ Hire bilingual/bicultural health workers; offer training in sensitivity to cultural and socioeconomic differences	X		x	X	x
▪ Support subsidized health insurance for low-income (include working) adults	X		X	X	
▪ Offer preventive health education , including medication mgmt, that is culturally, linguistically and literacy-appropriate targeted to groups at risk		x	X		
▪ Establish (or increase)1-stop/comprehensive primary care clinic services	X			X	
▪ Expand/make more flexible transportation options (vouchers, vans) intra- and inter-city			X		x
▪ Increase education programs, parent support groups and enforcement regarding substance abuse		X	x		
▪ Establish a wellness center and affordable gym that would also be a place for health screenings and to meet and socialize	X				x
▪ Support mental health counseling services (e.g., anger mgmt) and support groups			X	x	
▪ Support “ companion ” services for homebound elderly for socialization, improved meals, simple chores and transportation to appointments	x				
▪ Establish and support a program of peer support for chronic disease mgmt	X				
▪ Support more dental services (for kids, adults, seniors) including scope					x
▪ Support free and localized <i>appropriate</i> (i.e., acceptable) after-school and summer programs for young people.					x
▪ Support affordable 24/7/365 childcare with a sick bay					x
▪ Establish a central resource in the county for capacity to translate materials into Spanish and Tagalog.					x
▪ Support Promotores, caseworkers, advocates and health-related clubs at schools.					X
▪ Expand Head Start and its nutrition programs, such as going into home and showing families nutritious ways to cook.					x
▪ Recycle medical supplies and prescription drugs through a central location.					x
▪ Support communication devices for people without telephones	x				

X = The recommendation was mentioned; **X** = The recommendation appeared to really resonate with the group.

The most commonly-recommended strategies the focus group participants wished to have organizations fund involved (1) increasing awareness of available services (particularly for higher-risk/vulnerable populations), and (2) increasing the number of Spanish-speaking (bicultural, preferably) health workers, and front office staff who would be more sensitive to patients' cultural differences as well as low-income status. The majority of the participants believed "some sort of program" was needed to make sure people knew about the services they were eligible for or entitled to. Beyond interpreter services at health facilities so that patients could better understand providers and be better understood by them, participants felt that training of staff was needed to increase basic respect for clients.

Better access to medical services, particularly in certain locations (e.g., American Canyon), through establishing health centers or creating health insurance solutions was also a common priority recommendation that especially resonated in the groups where it was mentioned. Specific ideas included making health insurance available on a sliding scale proportionate to income and requiring employers and government to share a large portion of the cost.

Preventive health recommendations included nutrition education programs ("to deal with diabetes") and affordable opportunities for physical activity such as gyms and wellness centers (which would also offer an opportunity for socializing for groups such as seniors).

Recommendations that addressed substance abuse tended to be in the context of schools, with parents and law enforcement working together with teachers to "advise the youth about drugs and alcohol" and "be more vigilant to protect the youth."

KEY INFORMANT INTERVIEWS

Characteristics of the Sample

The 21 key informants interviewed represented a broad cross-section of the Napa County health and human service community that in addition to health care providers and leaders from community-based organizations included policy makers, advocates and individuals with a broad perspective about unmet health needs. While most of the interviewees spoke to the issues they knew best from their professional roles, all of them were able to consider and cite additional health-related needs and problems when prompted with questions such as "...and what about when you think of residents who may live in certain areas of the county? who may be ethnic minorities? who may be in certain age groups.....?" and so forth.

Identified Needs

The interviews with key informants yielded very similar information to the community focus groups. Because the identified needs and gaps covered a wide range of issues many of them were only identified by a few people. However, two of the priority issues received mention by more than two-thirds of the respondents: mental health and inadequate health insurance coverage. Needs related to oral health, such as dental decay, were cited as a priority issue by one-half of the individuals (Table 72).

Table 72. Health Problems/Needs Identified by Key Informants

Problem/Need	Frequency of Mention
Mental health (gaps in service = 8; depression=7)	15
Lack of health insurance (gaps in coverage=2)	14
Dental (for kids=6; adults/srs=4; sedation/spec needs pop=2; disease=1; no D-C=1)	10
Lack of bilingual/bicultural health workers/health professionals	5
Obesity (including need for good nutrition), child and adult	5
Ignorance, lack of understanding/adoption re. prevention and healthy lifestyle	4
Diabetes rates/pre-diabetes risk	4
Chronic disease management/self-management	4
Too few subspecialists (medical=3; dental=1)	4
Lack of awareness about where to find/eligibility for services (fear to use=2)	4
Alcoholism/drug and alcohol abuse (perinatal subst. abuse = 1)	4
Transportation to services	4
Affordable housing	3
Adolescent reproductive health needs, services and sex education	2
Inadequate support services for seniors	2
Unaffordable pharmaceuticals/medications for seniors	2
Violence (domestic violence=1; elder abuse=1)	2

Table continues on next page

No funding program for colon-rectal screening	1
Asthma and allergies	1
No fluoride in community water supply	1
Inadequate affordable long-term care slots in the community	1
Homelessness	1
Poor basic sanitation in the schools and retail outlets where teens work	1

Mental Health

Those citing mental/emotional health as a top problem specified mental health *conditions* as often as those citing *service gaps*. Observations about the latter were generally the lack of adequate family therapy (particularly culturally appropriate), support groups, and school counselors. Comments related to the former generally noted a great deal of depression among individuals. One person remarked that mental/emotional illness was “a huge unrecognized need because no one is looking for it.” The two most common examples of the contributors to depression were (a) aging seniors in poor health losing their independence, losing family and friends through death, feeling increasingly isolated, and anxious about finances; and (b) the challenges associated with acculturation: non-English speaking parents and immigrants—particularly those who are undocumented—feeling disconnected from children who can speak English, low self esteem, trying to figure out how to make a place for themselves, fearful of visibility, anxious about the possibility of not being able to return to family in Mexico, and increasing feelings of socially isolation.

Mental health services were described in short supply even for those with health insurance. Several interviewees observed that “the demand for mental health services is high no matter what insurance coverage a person has. All insurance carriers offer poor coverage for mental health.”

Health Insurance/Access

The majority of the key informants acknowledged the strides that have been made in improving coverage for children through the Children’s Health Initiative. While they acknowledged that not all families have enrolled their children in programs for which they are eligible or have the ability to deal with barriers to services, children relative to other Napa County population groups were generally said to be adequately covered for health insurance. The interviewees generally believed that among age groups, adults and seniors experience the greatest extent of problems accessing services largely because of no insurance, poor coverage, confusion about eligibility or unwillingness to enroll in programs.

Some individuals felt that there is a “lack of depth in the ability to provide good medical care for poor people” in Napa County. The few in number, geographic maldistribution and limited availability of many subspecialists (e.g., neurosurgeons) were given as examples.

Oral Health

Oral health needs were generally expressed as access issues or service gaps rather than observations about the extent of dental disease in the community (which may be because no dental professionals were among those interviewed). Needs related to children and adults/seniors were cited about equally. Two people specifically pointed out that while it affects a small number of people, the lack of local availability for sedation and surgical services is a problem. While dedicated operating room (OR) time for dental care is at a premium regardless of insurance coverage, an area that is even a more of a problem is the group of children and adults with disabilities and other special needs and patients with severe decay that requires sedation to treat. Medi-Cal enrollees have to be sent out of county to UC San Francisco where there is commonly an 18-month wait for OR services related to dental conditions.

Of particular concern to some key informants about oral health needs were farm workers. There was a belief that there has been less success in reaching this population, “especially the young adult and adults males who live in the camps.” Cultural beliefs (e.g., you don’t see a dentist until you have pain) and lack of patient motivation (young men in general do not typically seek dental services) were considered to be the primary reasons.

Prevention/Wellness/Healthy Lifestyle

Combined, problems associated with not adopting a preventive health/healthy lifestyle such as experiencing diabetes, obesity, poor nutrition and dietary habits, and lack of exercise received a great deal of attention. One interviewee involved with serving children put it rather succinctly as “we see many parents who basically feed their kids garbage because they don’t know any better way to do it.”

Needs associated with managing chronic disease were also addressed. One provider’s statement that “effective chronic disease management, including self-management, could save millions in healthcare and other costs each year” resonated with everyone who addressed concerns about the burden of diabetes, obesity and other chronic conditions.

Transportation

The lack of acceptable transportation options, described for public transportation sources as restricted schedules, limited routes, and difficult drop-offs and pick-ups for people with limited mobility, echoed the problems noted by the focus group participants. The key informants noted that transportation issues not only impacted access to appointments but also affected mental health by contributing to social isolation and feelings of disconnectedness.

Substance Use and Abuse

Alcohol and drug use cited as priority concerns were generally related to its impact on rates of cirrhosis of the liver, domestic violence, school dropouts and traffic fatalities. Some interviewees also considered that the culture and apparent tolerance for alcohol in the Napa

Valley may play a larger part in contributing to these problems, as well as underage drinking, than in other counties.

Seniors

Problems and issues identified relative to seniors were generally addressed within the context of how they were affected by the particular unmet need or problem described (e.g., lack of transportation) rather than an underserved population group, per se. A particularly noteworthy observation directed specifically at older residents was the observation that “lots of seniors end up in nursing homes because of the lack of community support services.”

Unique Characteristics Affecting Health

In every community there are unique factors or characteristics that contribute to health and well being or that threaten good health. The key informants were asked what distinctive characteristics about Napa County play a part in promoting or protecting health or in undermining it. Their remarks are displayed in Table 73. One of the most important assets mentioned was the unusual amount of collaboration that occurs among the health sector and other organizations, including public/private agencies. Over half (11 of 21) of the interviewees cited this characteristic, many volunteering the observation even before the question was asked. Turf issues and competition were said to be minimal. Working together to cover the uninsured was recognized as a primary example.

The presence of Clinic Ole and its critical role in the community as a safety net provider was widely noted and acknowledged as an asset by many of the key informants, although some wondered if having this organization “relieved other health providers of stepping up to the plate and sharing the responsibility and burden of caring for the poor.”

The generosity of support through fund-raising efforts of organizations such as Auction Napa Valley and Hands Across the Valley was also highly praised by many, as was the focus on health for the Tobacco Settlement money. One individual added that it “is easy to be cooperative when money isn’t tight and local funders are so supportive.”

Finally, it was believed that Latinos, considered by most to be a high-need population, were a common focus of care and that there is “a consistent desire to serve them.” An example cited was the monthly “empowerment” series that Queen of the Valley has been offering to the Latino community. In that program, a bi-cultural psychologist makes a monthly presentation called “Cultural Wisdom” focused on helping Latinos appreciate their own cultural and understand how it might be different from the U.S. culture. Its goal has also been to break down some of the division between those who are more recent immigrants and those who have been in Napa County for many years. Between 150-300 people, diverse in gender, age, education, and socioeconomic and acculturation levels were reported to attend every month.

Table 73. Unique Characteristics about Napa County that Affect Health and Well Being

<i>Assets</i>
<ul style="list-style-type: none">▪ Unusually high degree of collaboration among organizations▪ Minimal turf issues▪ Existence of highly-regarded Clinic Ole as a critical safety net provider▪ Presence of local, generous funders supportive of health▪ Consistent desire to serve high-need groups (e.g., Latinos)
<i>Challenges</i>
<ul style="list-style-type: none">▪ High cost of living in the area▪ Aura of wealth that camouflages poverty▪ High numbers of agricultural workers with unmet needs▪ Inadequate public sector resources for health education/health promotion and chronic disease prevention compared to other counties▪ Geographic barriers due to distance and spread between cities/towns▪ Poor inter-regional connectedness

Characteristics believed to challenge community health were said to include the high cost of living, making it very difficult to recruit professionals, particularly those at mid-level or middle-income level salaries; the “ambiance of wealth” with the “daunting aura of food and wine” that underexposes the fact that there are a substantial number of poor people (“the wealth doesn’t trickle down to the poor”); a lack of inter-regional connectedness (coordination, collaboration, communication) with neighboring counties; geographic distances and spread; low involvement of public health services in health promotion and chronic disease relative to other counties; a large agricultural worker population compared to other counties; and issues related to acculturation.

It was acknowledged that while Napa County is better off than most California agricultural counties and was “not really a poor county,” there were needs remaining unmet and under-addressed. Working relationships with other counties were not viewed as being as close as they might be to benefit Napa County, for instance regarding mental health services. The geographic barrier to access was described as being caused by the 30-mile span north to south, limited access to the inhabited areas of the eastern hills, few roads leading up the Napa Valley, and inequitable availability of resources within the county. And, the relatively large Latino population challenges related to acculturation included the following examples:

- “Poor English skills make parents feel unqualified to be involved in their kids’ education. It makes them feel disconnected from their children.”
- “Immigrant parents still hold kids to their own standards but it’s a conflict; kids are caught in the middle of both worlds and can’t identify with either culture—resulting in frustration for both parents and children.”
- “Newcomer Latinos aren’t identifying with Latinos who were born here/live here. They take even longer to develop trust to use services.”

Suggested Solutions

The key informants were generally consistent in suggesting “wish lists” for future funding that matched the priority problems and unmet needs they identified. The two most commonly recommended topic areas concerned mental health and preventive health (Table 74). The recommendations specific to age and ethnic groups are entwined with the topic area.

Table 74. Strategies Key Informants Believe Should Receive Priority Funding Support

Recommendations	Frequency of Mention
<i>Regarding Programs and Services</i>	
Mental health services, e.g., schools, crisis, family therapy, Latina support grps	9
Comprehensive prev. health education, e.g., campaign, change cultural norms	7
Dental services (adult/srs=1; outpt. surg cntr=1; mobile van for adults =2)	4
Bilingual training, e.g., encourage HS grads as certified med. interpreters	4
Primary care clinics, including dental, e.g., increase capacity of Clinic Ole	3
Low-cost insurance product for uninsured adults	2
Support services for seniors, e.g., helpers for chores, transportation, appts	2
Alternative/more flexible transportation options countywide	2
Establish information and resource center for informing about services	2
Establish institute on aging, training in geriatrics	2
K-12 education enhancements (wellness curriculum=1; basic sanitation=1)	2
Youth development to break the cycle of poverty	1
Seniors pharmacy assistance program	1
System navigators/ombudsman services	1
Affordable screening program for colorectal cancer	1
Childhood obesity prevention and treatment	1
Perinatal substance abuse interventions	1
Establish comprehensive health services in American Canyon	1
Establish senior center/wellness center in American Canyon	1
Outreach and in-home assessments of seniors	1
A community endowment for long-term care subsidies	1
<i>Regarding Grantmaking and Other Ideas</i>	
Generally fund only big-bang-for-the-buck strategies	1
Make more long-term investments, not short-term, “band aid” fixes	1
Promote collaborative agreements to focus on 1 or 2 issues of importance	1
Develop more integrative vision and strategy-building around community needs	1
Look at redundant services and evaluate for effectiveness	1
Support succession planning/leadership for exec. dirs. to keep feeding the system	1

Mental Health

Ideas regarding mental health ranged from improving systems of care for children, especially those that “neutralize stress and anxiety and promote nurturing relationships,” to establishing and maintaining education and support groups for Latinas to linking lonely seniors living at home to “friendly visitors” and other practical support services. Specific suggestions included:

- Community-placed mental health counseling, e.g., in each municipality, at work, at school.
- Family therapy for better family functioning (“keep families intact so they can move forward economically”).
- Increasing the number of school-based counselors.

Health Promotion/Prevention of Chronic Disease

Projects that result in behavior change and change cultural norms so that people make healthier choices and adopt healthier lifestyles were considered one of the most important areas for grant dollars. Those efforts clearly need to be delivered with linguistic and cultural appropriateness to be effective, however, according to the respondents. And, efforts focused on children need to start and be supported as early as possible in a child’s life “so there aren’t missed opportunities.”

One interviewee remarked, “We need to harness the energy and passion that exists for preventive health and create a culture for wellness in the county that includes the workplace, schools and even traffic safety.” Examples cited of healthy workplace programs included:

- Washington Wellness Works, focusing on improving the health of all Washington State employees, retirees, and their families.
- American Cancer Society Workplace Solutions, a practical program designed to illustrate the business case for employer-sponsored cancer prevention, and to show employers how to implement best practices in prevention of cancer and other chronic diseases.

One individual noted that “individual hospitals and other organizations can’t do anything on a mass scale to change behavior; there has to be a countywide or statewide effort supporting it hand in glove with an effective media campaign, similar to the anti-tobacco effort, for this to work.” Another individual suggested identifying the best health education curriculum that includes a strong wellness component and finding the funds to implement it in Napa County K-12 school districts countywide.

Dental Services

Suggestions related to oral health included:

- Outreach to populations that have identified unmet oral health needs such as seniors and agricultural workers in labor camps and offer mobile dental services to those communities.
- Fund access to specialty care (endodontics, periodontics, orthodontics) for those who lack insurance coverage.

Bilingual/Bicultural Workforce

Support for recruiting and training bilingual, ideally bicultural/bilingual, health and human service workers was mentioned as an important strategy for providing better quality of care and encouraging increased utilization of services. Ideas included encouraging high school graduates to train as certified medical translators.

Related to this issue was the suggestion that navigation systems be supported that assist non-English-speaking persons in making appointments and following through with keeping them.

Access to Comprehensive Primary Care Services

Specific suggestions to improve access to comprehensive health care services included:

- Develop and support a low-cost health insurance product for adults.
- Increase the capacity of Clinic Ole for medical, dental and mental health by providing funding for: more physical space, staffing and equipment at current locations; the ability to establish sites in new locations (e.g., American Canyon); and ongoing support for operational costs.
- Look for best practices, including providing incentives, that would encourage more private physicians (and dentists) to accept Medi-Cal and Healthy Kids.
- Create less restrictive policies that are sensitive to cultural and socioeconomic circumstances (e.g., re-scheduling an appointment if someone is 5 minutes late) and solicit commitments from public and private health facilities to implement them.

Related to *having* an array of services in the community is the need to *inform* people about the services that are available, where they are located and how to access them. A couple of people remarked that “ignorance and fear are the biggest obstacles in the community to seeking services,” and “people don’t lack the will, they lack the knowledge.” The recommended solution was to maintain support for resource centers and onsite access to services; an example cited was Puertas Abiertas where a group of about 25 non-profit human service agencies in Napa County offer services at one location “trusted” by the community.

Suggestions Specifically Related to Seniors

The following recommendations were made relative to seniors that were not mentioned elsewhere within the context of other suggestions. The suggestions were for these efforts to occur within Napa County.

- Create a community endowment to help fund affordable long-term care for seniors, including those on Medi-Cal.
- Establish an institute on aging.
- Train geriatricians.



■ CONCLUSIONS AND RECOMMENDATIONS FOR PRIORITY CONSIDERATION

"I would say 'Invest in a local problem with a local solution; don't try to influence what can only be debated at a statewide or national level.'"—Key Informant Interview

The 2007 Napa County community health needs assessment identified challenges, such as the major health problem of diabetes and the dental needs of seniors, and high-risk behaviors like underage alcohol use. The assessment also identified trends on issues of special significance to Napa County, such as the rapidly growing numbers of seniors. It also shed light on opportunities for improving health trends that are related to the community's overall health status.

Certain findings were expected and supported the Collaborative's assumptions: the percentage of the population without health insurance, difficulties related to language barriers, rates of childhood asthma, and the extent to which the community depends on Clinic Ole as the primary safety net for the poor, to name a few. However, some findings were a surprise. On the positive side, these included high rates of screening for breast and colorectal cancer, low rates of effects from pesticide use, the degree to which seniors rated themselves as being in good health and community awareness about the value of healthy living and the degree of sophistication in identifying wellness as a top-priority need. Across the board among community participants there seemed to be a move away from simply "I need a doctor" to more of a sense of needing to manage their own health.

Another unanticipated though not necessarily surprising finding was the extent to which community leaders identified collaboration as a key factor about Napa County that influences health and well-being. The lack of turf issues, open communication, and supportive relationships—from planning for services to jointly seeking grants to delivering services—was widely recognized as facilitating the great deal of cooperation that exists among provider organizations and professionals in the county.

On the other side, the growing trend toward obesity among children and adults—mirroring state and national trends—was anticipated but the extent of the problem was unexpected.

Depression and social isolation, particularly for new arrivers and seniors, was a troublingly common theme revealed throughout the surveys conducted for this assessment, and supported similar findings by others. Reviewing the published data in conjunction with the results of the community input process not only created a better understanding of what the mental health needs are, but suggested that the needs—created by life stressors, life changes, situational anxieties—are essentially the same for the affluent as they are for the low-income: the difference is access to help.

The findings from the needs assessment also point at the influence of acculturation—the process of adopting habits, beliefs, language and behaviors—on mental health as newcomers feel the pressure of assimilation and risk the of loss of separate ethnic identification. Acculturation has been studied elsewhere in relation to prevalence of chronic illnesses, and indicates that certain aspects of lifestyle (e.g., dietary habits, patterns of physical activity) may affect the development of specific diseases.⁸⁴ Beliefs about causes, treatment, and prevention of illnesses, as well as barriers to access, may also affect the utilization of health services. Napa County's large numbers of Latinos, particularly resident and seasonal agricultural workers, presents a unique challenge to funders in Napa County in providing culturally and linguistically accessible mental health and primary care services in an increasingly diverse county.

Napa County, like many other counties, has a significant issue with alcohol abuse. It is not at all clear that this is related to the wine industry. Rather, it is likely related to the inter-relatedness of poverty, family dynamics, mental health and other complex issues. Specifically with regard to youth alcohol use, it is possible that in a culture where wine is a customary factor in dining experiences and the social culture, acceptance of such may have an indirect influence on youth behavior. Parents' drinking behavior and favorable attitudes about drinking, for instance, have been positively associated with adolescents' initiating and continuing drinking.⁸⁵ Although a minority of youth in Napa County reported using alcohol and binge drinking, higher than statewide averages of juvenile arrests for alcohol and drug offenses and youth alcohol-involved motor vehicle accidents suggest areas for community intervention. Additionally, considering the beverage-specific alcohol consumption by youths—hard liquor and beer being the likely choices—is important when developing alcohol-control policies.

⁸⁴ See, for example, Hazuda HP, Stern MP, Haffner SM: Acculturation and assimilation among Mexican Americans: scales and population-based data. *Soc Sc Q.* 1988;69:687-706. Solis JM, Marks G, Garcia M, Shelton D: Acculturation, access to care, and use of preventive services by Hispanics: Findings from HHANES 1982-84. *Am J Public Health* 1990;80 (Suppl):11-19. Hazuda HP, Haffner SM, Stern MP, Eifler, CW: Effects of acculturation and socioeconomic status on obesity and diabetes in Mexican Americans. *Amer J Epidemiology* 1988;128:1289-1301.

⁸⁵ See, for example, Andrews, J.A., et al. Parental influence on early adolescent substance use: Specific and nonspecific effects. *Journal of Early Adolescence* 13(3):285-310, 1993. Hawkins, J.D., et al. Exploring the effects of age of alcohol use initiation and psychosocial risk factors on subsequent alcohol misuse. *Journal of Studies on Alcohol* 58(5):280-290, 1997.

Overall, Napa County does not look markedly different from other California counties with regard to many commonly examined indicators of illness and death. And because the morbidity and mortality data did not show that Napa County is strikingly different than other places, it allows the Collaborative to look more closely at what the community's needs and perspectives are from the vantage point of the community.

RECOMMENDED PRIORITIES

The Collaborative recognized that while each organization represented among the group will ultimately choose to fund or support community health interventions that are a best fit with its own mission and priorities, an important opportunity exists in Napa County for all health partners to focus on the area of preventive “healthy living” and wellness. Other priority areas the Collaborative found compelling from evaluating the assessment findings were the continuing unmet need for community-based mental health services, dental care for low-income seniors and children and programs and services that address alcohol abuse, particularly underage drinking. In a scenario with limited resources, the Collaborative believes all of these areas should receive highest-priority consideration for focusing resources on community investments.

Healthy Living and Wellness

Recommendations to improve community health related to the priority area of healthy living and wellness include the following elements:

- Create and implement a community health action campaign that is comprehensive and far-reaching; schools, workplace and community involvement is essential for success.
- To be sustainable, strategies should include support for physical infrastructure improvements such as walkable communities.
- To be long-lasting, health and wellness strategies should address the whole family.
- Programs and campaigns are particularly needed that focus on the problem of obesity among children and adults, tobacco prevention and cessation and cancer screening.
- Community approaches to reach high-risk populations, and community-based programs and linkages to effective community resources (for example, to address diabetes) are best.
- Programs that address the care needs or support infrastructure for family, friends, and caregivers of those suffering from depression, like all programs and services, must be culturally and linguistically appropriate and community-based in places that engender trust and promote utilization.
- To be successful, educational interventions should be directed at what it takes to get people to make long-term behavior changes (for example, providing meaningful

incentives) and be provided in places where people already meet or gather (at PTA meetings, for instance).

- Emphasis related to the priority areas should be placed on prevention efforts, initiatives that focus on self-management of conditions and on reaching out to under-served and special populations.

Mental Health

Creating a healthier community also involves efforts focused on promoting mental health and positive social and emotional development. Opportunities to support community-based mental health efforts are well spelled out in the County's Mental Health Services Plan assessment, and as well should consider the following essential elements:

- Mental health should be woven more firmly into programs that are designed to help people access other social and medical services, such as at Family Resource Centers.
- Services should be at places *where* they are needed and available *when* they are needed; they do not necessarily always need to be delivered by a mental health professional.
- Efforts that address depression should be responsive to issues associated with poverty and cultural and social isolation.
- With regard to programs that aim to improve mental health among seniors, novel ways and locations should be found that provide services in ways that are both accessible *and* acceptable to seniors.
- To increase the likelihood of continuity and success, funded projects should ideally be collaborative and linked to other community-based programs.

Dental Services

Dental services should be expanded to populations of greatest need including those with the highest risk of dental decay and other oral disease.

- Expand dental services for children, including preventive services and educational guidance for parents and other caregivers.
- Expand existing and implement new programs that result in more access to dental services for low-income seniors, including help paying for dentures.

Alcohol Abuse/Underage Drinking

To address alcohol abuse and underage drinking, funders in Napa County are encouraged to consider the following recommendations.

- Programs and services should largely target children and youth and be focused on prevention and early intervention.
- Targeted interventions should be high intensity, integrated with other appropriate youth-service activities and be multi-level involving individual students, parents, peers, community members, businesses and organizations.
- Programs should be comprehensive and address other issues such as smoking that go along with adolescent alcohol abuse and underage drinking. (Teen smoking is an early warning sign for additional substance abuse problems like heavy drinking according to the Campaign for Tobacco-Free Kids.)
- Program strategies should employ evidence-based approaches, for example a peer- and teacher-led classroom curriculum focusing on resistance skills and normative expectations regarding teen alcohol use.
- Social marketing efforts should be supported to discourage teen drinking and change social norms.
- Efforts that address adult alcohol abuse should be community-based, culturally and gender-appropriate and include an array of services throughout the county for the prevention, intervention, treatment and rehabilitation of alcohol abuse and dependency. These services should be coordinated and integrated or linked to other community services—health, mental health, social services, workplace assistance programs—to comprehensively address the needs of individuals suffering from alcoholism and their families.

The Collaborative believes that projects based in the community have the best opportunity to make a real difference in the health of individuals and their families and those providing such care. Visions for future community support in all areas will require identifying suitable leadership, raising awareness of stakeholders (such as by sharing the findings from this needs assessment) and determining how to involve them, and agreeing in what areas and how each group will cooperate.

ATTACHMENTS

ATTACHMENT 1

NAPA COUNTY COMMUNITY HEALTH NEEDS ASSESSMENT WORKING COMMITTEE

P.J. LoDuca, M.S., R.N., Executive Director
Community Outreach
Queen of the Valley Medical Center

Gayle H. Hunt
Napa Solano Community Benefit Manager
Kaiser Foundation Health Plan

Linda Schulz, M.S., Director
The Women's Center of St. Helena Hospital

Karen Smith, M.D., M.P.H., Public Health Officer
Napa County Public Health

Suzanne Shiff, M.A.
Grants Outreach Consultant
Auction Napa Valley/Napa Valley Vintners

Beatrice Bostick, Executive Director, and
Stacey McCall, Assistant Executive Director
Community Health Clinic Ole

Catherine Hoffman, ScD., R.N.
Community volunteer to the project
Associate Director
Kaiser Commission on Medicaid and the Uninsured

Donald Hitchcock, M.D., Medical Director
Community Outreach
Queen of the Valley Medical Center

Jennifer Henn, Ph.D., Epidemiologist
Napa County Public Health

The committee would like to express appreciation to Yolanda Arias, Queen of the Valley Community Outreach, for her work in organizing and providing support for the meetings, and to Robert Moore, MD, MPH, Medical Director, Clinic Ole, for reviewing and providing comments to a draft of this report.



HEALTHY COMMUNITY QUESTIONNAIRE

The Napa County Health Collaborative would like your help. We are working to improve the health of everyone in our community. Please take a moment and share your views with us.

1. When you think about Napa County and all the people you know here, what do you think are the "Top 5" health problems or needs? Is the problem greater for certain groups?

Problem/Need:

Which group? Everyone?

2. When you or your family need health care, are any of the following usually a problem?

No

Yes

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Childcare |
| <input type="checkbox"/> | <input type="checkbox"/> | Transportation |
| <input type="checkbox"/> | <input type="checkbox"/> | Finding a place where they speak my language |
| <input type="checkbox"/> | <input type="checkbox"/> | Finding someone who takes my insurance (including Medi-Cal) |
| <input type="checkbox"/> | <input type="checkbox"/> | Finding somewhere that offers reduced-cost or free care |
| <input type="checkbox"/> | <input type="checkbox"/> | Finding an office or clinic that is open when I'm not working |

Other (What?) Please describe: _____

3. What are your ideas to improve the health of people in our community? (List in order of importance)

4. How would you rate your general health? Excellent Good Fair Poor
5. How long ago was your last dental check-up? 1 year 1-2 years 2+ years
6. What is your gender? Female Male
7. What is your race/ethnicity? Asian African America Hispanic/Latino
 White Native American Other
8. What is your age group? Under age 21 21-64 years Age 65+

If you have questions about this study, please call the Napa County Public Health Department at (707) 253-4773.

COMMUNITY FOCUS GROUP QUESTIONS

1. When you think about what you see and hear, and what you read about Napa County—for example, in the newspaper or on TV news, or when you go shopping—what do you think are most important health problems in the community? *[Look for health needs/unmet needs, issues, problems. Don't necessarily try to create a laundry list; ask for the "most important" "top" problems. Ask for clarification if something is vague—for example, if someone says "women after they've given birth"—do they mean postpartum depression? Do they mean women now needing birth control services? Do they mean women needing to find a doctor for well-baby exams?]*
2. Who in the community is most affected by these problem/issues? *[Look for a drill-down on which groups are perceived to be most affected by the identified problems or issues]*
3. What are the main reasons why people have trouble trying to take care of these problems? *[Try to identify barriers that interfere with getting these health needs met]*
4. Do you think most people here know about the kind of health services available to them? How do they learn about them? *[Look for familiarity, awareness of resources, sources of information]*
5. If the Good Fairy came along *[alternate: you won the lottery]* and you could improve the health of people in Napa County, what are your ideas for the service or programs you would want to see more of/improved? *[alternate: how would you recommend this money be spent?]* *[Look for ideas for do-able, reasonable, practical solutions or strategies; be sure to help the participants tie these back to the identified health needs, if necessary. See if there's a particular type of program, service, location, etc. Look for perceptions about what needs to be available to make a healthier community, who can help]*

HEALTH PROFESSIONALS' FOCUS GROUP QUESTIONS

1. What profession are you in?
2. How often do you look for health-related needs or problems in your everyday work?
3. How would you define "a health need?"
4. What do you believe are the highest-priority health needs in Napa County?
5. Who's most affected by these problem/issues?
6. What are the main barriers to meeting these needs?
7. What are the biggest gaps in services or programs?

8. How do people in Napa County learn about the health-related resources available to them? To what extent do you think various populations are aware of these resources? (familiarity, awareness)
9. What are the data that substantiate or give evidence to these problems?
10. Are there other informational resources (data.....) we should be aware of that we may not be looking at? Where are these available? Who should be contact?
11. Are there important gaps in skill sets or competence to meeting these needs/filling these gaps (i.e., training needs)?
12. What needs to be available to make a healthier community? What are your ideas for do-able, reasonable, practical solutions or strategies?
13. What outcomes from this process would you like to see?

TELL US WHAT YOU THINK!

Join other Napa County residents and share your opinions about:

- What are the most important health problems in our community?
- What services or do we need more of?
- What would be helpful?



Date: Wednesday, June 20, 2007

Time: 7:00 p.m.

Place: Stonebridge Apartments, Community Service Room

Refreshments!

Free gift bag!



KEY INFORMANT INTERVIEWS AND OTHER CONTACTS

(Alphabetical Order)

Person Contacted	Agency/Organization
<i>Key Informant Interviews</i>	
Barbara Nemko, Superintendent of Schools	Napa County Office of Education
Beatrice Bostick, Executive Director	Clinic Ole
Brad Wagenknecht, Board Supervisory	Napa County Board of Supervisors
Dr. James Cotter	Napa Kaiser
Dr. Karen Smith, Public Health Officer	Napa County Public Health
Dr. Robert Moore	Community physician, Clinic Ole
Father Brenkle	St. Helena Catholic Church
Father Gordon Kalil	St. John the Baptist Church
Frances Ortiz-Chavez, Program Coordinator	Puertas Abiertas
Jill Techel, Mayor	City of Napa
Joelle Gallagher, Executive Director	COPE
Lori Pesavento, Executive Director	Family Service of the North Bay
Mark Bontrager, Deputy Director	Aldea
Mark Diel, Executive Director	Children's Health Initiative
MaryAnn Eckhout, Executive Director	Napa County Medical Society
Merritt Fink	Healthcare Consultant
Ruben Oropeza	Napa County
Sara Cakebread, Interim Executive Director	St. Helena Family Resource Center
Sherry Tennison, Executive Director	American Canyon Family Resource Center
Stephanie Snyder, Executive Director	Calistoga Family Center
Terri Restelli-Deits, Manager	Area Agency on Aging
LeAnne Martinsen, Executive Director	
Elizabeth Mautner, LTC Ombudsman Program	
Tom Amato, Executive Director	Angwin Community Teen Center
<i>Interviewed/Consulted for Specific Information</i>	
Dale Berry, Dental Services Manager	Clinic Ole
Dave Whitmer, Ag Commissioner	Napa County Department of Agriculture
Dr. Donald Hitchcock	Community Outreach, QVH
Felix Bedolla, Mental Health Services Act Mgr	Napa County Mental Health Division
Greg Clark, Deputy Ag Commissioner	Napa County Department of Agriculture
Jaye Vanderhurst, Director	Napa County Mental Health Division

KEY INFORMANT INTERVIEW QUESTIONS*

1. Please describe your agency and its services. *[Ask follow-on questions as appropriate]*
2. What do you believe are unique characteristics of Napa County that contribute to or threaten health?
3. What kinds of health problems do you observe members of the community are experiencing? *[Physical, mental, social]*. Which are the top problems or needs? Why?
4. What factors or causes do you think contribute to these problems?
5. Which community members do you think have the most urgent health-related needs? Why?
6. What resources are available to address these health problems? *[Organizations, funding, community expertise, advocacy, other strengths and asses....]*
7. To what extent do you believe people are aware of/utilize these resources? What are the barriers?
8. What are your thoughts about how funders can help meet these needs? *[Best, evidence-based, strategies and solutions appropriate to fund]*
9. Are there other assessments/studies/data you aware of that could help inform our assessment?
10. Are there additional comments would you like to make or additional information you can share?

* Note: Questions were not always asked in the same order. Questions were modified where necessary, e.g., to avoid asking something that was already known such as the type of services provided by the organization. Each interview began with an explanation of the purpose, assurance of confidentiality, intended use of the information, and so forth.