COMMUNITY HEALTH NEEDS ASSESSMENT (CHA) & NAPA OLDER ADULT ASSESSMENT (NOAA)

Board of Supervisors - April 23, 2024

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OVERVIEW

- Community Health Needs Assessment (CHA)
 - Purpose and Process
 - Community Health Themes
- Napa Older Adult Assessment (NOAA)
- Community Health Improvement Plan (CHIP) & Our Operational Strategy for Collective Impact

-2023

COMMUNITY HEALTH NEEDS ASSESSMENT

Napa County, California











To provide feedback on this CHNA or obtain a printed copy free of charge, please email Jennifer Henn, PhD, at Jennifer.Henn@countyofnapa.org or Teresa Smith at Teresa.Smith@Providence.org.

NAPA COUNTY CHNA-2023







PURPOSE AND PROCESS

- A CHA or CHNA is a comprehensive assessment that establishes the foundation for sustainable health improvements for Napa County
 - Performed every 3-5 years (includes both quantitative and qualitative data)
 - Focuses both on traditional measures of health (e.g., rates of disease) and on the Social Determinants or Drivers of Health (SDoH)
 - SDoH are the non-medical factors that influence health (such as the conditions of the places where people live, learn, work, and play that affect a wide range of health outcomes)
 - Establishes priority areas for community health improvement
- Link to CHA: 2023 Napa County Community Health Assessment





2023 CHA/CHNA JOINT PROCESS

Napa County HHSA and Providence QVMC partnered to produce a joint health assessment in 2023

 A Human-Centered Design process was utilized to understand the personal, lived experiences of community members.

 Engagement focused on communities whose voices are often underrepresented or unheard in public discourse and with community leaders working in both paid and unpaid capacities.

• Listening sessions and key informant interviews included 137 individuals from across Napa County: American Canyon, Calistoga, Napa, St. Helena, and Yountville







COMMUNITY HEALTH THEMES

FOUNDATIONS



RACIAL EQUITY & LGBTQ INCLUSION



HOUSING



BEHAVIORAL HEALTH



ECONOMIC STABILITY



FOOD ACCESS



ACCESS TO HEALTH SERVICES

BARRIERS



CHILDCARE



LANGUAGE ACCESS



TRANSPORTATION



EDUCATION /
DIGITAL INCLUSION





5 NEEDS IDENTIFIED

In selecting priority areas for focus, community partners were asked to consider the magnitude of the problem, the ability to have an impact, and alignment with existing priorities, including an equity lens.

Housing
Behavioral Health
Access to Health Services
Racial Equity & LGBTQ Inclusion
Economic Stability













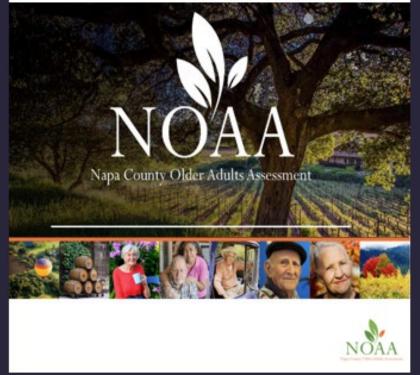




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NAPA COUNTY OLDER ADULTS ASSESSMENT

Methodology

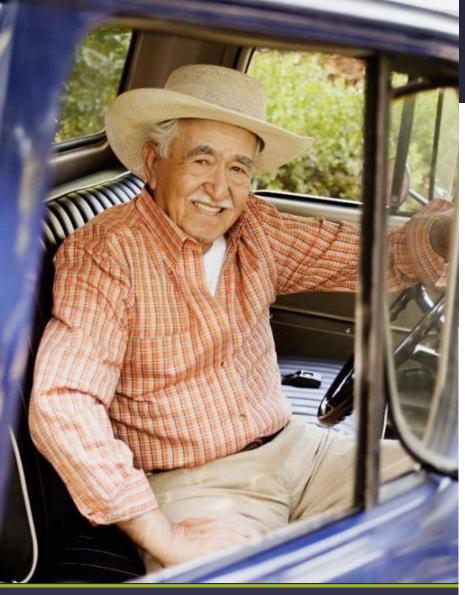
1530 surveys

21
interviews

76
focus group participants

Between March and October 2023, the NOAA project management team, advised by the NOAA Steering Committee, collected data to inform the Needs Assessment by conducting an online and inperson non-scientific survey, focus groups, and Key Informant Interviews (KII) to obtain the opinions of older adults (60 and up) who live in or serve as a caregiver in Napa County.

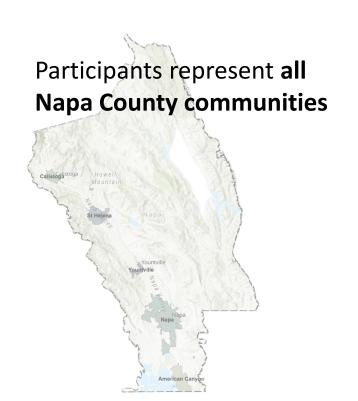


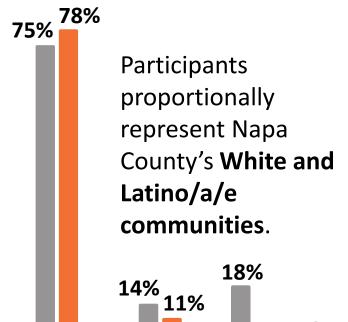


Health & Human Services Agency

OUR OLDER ADULT COMMUNITY

- Older adults make up **28% of Napa County** and are the most **rapidly growing population**.
- Over 68% of NOAA participants have lived in Napa
 County more than 20 years.





Latino

White

5%

BIPOC

Survey



Demographics

- 88% of respondents with an annual income over \$50K are White
- 66% of all White respondents have an annual income of \$50K or more

Income

 Annual income is over \$50,000



- **5** Connection
 - 28% live alone
 - 93% communicate with friends/family weekly or more
 - 82% rely on text/Nixle for emergency information
- 4 Transportation & Safety
 - 96% use their own vehicle
 - 3% use public transportation or non-profit services
 - 40% do not have an emergency kit

- 2 Basic Needs
 - 88% own their home
 8% rent their home
 - 90% can afford all their basic needs (based on a list of 12 basic needs including healthcare, bills, food, housing)
 - 96% can afford food they need/want
- 3 Health
 - 17% have a depression diagnosis
 - 35% have experienced a fall in the last year
 - 4% do not have access to dental care







Demographics

- 34% of respondents with an annual income under \$25K are Latino/a/e
- 66% of all Latino/a/e respondents have an annual income under \$25K



1 Income

 Annual income is under \$25,000



- 5 Connection
 - 61% live alone
 - 84% communicate with friends/family weekly or more
 - 42% rely on text/Nixle for emergency information
- 4 Transportation & Safety
 - 47% use their own vehicle
 - 29% use public transportation or non-profit services
 - 54% do not have an emergency kit

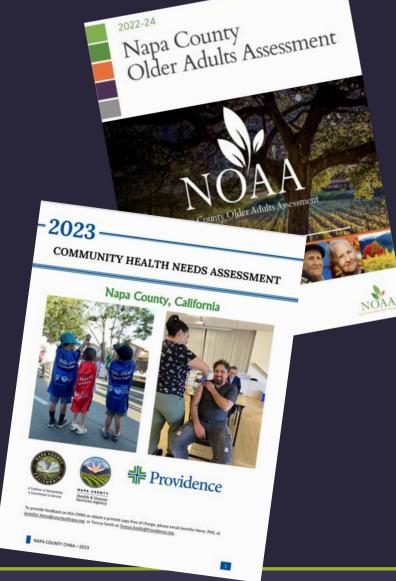
- 2 Basic Needs
 - 22% own their home
 60% rent their home
 - 41% can afford all their basic needs (based on a list of 12 basic needs including healthcare, bills, food, housing)
 - 60% can afford food they need/want
- 3 Health
 - 33% have a depression diagnosis
 - 49% have experienced a fall in the last year
 - 28% do not have access to dental care





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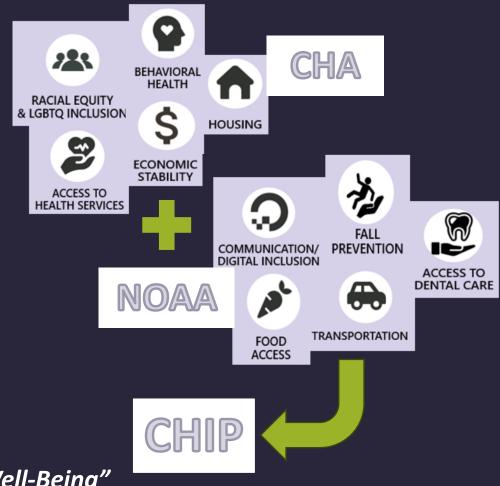






COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

Priority areas identified through the CHA – and the NOAA – drive the Goals, Objectives, and Strategies that form our CHIP → Our roadmap to coordinating resources and targeting efforts for "Collective Impact to enhance Community Health and Well-Being"



HHSA's Mission:

"To Serve our Community & Support its Health and Well-Being"





COLLECTIVE IMPACT: ALIGN PRIORITIES





COLLECTIVE IMPACT: ALIGN PRIORITIES + LEVERAGE FUNDING





- Master Settlement Agreement (MSA) Grant Award →
 targets needs identified in CHA/NOAA Priority Areas:
 1) Access to Health Services; 2) Housing; 3) Economic Stability; and 4) Racial Equity & LGBTQ Inclusion
- Mental Health Services Act (MHSA) RFP → targets Behavioral Health Priority Area (Mental Health) identified in CHA/NOAA; aligns with MHSA 3-Year Plan
- Opioid Settlement Funds (OSF) RFP → targets
 Behavioral Health Priority Area (Opioid Disorders)
 identified in CHA; aligns with Napa Opioid Safety
 Coalition (NOSC) Strategic Plan
- Funded Programs/Services = CHIP Strategies





OUR STRATEGIC PLAN IN ACTION: "COLLECTIVE IMPACT TO ENHANCE COMMUNITY HEALTH AND WELL-BEING"



Collaborate with Community Partners to Maximize our Reach and Collective Impact to Enhance Community Health and Well-Being

- Objective 1: Align and leverage community assessments and action plans in conjunction with community partners and internally across HHSA's divisions.
- Objective 2: Leverage funding to create opportunities for coordinated care in alignment with community assessments that aim to address service gaps.
- Objective 3: Enhance bi-directional communication, information sharing, and coordination of service delivery, both internally and externally.
- Objective 4: Maximize partnerships with population and service-based advisory boards, councils, and coalitions.



THANK YOU



