Taking Action for a Healthy Future

Napa County Community Health Action Plan Summary

June 2014

Taking Action for a Healthy Future

Live Healthy Napa County (LHNC) is a coalition of community stakeholders including representatives not just from health and healthcare organizations, but also business, public safety, education, government, nonprofits and the general public, focused on the collective vision that Napa County community members will take responsibility for improving and sustaining health through shared leadership, careful planning, meaningful community engagement, and coordinated action. While many opportunities exist for residents of Napa County, addressing ongoing health disparities through collaborative means will enable a better future for all.

By using the Mobilizing for Action through Planning and Partnerships (MAPP) framework[1] as a model for their work, LHNC embarked on a nearly two-year collaborative process beginning in July 2012 culminating in the development of two key planning documents:

- The **Community Health Assessment (CHA)** established the foundation for sustainable improvements in health in Napa County. The data presented in the CHA reflects an understanding that community strategies must consider the social, economic, behavioral, and structural factors that impact health.

- The **Community Health Improvement Plan (CHIP)** proposes a broad plan to address the health issues presented in the CHA. The CHIP outlines areas for developing new policies and determining health promotion strategies. This community-driven, living document will continue to evolve even during its implementation, reflecting the flexibility necessary to be responsive to changing community needs and dynamics.

The CHIP has served as a springboard for developing the strategic action presented in the Napa County Community Health Action Plan. Specifically, the CHIP describes **four priority areas** to focus the work ahead:

Improve wellness and healthy lifestyles.

Address the social determinants of health.

Create and strengthen sustainable partnerships for Collective Impact.

Ensure access to high quality health services and social supports across the life course.

Live Healthy Napa County Collaborative Planning

Overview of Napa County Community Health Action Plan

The Napa County Community Health Action Plan provides a roadmap for stakeholders to begin implementing the CHIP. The plan details strategic steps that put the four broad priority areas into action, prioritizing the health of Napa County residents while simultaneously aligning with health improvement efforts at the state and national levels (e.g., Let's Get Healthy California, Healthy People 2020, the National Prevention Strategy, and the work funded by Robert Wood Johnson Foundation).

Through the involvement of multidisciplinary partners in steering committee meetings, group discussions, community forums, and surveys, this Action Plan reflects strong community involvement that has existed throughout the life of the project. The intention of this wide-reaching collaboration is to ensure that each strategy in the Action Plan is crafted with careful consideration of the diverse populations and needs of the county. As a result of the collaborative approach that resulted in the CHA and CHIP and now the Action Plan, LHNC has effectively established the following five key elements of Collective Impact:

Collaborative planning has included the following key stakeholders:

- Health
- Healthcare
- Business
- Public Safety
- Education
- Government
- Nonprofits
- General Public

- **Common Agenda:** LHNC partners have come together to develop a shared vision.
- **Shared Measurement:** Agreed-upon data collection conducted by a neutral third-party has provided a foundation that supports informed discussion, insightful planning, and shared accountability.

- **Mutually Reinforcing Activities:** LHNC partners have brought their varied strengths and experiences to the effort in a coordinated way so that the whole is greater than the sum of its parts.
- **Continuous Communication:** LHNC partners have established consistent and open communication to build trust and maintain collective efforts.
- **Backbone Organization:** Primary LHNC member organizations have provided management and coordination for the initiative to serve as an organizational backbone for the effort, and the Napa County Public Health Division has taken a lead role in this effort.

Community Health Action Plan: Matrix

To clearly delineate its planned action steps, LHNC developed an Action Plan Matrix in collaboration with its steering committee and community partners. The matrix outlines specific strategies for each of the four priority areas, as well as measurable activities, performance measures, deadlines for activity completion, resources required, and current/planned evaluation.

Next steps include developing a more comprehensive evaluation framework and approach that will be necessary to track and learn from the implementation of the Health Action Plan. A comprehensive evaluation will also enable continued community input, reveal cross-cutting findings, and document the effects of the work across the county.

Components of the Full Community Health Action Plan

- Strategies
- Activities
- Performance measures
- Target completion dates
- Resources required
- Lead organizations
- Partners
- Evaluation components

NAPA COUNTY COMMUNITY HEALTH ACTION PLAN MATRIX

Priority Area #1: Improve Wellness and Healthy Lifestyles – Strategies and Activities

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Provide opportunities , support, and education for managing weight, healthy nutrition, and physical activity	The Healthy For Life Initiative will increase knowledge on topics related to childhood obesity among populations in Napa County who are most at risk	% of overweight or obese children that re-designate to a lower weight category	8/2014	Assessment Team and Data Analysis	St. Joseph Health Queen of the Valley Community Outreach	Napa Valley Unified School District, Synergy Medical Fitness Center, Kaiser Permanente, Community Health Clinic Ole, Napa Valley Pediatrics , Napa Community Nutrition Action Partners, Children & Weight Coalition	Assessments and Data Analysis	Annually
	Increase participation in TOPS (Taking Off Pounds Sensibly)	# of participants in TOPS	Ongoing	Resources for promoting the program in the community	Partnership Health Plan	-	Sign-up List	Every 6 months
	Increase the number of participants in Food for Life nutrition and cooking class series	# of participants per calendar year	Ongoing	Funds for advertising, donated space, volunteers	Food for Life Instructor (Kerri Zemko)	-	Class sign-in sheets	Annually
	The County Campus Coordinated Care Project provides services designed to reduce weight and improve overall health for individuals with chronic health conditions	1) Increased patient activation 2) Increase in number of nutritious meals 3) Increase in exercise 4) Decrease in waist circumference 5) Decrease in Body Mass Index (BMI)	January 2015 January 2016 January 2017	Many hours of staff time for primary care providers, health educator, care coordinator working with patients; Hours of patient time in activities; Collecting data daily	Community Health Clinic Ole (Tina Zoppel)	Napa County Health & Human Services Mental Health and Alcohol and Drug Services	Health registry report; Continuous improvement meetings	Review Annually

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
	Decrease consumption of sugar-sweetened beverages with Rethink Your Drink campaign	Rethink your Drink Event	12/2015	Paper, printing, staff time, consultant	Children and Weight Coalition	Napa Community Nutrition Action Partners	1)# of organizations that request or use materials 2)# of participants in the Event	Annually
Provide opportunities, support, and education for managing weight, healthy nutrition, and physical activity *(continued)*	Collaborate to leverage funding for a research and demonstration project for adults with disabilities & obesity. This includes: (1) a literature review to identify evidence-based and other promising practices in reducing obesity among adults with disabilities, (2) identifying potential sources of funding for such a project, and (3) crafting and submitting a proposal	Evaluation will focus on intervention in relation to change in (1) activity levels, (2) what participants eat and how much, (3) weight over time, and (4) BMI over time. Among participants and comparison group members with intellectual and developmental disabilities (I/DD), we hope to collaborate with North Bay Regional Center because they periodically collect information on height and weight of those they serve. We hope to include a few "success stories" as well to put a face on the data.	Lit Review: 6/30/14 Identification of potential source(s) of funding: 9/30/14 Submission of proposal: 11/30/14	None at this time. If funded, John Shea, Ph.D., economics, will lead the evaluation.	Napa Valley Coalition of Non-Profit Agencies - Disabilities Committee (John Shea)	-	Outcome evaluation, linking services received to changes in weight Success Stories	Yearly or half-yearly
	Collaborate with organizations and best practice specialists to increase knowledge on topics to promote senior wellness among populations in UpValley areas. This includes weight reduction, improved mobility and diet management.	1) Increase physical activity 2) Increase in number of nutritious meals 3) Increase in exercise 4) Increase in ease of movement	Ongoing	Facility space: Rianda House & Calistoga space, Kitchen/food prep-materials, tables chairs and open room. Specialists: Exercise, Nutritionist	Rianda House Senior Activity Center (Julie Spencer)	CANVI/Senior Nutrition, St. Helena Hospital, NVHAD, AAOA, HAPI partners, Exercise/Nutritional specialists, UpValley Family Centers	Class evaluations, attendance and satisfaction surveys	Weekly & Monthly activities

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Build capacity for people to be more physically active	Provide access to free, low cost recreation and exercise	1) % of adults and children reporting daily physical activity 2) % of people with knowledge of free ways to get active outdoors 3) # Days outside	1)June 1, 2015 2)August 31, 2014 3) 12/31/2015	1)-2) Staff time, political support, management support, limited funding. 3) Money for Advertising (Chino Yip, NCRPOSD)	Town of Yountville (Steve Rogers)	Yountville Community Recreation, Napa Valley Vine Trail, Napa Parks and Recreation, American Canyon Parks and Recreation, St. Helena Parks and Recreation, Calistoga Parks and Recreation, Boys and Girls Clubs, Napa County Parks and Open Space District, Rianda House Senior Activity Center	1)-2) Conduct survey of Yountville residents. Either on-line or in brochure. Include a listing of free ways to get active on website and in Park & Recreation brochures. 3) # persons at each activity	1) Annually 2) Quarterly 3) Monthly
	Provide opportunities for the community to learn how to safely ride bicycles for increased exercise and active transportation	# of participants in bike safety classes	12/31/2015	Grant from Air Resources Board (already received grant)	Napa County Bicycle Coalition (Mike Costanzo)	-	Attendance at classes (10 classes per year)	Annually
	Increase the proportion of individuals who use active transportation for trips of 2 miles or less	# of participants in April Fools event each year	Ongoing (Annually on 4/30)	Staff time and website support from League of American Bicyclists	Napa County Bicycle Coalition (Mike Costanzo)	-	# of individuals logging their bike rides	Annually; every April

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Create tobacco-free environments, prevent initiation of tobacco use, and promote cessation programs	Provide staff trainings on the Ask, Advise, Refer Medical Model	# of referrals made to quit smoking classes through staff trained in the Ask, Advise, Refer Medical Model as measured by Quit Smoking Program Intake Form	6/30/2015	Materials from California Tobacco Control Program	Community Action Napa Valley (Peggy Klick)	-	Staff attendance and staff evaluation	Quarterly
	Initiate Concierge Referral Program with the Queen of the Valley to provide a direct link to patients with quit smoking information and direct referrals to quit smoking classes	1) # of patients visited through Concierge Referral Service 2) # of patients who attend class and number of classes attended 3) # of patients who complete class series 4) # of patients who are smoke-free at 30 and 90 days	6/30/2015	-	Community Action Napa Valley (Peggy Klick)	St. Joseph Health Queen of the Valley Medical Center, Thoracic Surgeon at Queen of the Valley Hospital, Tobacco Advisory Board Member	Program evaluator (hired consultant)	Currently in approval status with Queen committees: Target Date to begin services May 31, 2014
	Adoption of comprehensive smoke-free outdoor parks and recreation area policies in all jurisdictions within Napa County	# of comprehensive policies adopted in local jurisdictions	1/2014-6/2017	-	Community Action Napa Valley (Peggy Klick)	-	Program evaluator (hired consultant), public opinion poll surveys, focus groups, key informant interviews	Ongoing
	Collaborate with the Napa County Office of Education to include e-cigarettes in district's non-smoking policies	# of NCOE school policies that include e-cigarette use in non-smoking policies	6/2016	-	Community Action Napa Valley (Peggy Klick)	Prevention Department, Napa County Office of Education	Program evaluator (hired consultant), Policy review	3 times per year
Enhance resources to increase breastfeeding rates	Create a community-wide Breastfeeding Plan to increase breastfeeding rates	Community-wide Breastfeeding Plan created	2016	-	Napa Valley Breastfeed-ing Coalition	St. Joseph Health Queen of the Valley Medical Center & Community Outreach, St. Helena Hospital, Kaiser Permanente, Partnership Health Plan, Napa County Health & Human Services Public Health	Plan Completed	Once

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Ensure home visitation services for high-risk people and families	Early prevention home visitation services to high- risk pregnant mothers	# of high-risk pregnant mothers who receive evidence-based, home visitation services from qualified providers	Ongoing	Adequate staffing to serve eligible families who desire HV services	Cope Family Center	Napa County Health & Human Services Public Health, Aldea Children and Family Services, ChildStart, St. Joseph Health Queen of the Valley Community Outreach	Number of families served with evidence-based home visitation Number of families eligible for Healthy Families America (or other evidence-based model) based upon current number of families surveyed as compared to number of families who qualify	Quarterly
	Create a Home Visiting Collaborative to integrate home visiting services and referral process for children age 0-5 and their families	1) # of quarterly meetings 2) Complete program matrix 3) Review Sonoma County MCAH HV Literature Review, Logic Model, and Evaluation Plan (with eye to developing similar for Napa County) 4) Create Napa County Logic Model and Integrated Program Document for home visiting 5) Create an integrated service and referral system plan for home visiting. Begin implementation	1) Begin by January 2014 2) 3/2014 3) 4/2014 4) 9/2014 5) 2015-2016	1) Representative from each agency providing 0-5 home visitation 2) All representatives complete program matrix 3) All representatives review documents 4) All representatives 5) All representatives	1)Cope Family Center 2)Public Health (Laura Keller) 3)Public Health 3)Cope/ Public Health 4)Cope/ Public Health	Aldea Children and Family Services, ChildStart, St. Joseph Health Queen of the Valley Community Outreach, Napa County Health & Human Services Public Health	1)Collaborative meetings 2)Completed Matrix 3)Completed Review 4)Completed document 5)Completed plan	1)At least quarterly 2)-5) Once

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Maintain programs to prevent alcohol and other drug abuse for teens	Friday Night Live builds partnerships for positive and healthy youth development	Increase environmental prevention efforts regarding alcohol, tobacco, and other drugs by utilizing youth leadership, advocacy and skill building models (i.e., youth development, roadmap, and SPF)	Ongoing Each project has a completion date	Training in capacity building, assessment, youth development, specific for the project Materials, transportation	Napa County Health & Human Services Alcohol and Drug Services/ FNL Coordinators, Advisors and FNL members	-	1) Cal OMS reports (Attendance) 2) Youth development survey 3) Members in Good Standing Report (MIGS)	1) Quarterly 2) Yearly 3) Once a year
Expand coordination and outreach for mental health and suicide prevention services focused on prevention, early identification, and intervention	Expand outreach presentations to teens and parents on mental health and mental health hygiene	1) Reach 30- 60 high school students and/or adults in workshop format, Participants will report growth in understanding of anxiety and skills for managing anxiety 2) Reach goal: Present to 300-500 students via school assemblies	1) August 2014 2) June 2015	1) Participants will pay program costs. Some scholarships may be offered. 2) TBD	Somos Napa (Debbie Alter-Starr)	-	1)Pre and Post Test surveys of participants 2)Possible follow up survey six months later 3)Post-event survey	1)After end of workshop 2)Six months post-workshop 3)Following event
	Suicide Prevention Committee will promote a suicide hotline and conduct a community needs assessment	1) Increase number of telephone calls to the North Bay Prevention Hotline 2) Collect 100 community need assessment surveys 3) Identify one project geared toward an area identified in the completed surveys	1) 6/2014 2) 2/2014 3) 6/2014		Napa County Health & Human Services Mental Health 1) HHSA – Stephanie Hogan 2) HHSA – Stephanie Hogan 3) HHSA – Jaye Vanderhurst	NEWS (Napa Emergency Women's Services), Family Service of Napa Valley, Aldea Children and Family Services, Napa County Commission on Aging, Healthy Minds, Healthy Aging, HAPI		1)Monthly 2)Completed 3)Ongoing

Priority Area #2: Address the Social Determinants of Health – Strategies and Activities

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/PLANNED EVALUATION	FREQUENCY
Increase awareness of the social determinants of health and how they affect health outcomes	Obtain training materials on SDoH from BARHII Materials and develop/adapt a Napa County presentation including Agenda, PowerPoint Presentations, handouts, activities, and evaluation	Develop a train-the-trainer presentation and have it approved by the Core Support Team	6/2014	SDoH Training materials from BARHII; Staff time of Health Education Specialist to adapt to Napa County	Napa County Health & Human Services Public Health (Cara Mae McGarry)	-	Approved by Core Support Team Y/N	Once
	Develop a pre- and post-test to determine participants' level of knowledge of the SDoH before and after attending the training	Develop the pre- and post-test and pilot the tool at the test session of the train-the-trainer	12/2015	Staff time of Health Education Specialist and Epidemiologist to develop pre/post test	Napa County Health & Human Services Public Health (Cara Mae McGarry)	-	Completed Y/N	Once
	Identify key leaders and community members representing groups to pilot test the training materials and incorporate suggestions based on feedback	Identify participants to pilot test materials, conduct the pilot test training for this group, and incorporate suggestions based on feedback	12/2015	10-30 key leaders and community members representing groups to pilot test the training materials and incorporate suggestions based on feedback	Napa County Health & Human Services Public Health (Cara Mae McGarry)	-	Admin support preparing training materials, registering participants; Training locations in City of Napa; training materials (PowerPoint slides, handouts, A/V equipment)	Once
	Work with the Steering Committee and Community Delegates to identify and recruit participants for the SDoH train-the-trainer presentation, and facilitate all logistics of conducting two trainings	Conduct the SDoH train-the-trainer a minimum of 2 times with at least one training in the City of Napa and one up-valley	12/2016	Admin support preparing training materials, registering participants; Training locations 1) City of Napa 2) Up Valley; training materials (PowerPoint slides, handouts, A/V equipment)	Napa County Health & Human Services Public Health (Cara Mae McGarry)	-	Written evaluation collected after every training	Minimum of two train-the-trainer sessions

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/PLANNED EVALUATION	FREQUENCY
Build community-centered wellness-support networks in under-resourced areas	Pilot an Asset Based Community Total Wellness Development Plan in Calistoga	1) 35 community leaders are identified with useful assets and willingness to generate and support wellness-support projects 2) 4-8 small resident-led wellness-support projects are implemented and sustained	December 2015	- Program design consultant – 10 weeks - Two bilingual interviewers (20 hrs/wk X 12 weeks) - One Coding/ data entry person (20 hours X 8 weeks) - One translator/ transcriber (20 hours X 9 weeks) - HHS Administrative support and guidance re: evaluation metrics - Funding support for Calistoga Institute overhead 7)Project support funds (4-8 projects X >$250)	Calistoga Institute (Eliot Hurwitz)	Rianda House Senior Activity Center	1) Survey (Perceived Wellness Survey: www.perceivedwellness.com) 2) TBD – general community wellness metric	1) 2X: First as part of the initial program interview then 1yr post program 2) TBD
Improve the built environment to encourage walkable and bikeable communities	Incorporate support for pedestrian safety, walkable and bikeable communities, and park and recreation facilities in the development of Local Capital Improvement Plan (CIP) processes for County/Local government	1) Linkage of the LHNC CHIP to incorporate into each Napa County public agency's CIP reinforcing the importance of including projects that will have an impact on the health of the community 2) Increase in overall identified projects which are included in the CIP document (funded or future projects) 3) Increase funding allocated by the public agencies for these projects	1)June 30, 2015 2)June 30, 2015 3)June 30, 2016 and ongoing	1) Nominal, staff time to reference LHNC CHIP in narrative of CIP project descriptions 2) Nominal to identify future or unfunded projects; more significant funding to fully implement identified projects 3)Significant new funding and/or political support to allocate available funding for these projects over other projects	Town of Yountville (Steve Rogers)	Calistoga Bicycle Advisory Committee, Napa County Bike Coalition, Napa River Trail	1) Identify that LHNC CHIP narrative and reference is included in local agency CIP for appropriate projects which maintain or improve pedestrian and bicycling capability or access to public recreation facilities. 2) Comparison of prior CIP documents to future CIP documents to review if there were an increased number of projects. 3) Review of funding allocated compared to previous years	1)-3) Annually

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/PLANNED EVALUATION	FREQUENCY
Partner with the community to promote and support the Charter for Compassion	The Chair of the Board of Supervisors will sign a proclamation adopting the Charter of Compassion and encourage all Napa County cities and the Town of Yountville to participate	1) Representatives from congregations, schools and other community entities will contribute compassion statements- whereas for the proclamation 2) Proclamation presented and signed at Board of Supervisors meeting 3) Proclamation presented at Martin Luther King celebration in January 2015	January 2015	Representatives from congregations, schools, and other community entities	County of Napa Board of Supervisors (Brad Wagenkn-echt)	-	1)Number of "whereas" statements collected 2)Minutes of BOS meeting 3)Attendance at MLK celebration event	1)ongoing 2)once 2)once
	Create a county-wide coalition to further the work of the Charter for Compassion begun by Thrive Napa Valley, BOS, Public Health, NVCSL and others	1)Steering Committee formed 2)Steering committee engages in planning process 3)Committee participates in Martin Luther King Celebration and presenting of Compassion proclamation as kickoff event for Compassion 4)Larger community Coalition formed for furthering compassion with implementation of plans	1) April 2014 2) April – December 2014 3) January 2014 4)2015-2016		Napa County Health & Human Services Public Health (Laura Keller)	County of Napa Board of Supervisors	1)Meeting minutes, number of attendees 2)Planning document 3)Event flyer and number of participants 4)Meeting minutes, number of attendees	1)Once 2)Monthly meetings One document 3)Once 4)Minimum quarterly
	Public Health will be a model compassionate organization by incorporating compassion as a fundamental principle in all of its work; encourage others to sign the Charter for Compassion	1) Compassion Committee formed and meets regularly 1a) Discussion by all staff of compassion as a core value of Public Health at Kaizen Retreat 1b)Recruitment of staff members for committee 2) Compassion Plan created and implemented to sustain compassion in Public Health 2a) Committee members complete plan and share with PH staff 2b) PH staff implement plan	1) June 2014 2) January 2015		Napa County Health & Human Services Public Health (Laura Keller)	-	1) Retreat attendance, meeting minutes/agenda 2) completed Compassion plan and survey	1) Once; Monthly 2) Once, Ongoing

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/PLANNED EVALUATION	FREQUENCY
Provide parent classes that will support them in becoming more effective parents and leaders at school and in the community	Napa Valley Parent University Initiative (NVPU) will create a learning environment for parents to engage in their child's education, gaining critical parenting and leadership skills	1) 225 parents will participate in early childhood education 2) 100% of parents will report they have more skills and confidence in their ability to be their child's first teacher 3) 100% of parents will report they spend more focused, quality time with their children 4) 25% of parents taking NVPU classes will be involved in their child's education through school volunteerism and/or events 5) 75% of parents and children will their literacy skills and become better English language readers 6) 75% of parents report they are more aware of the resources they need to support their children's learning and health	September 2014	1)-3) NVPU lead staff; NVPU curriculum; teachers; parent leaders; outreach materials; childcare providers; program materials and food 5) NVPU lead staff; Latino Family Literacy Project curriculum and lending library; teachers; parent leaders; outreach materials; childcare providers; program materials and food; partnership with Napa Valley Adult Education's ESL classes 6) NVPU lead staff; NVPU curriculum; teachers; parent leaders; outreach materials; childcare providers; program materials and food; Information and referrals for partner agencies	On the Move (Susie Garcia)	Napa Valley Unified School District, St. Joseph Health Queen of the Valley Community Outreach/Parent University (Maria Ruiz), First 5/Auction Napa Valley, Cope Family Center	1)Class Rosters 2)-3)Class Surveys 4)Class surveys, volunteer rosters 5)-6) Class Surveys	1)Gathered at each class 2)-3) Surveys will be gathered at the completion of each course 4) Surveys will be gathered at the completion of each course Volunteer rosters will be collected at each volunteer opportunity 5)-6) Surveys will be gathered at the completion of each course
	Inventory all agencies and organizations that offer parent education in the county	100% of agencies and organizations offering parent training will provide information for the inventory	August 31, 2014	Volunteers to help identify agencies, then design, administer, and analyze/summarize data from an assessment	NapaLearns (Peg Maddocks)	On the Move, Cope Family Center	We will create a Google Doc where agencies can enter information about their parent workshops. This will create a baseline of agencies and training offerings. The first year will be an awareness year. Year two will involve collaboration among agencies to provide access for more parents.	Bi-weekly meetings of team of volunteers to review data and encourage more participation

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/PLANNED EVALUATION	FREQUENCY
Provide parent classes that will support them in becoming more effective parents and leaders at school and in the community *(continued)*	Compare parent education efforts to develop a comprehensive community-wide training that aligns with the goals of the schools and can be offered to all parents who are interested	80% of all parents who want to attend parent training to improve their ability to help their children will be able to attend	June 30, 2015	Volunteers to organize project; Agreement by agencies to work together to create adequate offerings for all parents; grants to improve access	NapaLearns (Peg Maddocks)	On the Move (Nick Challed)	List of current parent offerings and curriculum, survey results of current offerings, evaluation of programs, attendance at various training sessions offered by different agencies	Quarterly and end of year
Provide educational programs targeted at vulnerable populations, including literacy and financial stability	Provide health and chronic disease management education focusing on outreach to the Latino population	Participants will gain knowledge and skills to be better able to self-manage chronic diseases	June 30, 2017	Continued funding for evidence-based Chronic Disease Self-Management Program	Area Agency on Aging (Leanne Martinsen)	Napa Valley Hospice & Adult Day Services, Rianda House Senior Activity Center	Record number of individuals who complete the "Tomando Control de su Salud" (6-session workshops) and collect the individual evaluations following the completion of each workshop	At least 2 workshops scheduled each year. Annual program evaluation.
	Farm worker education to increase bilingual literacy-building libraries and providing tutors at migrant camps	Migrant farm worker literacy program is established	May 20, 2014	The Napa County Library has purchased materials for the onsite library at each of the three centers through a donation from the Napa Valley Farm Worker Committee. The literacy program is currently recruiting volunteers for the literacy program.	Napa County Housing Authority (Nancy Johnson)	Napa City/County Library(John Thill)	Lodgers at the centers will receive training on all the resources available at the Library, online, and through the mail. Library cards will be issued to those who would like to participate. Books on a variety of subjects will be available at each center for use based on surveys of existing lodgers late in 2013. Literacy programs will be made available to all who wish to participate. Initial surveys of the lodgers indicate a unanimous desire to read, write and speak English. The Library is seeking grant opportunities to ensure continued success of the program.	Once

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/PLANNED EVALUATION	FREQUENCY
Provide educational programs targeted at vulnerable populations, including literacy and financial stability *(continued)*	Offer Employment and Financial Coaching to residents of Napa County	Increase participant income by 5%	12/2014	Short term training programs, access to employment opportunities that pay higher than minimum wage, and funds for staff to provide the much needed one to one employment counseling for individuals with limited skills and work experience	American Canyon Family Resource Center (Sherry Tennyson)	Napa Circles Initiative	Base line information is gathered at intake and follow up is conducted on a quarterly basis	Quarterly

Priority Area #3: Create and Strengthen Sustainable Partnerships for Collective Impact – Strategies and Activities

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNER S	CURRENT/ PLANNED EVALUATION	FREQUENCY
Develop initiatives to strengthen the collection, quality, and availability of data on under-represented populations	Research options and funding sources to oversample target populations in Napa County as part of the California Health Interview Survey (CHIS)	By 2015, funding source and timeline identified for oversampling one or more target groups as part of the Napa County CHIS	2015	Funding, Staff Time	Napa County Health & Human Services Public Health (Jennifer Henn)	-	One summary measure (completed, not-completed, in-progress)	Annually
	Work with representatives from Trilogy to better align Napa Health Matters indicator data to the Community Health Assessment and identified priorities	By 2015, create and implement 2 changes to the Napa Health Matters website that improve the availability of data from the 2013 Community Health Assessment	2015	Staff Time (HHSA and Trilogy)	Napa County Health & Human Services Public Health (Jennifer Henn)	-	One summary measure (e.g. # of changes implemented)	Annually
	Form a Data Workgroup with representatives from HHSA and other community organizations to: 1) Set priorities for needed improvements in data 2) Identify data currently collected that could be more efficiently distributed or shared 3) Identify opportunities for collection of data not currently available	By 2015, data workgroup has met a minimum of 2 times and has developed a list of data priorities to share with the LHNC Steering Committee	2015	Staff Time (HHSA and Trilogy)	Napa County Health & Human Services Public Health (Jennifer Henn)	-	Summary measures (e.g. # workgroup meetings, # data priorities)	Every workgroup

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNER S	CURRENT/ PLANNED EVALUATION	FREQUENCY
Coordinate strategic initiatives that span the entire community	Continue coordinating initiatives to prevent homelessness and re-house families and individuals who are homeless	1) % of homeless population that is sheltered 2) % of transitional housing participants moving into permanent housing 3) % of permanent supportive housing participants remaining in housing for more than six months	Ongoing; will look for increases in percentages over time	Coordination between agencies in Continuum of Care on: a) Sheltering and care coordination of homeless or at-risk individuals and families b) Data entry into Homeless Management Information System	Napa County Continuum of Care(Mitch Wippern)	-	Data from Homeless Management Information System	Annually
	Collaborate and coordinate to build capacity for all local Family Resource Centers to provide access to high quality health services and social supports	Representatives from Family Resource Centers will meet quarterly as a Coalition	Ongoing	Representatives from Cope Family Center, Up-Valley Family Center, American Canyon Family Center, Puertas Abiertas, and McPherson	Cope Family Center	Up Valley Family Resource Centers, American Canyon Family Resource Center, Puertas Abiertas, McPherson Family Center	Attendance at Collaborative meetings	Quarterly
	Investigate and explore community organizing/leadership engagement, faith-based/nonprofits, teachers (Common Ground model)	Workshops will be offered in 2015	December 2015	TBD	Napa Valley Lutheran Church	-	Completed workshops	Annual
	Collaborate and coordinate to expand access to basic needs, services and social supports required in an aging community	1) HAPI will develop and advocate for an Older Adult policy agenda for Napa County 2) HAPI partners will collaborate and coordinate to build capacity and strengthen initiatives for building a senior friendly county	Community forum – 9/30/14 Survey – January 1, 2015 Policy Agenda – May 2015	Survey of older adults in Napa Valley	Healthy Aging Population Initiative	25 member organiza-tions	Forum Attendance Results of Survey/# of those surveyed Policy Agenda completed	Monthly meetings

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Build sustainable funding capacity through collaboration	Partner with community-based organizations with MAA contracts	1) Outreach to ten (10) community agencies w/county-funding support (parallel strategies needed-monitoring Medi-Cal enrollment) and execute contracts as appropriate 2) Extend outreach and contracts effort to at least two (2) more community based organizations	1) Completed First contracts executed September 2013, Tenth contract to be executed in May 2014 2) Outreach to be completed by July 2014; applicable contracts to be executed by September 2014	TBD	Napa County Health & Human Services Administration (Teresa Zimny)	-	Program/ Contractor Reporting - accomplishment and outreach effort that results from contracts	Quarterly
	Create a coalition of agencies to work with Funding the Next Generation in Napa County	1) Hold first community-wide meeting in February 2014 2) Hire Project Coordinator to oversee process and ensure progress toward goals 3) Complete Children's Bill of Rights Agenda and Budget 4) Board of Supervisor's Resolution to adopt Children's Bill of Rights, Agenda and Budget	February 2014	1)Steering Committee to set agenda, find location and invite participants 2)Funding resources to hire Funding the Next Generation to create job description, determine appropriate lead agency and timeline for Coordinator 3)Coordinator work plan, meetings with stakeholders, data compilation	1)-2)Cope Family Center/Public Health 3)Agency housing Coordinator	First Five Napa County, Napa County Office of Education, Up Valley Family Resource Centers, American Canyon Family Resource Center, Community Resources for Children, NapaLearns, ChildStart, Napa County Health & Human Services Public Health	1)Attendance record 2)Coordinator hired 3)Completed Bill of Rights, Agenda and Budget 4)Board Resolution	1)One meeting in Feb. 2014 2)-4) Once

Priority Area #4: Ensure Access to High Quality Health Services and Social Supports across the Life Course – Strategies and Activities

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Improve access to dental services for low-income children ages 0-21	Provide Mobile Dental Clinic services	1) # of patients seen 2) % of QVMC Mobile Dental and Sister Ann's patients 6 months to 21 years of age having seen a dentist within the past year following the initial or recall exam 3) % of children 2-17 having seen a dentist in the past year in the county (CHIS) 4)% of mobile dental clinic patients who demonstrate oral health improvement at recall visit based on a set of clinical criteria	July 15, 2014	Staff Time, County Data Resources (CHIS)	St. Joseph Health Queen of the Valley Mobile Dental Clinic	Community Health Clinic Ole	1)Monthly statistics recording 2)Monthly statistics recording 3)CHIS Data review (County Wide Measure) 4) Monthly random chart audit of 20 charts of children under the age of 6 and 20 chart audits of children over the age of six	Monthly
Conduct research initiatives for potential service quality improvement	Implement a community paramedicine pilot project to determine whether paramedics working in an expanded role in Napa can help improve health system integration, efficiency, and fill identified health care gaps	1) Determine number of patient contacts that have been discharged from a hospital within previous 30 days 2) Determine if patients could have received alternative care from a non-emergency destination 3) Identify frequent users of the 911 system Target and data source: The NFD will survey all persons who request emergency response for medical purposes (NFD Records Management System)	Survey completed by 2/15	N/A	City of Napa Fire Department (Mike Randolph)	HHSA Local Emergency Medical Services Agency, Community Health Clinic Ole, Partnership Health Plan	Monthly data review at meetings and work with EMS	Monthly

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Increase advanced care planning	Implement Honoring Choices Napa Valley	By the end of 2016, 80% of Napa County residents who die have their values and wishes honored, as rated by family and the care team	12/2016	Staff Funding Training - Expertise	Napa Valley Hospice & Adult Day Services/ Carol Williams	Partnership Health Plan, St. Helena Hospital, St. Joseph Health Queen of the Valley Medical Center, Napa County Health & Human Services Public Health, Veteran's Home, Rianda House Senior Activity Center	Survey	Once, following death

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Increase access to affordable health care	Napa CHI will broker the health exchange and assist in assessing eligibility	Increase % of individuals with health insurance 1) Contact all parents of potentially uninsured children in 43 public schools throughout Napa County. 2) Enroll all uninsured children and their family members in health insurance. 3) Make sure they are connected to a medical home, able to utilize health care services, and that all of their questions get answered. (At least 80% of parents will report that their child has a medical home other than the emergency department, and at least 90% of parents will report that their child has access to all needed health care services.) 4) Contact families prior to their annual renewal date to provide assistance with the process. 5) Make sure there is an adequate network of trained health insurance application assistors throughout Napa County. (Hold at least 10 trainings with an average attendance of 15). 6) Assisting the County of Napa with incomplete Medi-Cal applications. (Provide on-site assistance at least 3 days per week serving at least 2,250 individuals per year.) 7) Provide outreach and education about health insurance options at health fairs and community events. 8) Provide staff training at partner agencies to facilitate a "no wrong door" enrollment system.		1) CHI staff time, outreach materials, phone calls, CRM system and contracts with schools. 2) CHI staff time, County of Napa eligibility reports, health insurance applications. 3) CHI staff time, phone calls, CRM system. 4) CHI staff time, phone calls, CRM system. 5) CHI staff time, educational materials, staff time from partner agencies. 6) A contract with the County of Napa, County of Napa and CHI staff time to identify incomplete applications and follow-up with the families to make sure the applications are completed. 7) CHI staff time and outreach materials 8) CHI staff time, facility space, CRM and enrollment system.	Children's Health Initiative (Mark Diel)	Napa County Health & Human Services Agency	1) Call logs 2) Enrollment records 3) Follow-up survey 4) CRM 5) Attendance Log 6) County of Napa Tracking Log 7) Sign-up sheets, information distributed 8) Enrollment records	1) Annually 2) Annually 3) Semi-annually 4) Semi-annually 5)Ongoing 6) Ongoing 7) 60 per year 8) Ongoing

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Reduce barriers and increase access to services through improved health care provider collaboration and integration	Develop and maintain primary care clinic on the Health & Human Services campus to improve access to health care	1) # of patients of County Campus 2) # of new patients 3) # of referrals from mental health and substance abuse services 4) # of patients with a diagnosis of a chronic illness	January 2015 January 2016 January 2017	Staff time for data entry and analysis Health Registry appropriately programed	Community Health Clinic Ole (Tina Zoppel)	Napa County Health & Human Services Agency	Review of health registry reports Continuous improvement meetings	Annual Review
	Develop regional policy for providers and ERs to reduce use of prescription opioids for chronic non-malignant pain	Complete plan under development, including performance measures	December 2015	Leadership involvement/commitment From community stakeholders.	Partnership Health Plan (PHP)	Napa County Health & Human Services Agency; Community Health Committee, Napa County Medical Society	Variety of sources	Varies
	Provide Community Based Chronic Disease Case Management	1) % improvement of clients in disease self-management and self-sufficiency, as measured on acuity scale by clinicians 2) % reduction in emergency room visits and hospitalizations post enrollment compared to one year prior.	1) July 30, 2014 2) July 30, 2014	1) Staff time and Data analysis 2) Data analysis	St. Joseph Health Queen of the Valley CARE Network	Area providers, Clinic Ole, St. Joseph Health Queen of the Valley Medical Center, and multiple Community Based Organizations in the area	1) Comprehensive service plan acuity and data analysis 2) Data Analysis	Annually

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
	Complete an analysis of HHSA's Hub Project	Analysis report is completed	November 31, 2014	Data collected from Hub application reports	Napa County Health & Human Services Agency (Sarah Hayes)	-	Outcome reports(i.e., % of clients referred to Hub, % of clients referred to Hub that participate in referral service)	Once

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Reduce barriers and increase access to services through improved health care provider collaboration and integration *(continued)*	Provide Hospital to Home transition care	1) Transitional care will help the client to better manage medication regimen, recognize worsening symptoms, follow-up with their primary physician, and better manage future changes in their chronic health conditions 2) The readmission rate for home discharges will be below that of 2012	Ongoing	Staff	Napa Valley Hospice & Adult Day Services (Laura Valencia)	St. Helena Hospital	Reports Post program discharge survey	Quarterly/ Once
	Provide Transitional Care for SJH-QV	30-day readmission rate for those served in the program (target 9-13%)	July 30, 2015	Staff time and Data analysis	St. Joseph Health Queen of the Valley Community Outreach	St Joseph Health Queen of the Valley Medical Center	Data Analysis	Annually

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
	Provide preventive care focusing on outreach to the Latino population	1) Older Latino Adults will be better informed about topics related to healthy aging and available resources, learn to communicate with their health care providers, better manage chronic health conditions, and lessen impact on their lives 2) Of the clients that complete the CDSMP workshops, 75% will report that they feel better able to manage their chronic health care conditions	1) Ongoing 2) Ongoing	1)Staffing Spanish educational materials 2)Staffing	Napa Valley Hospice & Adult Day Services(Carol Williams)	Adult Day Services (ADHC/CBAS), St. Joseph Health Queen of the Valley Medical Center (Transitions Palliative Care Program), Area Agency on Aging	Reports Post program discharge survey	Quarterly Once

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Increase access and ensure coordinated delivery of community based mental health and social services	Expand access to Healthy Minds Healthy Aging to reach older adults who are experiencing mental and cognitive health issues and other psychosocial concerns	1) Number of older adults screened for issues and served 2) Of cases closed, 75% will demonstrate improved PHQ9 scores	6/30/2017	Continued funding for Healthy Minds-Healthy Aging Program	Area Agency on Aging	Napa Valley Hospice & Adult Day Services, Family Service of Napa Valley, Queen of the Valley Community Outreach, Napa Healthy Aging Population Initiative, Napa County Health & Human Services Comprehensive Services for Older Adults, Rianda House Senior Activity Center	1) Review records of older adults that have been screened and evaluate issues and services provided. 2) Review records of closed client cases to document improved PHQ9 scores.	Annually

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Increase access and ensure coordinated delivery of community based mental health and social services *(continued)*	On the Move's Innovations Project will increase access to mental health services for underserved populations	1) Increased participation and effectiveness in leadership roles within systems that impact the mental health of individuals from identified underserved communities 2) Improved relationships between identified underserved communities and mental health practitioners 3) Increased value of collaboration for identified underserved communities and mental health practitioners 4) Development and documentation of a best practice model to improve relationships and the value of collaboration between identified underserved communities and mental health practitioners 5) Design and implementation of programs to address disparities and barriers for underserved communities	1)-5) Ongoing	1)-5) On The Verge Leadership Program; Leadership Coaches; Evaluator; Community Partnerships	On the Move (Nick Challed and Leslie Medine); Evaluator (Mechele Small Haggard)	Aldea Children & Family services, Buckelew, Family Service of Napa Valley, Progress Foundation, McPherson Family Resource Center, VOICES, Calistoga FRC, American Canyon FRC, Napa County Mental Health Division, Napa County Public Health, NEWS, St. Joseph Health Queen of the Valley Community Outreach, LGBTQ Connection, Parents Can, People Empowering People, Suscol Inter-Tribal Council, Napa Valley College Veterans Educational Benefits Services	1) Participant Surveys; Participants Skills Assessments; Program Records (i.e., public performance agendas and community project action plans; etc.) 2)-3) Focus Groups 4) Program Records (Meeting agendas; Community Project materials; partnership agreements and MOUs; etc.) 5) Program Records (Community Project materials; Town Hall Meeting agendas and sign-in sheets; partnership agreements and MOUs; etc.)	1) Evaluation in June 2014 and June 2015 2)-3) Focus Groups dates TBD 4) Materials will be gathered in Spring 2015 5) Ongoing gathering of materials

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
Increase access and ensure coordinated delivery of community based mental health and social services *(continued)*	Provide mass training to enhance warm handoffs to mental health services	1) 1000+ people will complete the training 2) 90% will report greater awareness of how to recognize signs of someone in crisis as well as what to do (training and post training survey) 3) 90% will report reduced perceived stigma toward mental illness (training and post training survey)	6/30/2019	Funded through the Napa Valley Vintners	Aldea Children and Family Services (Jim Diel)	Family Service of Napa Valley, Napa County Health & Human Services Mental Health	1) Attendance rosters from trainings held 2) Evaluation based on post-surveys completed 3) Evaluation based on post-surveys completed	Scheduled trainings held at community locations and Aldea facilities with at least 8 individuals in attendance (no upward limit on numbers who attend). Training frequency varies due to demand, but occurs at least quarterly and as often as monthly.
	The County Campus Coordinated Care Project will implement Screening, Brief Intervention, and Referral to Treatment (SBIRT)	1) # of SBIRT screenings 2) # of brief interventions for depression and anxiety 3) # of referrals to mental health treatment 4) # of brief interventions for alcohol or drug use 5) # of referrals to substance use treatment 6) # of referrals that led to admission or treatment	January 2015 January 2016 January 2017	Staff time at County Campus to do screenings and brief interventions for all patients establishing care Staff time at HHSA Policy, Planning & Evaluation & Compliance department to scan, analyze data provide feedback for 6mo re-screening	Community Health Clinic Ole	Napa County Health & Human Services Mental Health and Alcohol and Drug Services (Mark Woo)	Review of Data Continuous improvement meetings	Review Annually

STRATEGY	ACTIVITY	PERFORMANCE MEASURE	TARGET COMPLETION DATE	RESOURCES REQUIRED	LEAD	PARTNERS	CURRENT/ PLANNED EVALUATION	FREQUENCY
	Provide Cognitive Behavioral Therapy Program	1) All clients are screened and assessed 2) 80% will demonstrate improvement on pre/post scales for anxiety, depression, and trauma	Ongoing	N/A	Family Service of Napa Valley (Rob Weiss and Marti Palmer)	-	Likert scale outcome measures forms that measure symptoms and their severity	Ongoing
Increase access and ensure coordinated delivery of community based mental health and social services *(continued)*	Collaborate to provide Trauma Informed Care	Provide Trauma Informed Care training	Ongoing	N/A	NEWS (Napa Emergency Women's Services)	Family Service of Napa Valley, Aldea Children and Family Services	Attendance list	Ongoing
	Universal Screening and Referral System for perinatal depression	% of clients that report reduced depression as measured through a validated tool	July 30, 2014	Collaborative participation of OB and Pediatric Providers, Staff time	St. Joseph Health Queen of the Valley Community Outreach	Community Health Clinic Ole, Napa County Health & Human Services Public Health, Healthy Moms and Babies, Pediatric Practices, OB Practices	Validated Tool (Edinburgh or PHQ9)	Annually
	Provide consultation and education for family caregivers, with targeted outreach to the Latino population	Napa Valley Hospice & Adult Day Services will provide caregiver education, family consultations, memory screenings, and caregiver support	Ongoing	Staff Spanish educational materials	Napa Valley Hospice & Adult Day Services (Celine Regalia)	Rianda House Senior Activity Center, Alzheimer's Assoc.	Personal follow up	3 – 6 months after intervention

	Homelessness service providers will conduct coordinated assessments for needs of services for homeless individuals and families	% of designated Continuum of Care service provider agencies that conduct coordinated assessments of clients at intake	April 2015	Participation of Continuum of Care member agencies; data collection and tracking	Napa County Continuum of Care (Mitch Wippern)	-	Data reported by participating agencies	Annually
Increase access and ensure coordinated delivery of community based mental health and social services *(continued)*	Develop and implement a Universal Screening system for all children 0-5 and their families to enhance preventative work and increase access to developmental and infant-parent mental health services	1) At least 250 children age 0-5 screened 2) 75 children age 0-5 will be provided mental health services 3) 100% of those screened and found to be in need of services will be referred 4) 80% of those provided with services will demonstrate an improvement on standardized instruments	1) 6/30/2016 2) 6/30/2015 3) ongoing 4) 6/30/2015	Funded through First5 Napa and EPSDT Medi-Cal services.	Aldea Children and Family Services	Early Childhood Social Emotional Wellness Collaborative, Project Connect, Health & Human Services Mental Health Services	1) Number of screening tools completed (Ages and Stages Questionnaire –III or Social-Emotional) 2) Number of children served and number of sessions per client. 3) Number and category of referrals to meet client needs. 4) Improvement of clients served in functioning as evaluated by pre-post measure (CANS 0-5).	1) At presentation of presenting concern 2) Weekly dyadic psychotherapy for up to 24 weeks 3) As needed 4) At intake, six month intervals and following discharge
	Maintain StopFalls Napa Valley to assist older adults at risk of falling	1) Clients will receive screening, assessment and referrals 2) Following completion of services, 75% will report a positive change in behavior and demonstrate improvement in awareness of fall prevention behaviors	6/30/2017	Continued funding for StopFalls Napa Valley Program	Area Agency on Aging	Stop Falls Coalition, Napa Healthy Aging Population Initiative	1) Review records of older adults at risk of falling that have been screened and assessed and document referrals or services provided. 2) Review and summarize follow-up surveys with clients following interventions.	Annually