Community Health Improvement Plan

2025 Annual Report for FY 24/25

NAPA COUNTY
Health & Human Services Agency

Napa County

December 2025

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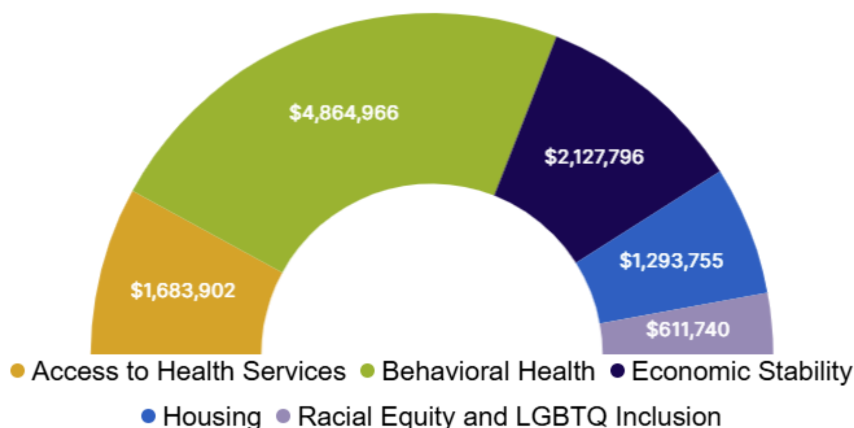
Introduction

The 2024 Napa County Community Health Improvement Plan (CHIP) represents a community driven, data-informed process that includes priorities identified in both the 2023 Community Health Assessment (CHA), carried out jointly with Providence Queen of the Valley Medical Center, and the Napa Older Adult Assessment (NOAA), which began in late 2022. Five health priority areas were identified by community partners: **Housing, Behavioral Health, Access to Health Services, Racial Equity & LGBTQ Inclusion, and Economic Stability**. This annual update describes 45 strategies of community and County organizations, often working in partnership with the community members they serve, to uplift the physical and social drivers of health in Napa County. While we are so proud of the programs and metrics outlined in this report, we also understand that they cannot begin to adequately describe the full scope of efforts put forth by the individuals who make up the organizations named here. The community represented in this annual report has come together through floods, earthquakes, fires, pandemics, and government shutdowns. Through diverse challenges, often facing unknown outcomes, we recognize our strength lies in our ability to offer services in collaboration, leveraging resources and shared understanding, ensuring that all in Napa County are able to live healthy and fulfilling lives.

Our strength lies in our ability to offer services in collaboration, leverage resources and shared understanding.

Operationalizing the CHIP

For the first time in Napa County history, the CHIP has been operationalized by Health and Human Services Agency (HHSA) through three funding streams: the Tobacco Master Settlement Agreement, the National Opioids Settlements, and the Mental Health Services Act, totaling $10.8 M, spread across 37 community health strategies. For many CHIP partners, this support represents just one piece of the many funding sources that provide the necessary resources for program operations. Napa County HHSA is honored to be a part of the work detailed in this annual report. It represents both a first of its kind system of braided funding support from the County and a continuous cycle of collaboration, communication, and design work between government, health and education systems, non-profit organizations, and community members.



CHIP Implementation and Monitoring

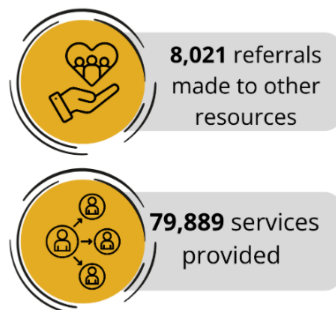
The 2024 CHIP is made up of 37 funded strategies and 11 strategies that either required no funding, or had already secured funding elsewhere. This year we added two additional strategies (Napa Valley Together and Be Well Mobile Services). Napa Valley Together is an addition to strategies in the CHIP receiving MSA funding. CHIP partners with funded strategies submit reports on a quarterly or biannual basis to contract liaisons from different HHSA divisions. CHIP partners with unfunded strategies, or strategies that received funding elsewhere, submit updates on their identified strategy metrics on request. All CHIP partners are invited to quarterly meetings held by Live Healthy Napa County (LHNC), our community health collaborative. HHSA's Public Health Division provides administrative support for LHNC and Napa County's community health assessment and implementation work. Looking forward, we hope LHNC quartlery meetings will be a space where CHIP partners can build partnerships, ask for technical assistance, and provide their own expertise as appropriate.

Population Health

The population health metrics included in the 2023 CHA will be updated annually on the Napa County Data Dashboard CHIP Population Metrics page. This page focuses on the quantitative population-level data, which is grouped into five sections, each representing one of the identified top health priority areas. Five additional themes were also identified and are included as a subset of economic stability: Food Access, Childcare, Language Access, Transportation, Education/Digital Inclusion.

Collective Impact

Each funded strategy tracks program metrics that were identified at the beginning of their funding cycles. While not all projects are tracking similar metrics, our goal is to tell a collective data story that both informs our community of the work being done to improve health across the county *and* keeps our funded partners aware of their cohort's cross sector impact in a way that is meaningful and measureable. Across funded strategies, referrals and services provided were the most abundant data. In fiscal year 2024-25, across all CHIP strategies, there were:



Housing

Our Vision: Healthy, safe, stable, and affordable housing is available for all in Napa County.

Housing

Goal 1: Ensure healthy, stable, and affordable housing for all in Napa County.

Objective 1.1: Increase economic stability for community members experiencing life transitions, such as those exiting foster care, transitioning to a fixed income, or becoming new parents.

LEAD ORGANIZATION	UpValley Family Centers
STRATEGY/PROGRAM NAME	Increasing housing stability and preventing homelessness
TARGET POPULATION(S)	Lower Income Families and Older Adults

STRATEGY/PROGRAM DESCRIPTION

UpValley Family Centers (UVFC) provides services to stabilize housing and prevent homelessness to housing-insecure households through comprehensive case management, emergency financial assistance, economic success programs, referrals to public benefits and safety net programs, and community outreach and education. Services are provided through UVFC offices in Calistoga, St. Helena, at local schools, and via targeted outreach in remote areas.

HIGHLIGHTED YEAR 1 OUTCOMES

43 households received direct Emergency Financial Assistance.
59 households received housing navigation services.
56 households connected with other financial aid programs.
50 households received economic success services.
60 clients assisted with safety net programs.
2012 community members educated on tenant rights and housing resources.
100% of households improved financial status through economic success services (took actions to build credit, set up payment plan, secured renter's insurance).

Goal 1: Ensure healthy, stable, and affordable housing for all in Napa County.

Objective 1.2: Increase access to stable housing and a range of support services for those experiencing homelessness and those who are insecurely housed.

LEAD ORGANIZATION	On The Move
STRATEGY/PROGRAM NAME	Napa Housing Stabilization Program
TARGET POPULATION(S)	Lower Income Families with Young Children

STRATEGY/PROGRAM DESCRIPTION

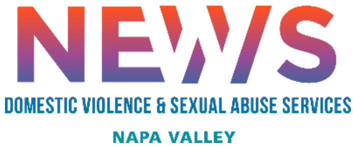
Napa Housing Stabilization Program provides housing stabilization services for low income or under-resourced families who are either experiencing homelessness, unstable housing, or at risk of becoming unhoused. The program provides case management, rental assistance, housing education, housing navigation, community outreach, and referrals. The program partners with OTM's Family Resource Centers, schools, faith-based institutions, Napa County HHSA, and other partnering organizations who assist in identifying families who are at risk of homelessness and require housing navigation support.

HIGHLIGHTED YEAR 1 OUTCOMES

1220 Community outreach and referral services provided including Housing Navigation, Housing Search and Move-in/Rental Assistance.

278 individuals received case management services
18,326 Housing Education distributed.
100% of clients made progress towards at least one of their personalized housing plan goals**.**
278 Individuals received rental or utility assistance**.**
49 Individuals secured housing.

Housing

Goal 1: Ensure healthy, stable, and affordable housing for all in Napa County.		
Objective 1.2: Increase access to stable housing and a range of support services for those experiencing homelessness and those who are insecurely housed.		
	**LEAD ORGANIZATION**	NEWS
	STRATEGY/PROGRAM NAME	Domestic Violence Housing First
	TARGET POPULATION(S)	Domestic Violence and Sexual Assault Survivors
STRATEGY/PROGRAM DESCRIPTION		
The Domestic Violence Housing First (DVHF) program helps domestic violence survivors obtain safe and stable housing as quickly as possible and provides ongoing supportive services to help them move forward with their lives and heal mentally and physically from trauma. NEWS' DVHF program helps survivors overcome barriers to safety and stability by prioritizing safe and secure housing, providing financial assistance and case management, offering advocacy, and providing community referrals and linkages.		
HIGHLIGHTED YEAR 1 OUTCOMES		
34 Individuals received Case Management while at the NEWS Shelter.		
18 Shelter clients were subsequently enrolled in DVHF Program.		
14 households received rental assistance with MSA funds.		
14 months of rent paid for with MSA funds.		
105 individuals received case management from NEWS Housing Advocates.		
86% of shelter clients secured a safe housing option upon exiting shelter.		
77% of clients maintained or increased housing security level during program period.		

Goal 1: Ensure healthy, stable, and affordable housing for all in Napa County.		
Objective 1.2: Increase access to stable housing and a range of support services for those experiencing homelessness and those who are insecurely housed.		
	LEAD ORGANIZATION	Greater Napa Valley Fair Housing
	STRATEGY/PROGRAM NAME	Displacement and Homelessness Prevention
	TARGET POPULATION(S)	Lower Income Renter
STRATEGY/PROGRAM DESCRIPTION		
Fair Housing Napa Valley's (FHNV) Displacement and Homelessness Prevention program provides broad and comprehensive homeless intervention and tenant counseling services for individuals and households facing challenges to their housing stability and/or the risk of homelessness/displacement. FHNV provides case management, education and outreach, housing rights workshops, as well as workshops tailored to community partners.		
HIGHLIGHTED YEAR 1 OUTCOMES		
453 Tenant Intakes completed. **58** Landlord Intakes completed. **16** Housing Rights Workshops for clients/public held, five of which were in Spanish. **5** Housing Rights Workshops held for community partners. **511** clients provided case management. **418** total workshop attendees, providing education and outreach.		

Housing

Goal 1: Ensure healthy, stable, and affordable housing for all in Napa County.
Objective 1.3: Increase both the availability and appeal of senior living communities as an option for cost-effective and supportive housing for older adults.
STRATEGY/PROGRAM DESCRIPTION
A strategy responsive to this objective has not been identified and will be an area of ongoing discussion among community partners.
HIGHLIGHTED YEAR 1 OUTCOMES
NA

Goal 1: Ensure healthy, stable, and affordable housing for all in Napa County.		
Objective 1.4: Increase the feasibility of aging in place for older adults living in Napa County.		
A Tradition of Stewardship A Commitment to Service	**LEAD ORGANIZATION**	Housing and Community Services
	STRATEGY/PROGRAM NAME	Stable Housing And Community Resilience (SHARE) Program
	TARGET POPULATION(S)	Older Adults at risk of homelessness
STRATEGY/PROGRAM DESCRIPTION		
The Stable Housing and Community Resilience (SHARE) program provides up to $800 in monthly rental assistance to low-income older adults who meet program eligibility requirements. In addition to rental assistance, program participants are be assigned a case manager to assist with program navigation, check on their general health and well-being, and find other resources to help participants stay in their home.		
HIGHLIGHTED YEAR 1 OUTCOMES		
74 Total clients enrolled. **$322,249** Total assistance provided. **$696.09** Average rental subsidy.		

Behavioral Health

Our Vision: Everyone in Napa County has access to high-quality, culturally responsive, and equitable behavioral health services, with a focus on building upon strengths while promoting recovery and wellness.

Behavioral Health

Goal 1: Maintain and Strengthen Suicide Prevention Services.

Objective 1.1: Collect, review, and share data to better understand and address the problem and impact of suicide in our county.

LEAD ORGANIZATION	HHSA-Behavioral Health Services Division
STRATEGY/PROGRAM NAME	Suicide Prevention Council Data Subcommittee
TARGET POPULATION(S)	Youth - Older Adults

STRATEGY/PROGRAM DESCRIPTION

The Suicide Prevention Council Data Subcommittee's purpose is to advance the Suicide Prevention Council's understanding of local and national suicide statistics, research and any other information that would support suicide prevention and intervention efforts in Napa County, as outlined in Goal 2 of the 2023-2026 Napa County Strategic Plan for Suicide Prevention.

HIGHLIGHTED YEAR 1 OUTCOMES

• The Suicide Prevention Council Data Workgroup convened regularly, with members including representatives from Napa County HHSA, Mentis, Queen of the Valley Medical Center.
• A presentation about local, state, and national suicide data at a special Suicide Prevention Council hybrid in-person/virtual meeting, with the invitation extended to partner organizations working with older adults, including the Healthy Aging Population Initiative (HAPI), Napa County HHSA Comprehensive Services for Older Adults (CSOA) Division of Veterans Services, the Napa/Solano Area Agency on Aging, the Napa Long-Term Care Ombudsman's Office, and Molly's Angels.
• Data from the Workgroup informed the populations of focus for the breakout groups for the 2nd Annual Suicide Prevention Conference: older adults, veterans, and LGBTQ+. The Conference featured a local keynote speaker, Calistoga City Councilmember Lisa Gift.

Goal 1: Maintain and Strengthen Suicide Prevention Services.

Objective 1.2: Increase early identification of suicide risk and connection to services for youth, adults, and older adults.

LEAD ORGANIZATION	Mentis
STRATEGY/PROGRAM NAME	Suicide Prevention Council
TARGET POPULATION(S)	Youth - Older Adults

STRATEGY/PROGRAM DESCRIPTION

The Napa County Suicide Prevention Council supports existing local suicide prevention efforts to reduce stigma and encourage access to mental health services through outreach, education, and community building. Their goal is to better understand local and national suicide statistics; increase the number of individuals, communities and organizations trained to recognize and refer to someone at risk of suicide; and offer support to support survivors of suicide loss with resources, education, peer and professional support.

HIGHLIGHTED YEAR 1 OUTCOMES

225 individuals attended the SPC-led event during Suicide Prevention Week 2024.
Over **240** youths trained in QPR.
99% of SPC-led event attendees reported greater knowledge of suicide risks and resources available.
99% of SPC-led event attendees reported increased understanding that suicide is preventable.
99% of QPR trainees reported feeling knowledgeable about suicide prevention techniques.

Behavioral Health

Goal 2: Prevent and effectively treat substance use disorders and harmful use of substances such as tobacco and alcohol.

Objective 2.1: Increase access to prevention and treatment resources for opioid use disorder.

LEAD ORGANIZATION	Providence Queen of the Valley Medical Center
STRATEGY/PROGRAM NAME	Substance Use Navigator (SUN) Program in the ED
TARGET POPULATION(S)	Youth - Older Adults with Opioid Use Disorder (OUD)

STRATEGY/PROGRAM DESCRIPTION

The Substance Use Navigator (SUN) program seeks to increase access to treatment and services by offering SUN services to all emergency department patients in need, continuing education to hospital providers around the availability of SUN services and assisting patients with scheduling medications for addiction treatment (MAT) services.

HIGHLIGHTED YEAR 1 OUTCOMES

27% increase in number of patients diagnosed with an OUD that are prescribed MAT in the ED.

97 patients diagnosed with an OUD were prescribed MAT in the ED.

633 connections made by SUN, providing education and resources for SUD and OUD services available throughout Napa County to hospital caregivers, patients, and family members.

252 unduplicated hospital providers and staff reached by SUN.

381 unduplicated patients and family members reached by SUN.

Goal 2: Prevent and effectively treat substance use disorders and harmful use of substances such as tobacco and alcohol.

Objective 2.2: Increase understanding of the risks of substance use, especially among youth.

LEAD ORGANIZATION	On The Move
STRATEGY/PROGRAM NAME	VOICES Opioid Prevention Support
TARGET POPULATION(S)	Youth and Young Adults

STRATEGY/PROGRAM DESCRIPTION

VOICES Opioid Prevention Support (VOPS) prevents opioid addiction among youth and young adults by educating youth, parents, and the community about the risks of substance use and available preventions resources. VOPS provides youth-led strategies for increasing awareness, education, and prevention around the dangers of fentanyl, and strengthens youth's beliefs that they are capable, loveable, and worthy.

HIGHLIGHTED YEAR 1 OUTCOMES

7 youth and family members recruited to form the VOPS Leadership Team.

73 youth and family members engaged in focus groups and interviews.

62 subject matter experts and community leaders engaged.

19 recommendations developed by VOPS Leadership Team.

20 strategies piloted by youth leaders and VOPS staff within cycles of action research.

68 youths engaged through youth-designed and youth-led substance abuse prevention strategies.

73 youth-serving professionals and volunteers trained in VOPS prevention and peer-to-peer strategies in their work.

96% of youth and leaders demonstrated gains in understanding about the scope and causes of the fentanyl crisis among youth in Year 1.

Behavioral Health

Goal 2: Prevent and effectively treat substance use disorders and harmful use of substances such as tobacco and alcohol.

Objective 2.2: Increase understanding of the risks of substance use, especially among youth.

	LEAD ORGANIZATION	UpValley Family Centers
	STRATEGY/PROGRAM NAME	Opioid Addiction Prevention Education and Outreach in UpValley
	TARGET POPULATION(S)	Youth and Families

STRATEGY/PROGRAM DESCRIPTION

The Opioid Addiction Prevention Education and Outreach in UpValley program provides outreach, education, and backbone coordination for the multi-partner coalition UpValley Partnership for Youth (UVPY), in order to prevent opioid addiction through educating youth, parents, and the community on the risks and dangers of substance use and available resources, as well as broadening the prevention outreach campaign to reach isolated and underserved members of the UpValley community.

HIGHLIGHTED YEAR 1 OUTCOMES

67 outreach and education sessions delivered.

64 parent/community education workshops with opioid use prevention messaging.

21 professional development trainings.

177 youths engaged and trained to implement student/peer-focused outreach.

63 public awareness campaigns, social media and/or community messaging.

232 individuals attended parent education workshops.

10 trusted leaders trained and equipped to lead opioid abuse prevention education throughout the UpValley community.

Goal 2: Prevent and effectively treat substance use disorders and harmful use of substances such as tobacco and alcohol.

Objective 2.2: Increase understanding of the risks of substance use, especially among youth.

	LEAD ORGANIZATION	Michael Leonardi Foundation
	STRATEGY/PROGRAM NAME	Opioid Awareness, Prevention, and Education Campaign
	TARGET POPULATION(S)	Youth and Families

STRATEGY/PROGRAM DESCRIPTION

The Opioid and Fentanyl Awareness and Education Campaign provides a comprehensive Opioid Awareness and Prevention Program targeting youth, parents, and the wider community. The program equips individuals with the knowledge and tools necessary to prevent opioid misuse, addiction, and dangers of fentanyl poisoning through education, outreach, and resource dissemination.

HIGHLIGHTED YEAR 1 OUTCOMES

224 social media posts – Instagram & Facebook.

56% increase in knowledge of substance use risks and prevention resources reported by youth, parents, and the community as measured by pre and post survey data.

58% increase in knowledge of harm reduction strategies such as naloxone administration and fentanyl test strips, as measured by pre and post survey data.

38% increase in local stakeholder partners and collaborations, as measured by the number of new entities participating in events.

Behavioral Health

Goal 2: Prevent and effectively treat substance use disorders and harmful use of substances such as tobacco and alcohol.

Objective 2.2: Increase understanding of the risks of substance use, especially among youth.

LEAD ORGANIZATION	HHSA-Public Health Division
STRATEGY/PROGRAM NAME	Reducing Youth Tobacco Use (Friday Night Live)
TARGET POPULATION(S)	Youth

STRATEGY/PROGRAM DESCRIPTION

Friday Night Live (FNL) builds partnerships for positive and healthy youth development which engage youth as active leaders and resources in their communities. With eight school chapters in Napa County, FNL is dedicated to empowering youth, promoting healthy lifestyles, and preventing substance abuse through youth-led initiatives, education, and community engagement.

HIGHLIGHTED YEAR 1 OUTCOMES

99% of youth in Friday Night Live and Club Live report learning about the risks of alcohol, tobacco, and other drugs.

96% of youth in Friday Night Live and Club Live report helping other youth to make healthy choices that do not involve alcohol, tobacco, or other drugs.

99% of youth in Friday Night Live and Club Live report that FNL helps them decide to do other things instead of using alcohol, tobacco, or other drugs.

Goal 2: Prevent and effectively treat substance use disorders and harmful use of substances such as tobacco and alcohol.

Objective 2.3: Provide education, and assistance in implementing policies that reduce exposure to tobacco products and secondhand smoke.

LEAD ORGANIZATION	HHSA-Public Health Division
STRATEGY/PROGRAM NAME	Empowering Youth-Led Civic Engagement to Reduce the Harms of Tobacco
TARGET POPULATION(S)	Youth

STRATEGY/PROGRAM DESCRIPTION

The Coalition for a Tobacco Free Napa (TFN) is dedicated to promoting social norm change through policy that protects Napa County residents from the harms of tobacco products and secondhand smoke. They provide education, advocacy, and support for tobacco prevention in the community and are dedicated to reducing the impact of tobacco and cannabis products, including electronic smoking devices, on vulnerable populations.

HIGHLIGHTED YEAR 1 OUTCOMES

The Coalition for a Tobacco Free Napa (TFN) meets quarterly with members from Napa County HHSA, Queen of the Valley Medical Center, UpValley Family Centers, Napa County Office of Education, and other partners. Coalition members received training regarding General Plans, Community Health Assessments, and Community Health Improvement Plans and their implementation. The coalition is focusing on aligning its work with the Napa Youth Council. This included reviewing and updating recruitment strategies for coalition members and identifying opportunities to support a youth-led local campaign to implement a tobacco retail license in Napa County.

Behavioral Health

Goal 2: Prevent and effectively treat substance use disorders and harmful use of substances such as tobacco and alcohol.

Objective 2.4: Provide education and assistance in implementing policies and programs that increase safe medication storage and disposal.

LEAD ORGANIZATION	HHSA - Behavioral Health and Public Health Services Divisions
STRATEGY/PROGRAM NAME	Napa Opioid Safety Coalition (NOSC)
TARGET POPULATION(S)	Youth - Older Adults

STRATEGY/PROGRAM DESCRIPTION

The Napa Opioid Safety Coalition (NOSC) is a local collaboration of dedicated community partners, individuals, organizations, and agencies committed to preventing opioid misuse, reducing overdose deaths, and expanding access to treatment throughout Napa County. Aligned with NOSC's strategic priority to develop safe practices for opioid prescribing and patient use, this strategy focuses on fostering safe medication storage and disposal through resource development and community education.

HIGHLIGHTED YEAR 1 OUTCOMES

The Napa Opioid Safety Collation (NOSC) conducted strategic planning sessions that successfully conceptualized a new training and education project focused on safe medication handling for older residents in independent living facilities. Initial discussions were held with key collaborators regarding the formation of task force to lead this effort, with the formal launch slated for Year 2.

Goal 3: Support mental health and wellbeing of Napa County residents.

Objective 3.1: Increase mental wellbeing among Latine, BIPOC, underserved/unserved, and low-income youth, adults, and older adults with an approach that encompasses culturally competent strategies to support mental, physical, financial, and social wellbeing.

LEAD ORGANIZATION	Napa County Triple P Collaborative (Cope Family Resource Center, ParentsCAN, UpValley Family Centers)
STRATEGY/PROGRAM NAME	Triple P Parenting Program
TARGET POPULATION(S)	Children and Families

STRATEGY/PROGRAM DESCRIPTION

Napa County's Triple P Collaborative provides a system of mental and behavioral healthcare interventions for families at risk of child abuse. Utilizing the evidence-based Triple P program, the collaborative offers parent education services to community members who are struggling with the pressures of parenting. By continuing the Triple P parent education system county-wide, this collaborative ensures that families will have access to prevention services, which improve family functioning and child well-being.

HIGHLIGHTED YEAR 1 OUTCOMES

79% of program participants reported improved parent-child relationship.
55% of program participants reported reduced parent anxiety, depression, and stress.

Behavioral Health

Goal 3: Support mental health and wellbeing of Napa County residents.	
Objective 3.1: Increase mental wellbeing among Latine, BIPOC, underserved/unserved, and low-income youth, adults, and older adults with an approach that encompasses culturally competent strategies to support mental, physical, financial, and social wellbeing.	

LEAD ORGANIZATION	Cope Family Resource Center
STRATEGY/PROGRAM NAME	Pathways to Family Mental Health and Wellbeing
TARGET POPULATION(S)	Children and Families

STRATEGY/PROGRAM DESCRIPTION

Pathways to Family Mental Health and Wellbeing (Pathways) Program bolsters mental wellbeing and improves access to mental health services through two core services: The Family Resource Center (PRC) and the Parents as Teachers (PAT) home visiting program. The PRC serves as a community-based hub, identifying and engaging at-risk families to address immediate needs and connect them to additional resources. The PAT program serves families with children aged 0-5 years, offering comprehensive and long-term parental guidance and support. Together, the PRC and the PAT utilize a community pathways model to coordinate and expand service navigation services and oversight to address risk factors for potential serious mental illness, while building protective factors for children and their families.

HIGHLIGHTED YEAR 1 OUTCOMES

541 families received safety net assistance.
2433 resource connections provided to families.
33 parents' mental health needs identified and met with a referral within 48 hrs of intake assessment.
67% of parents/caregivers reported increased confidence in mobilizing resources.
53% of connections to referred resources confirmed by staff follow-up contacts with clients at 30, 60, and 90 days.

Goal 3: Support mental health and wellbeing of Napa County residents.	
Objective 3.1: Increase mental wellbeing among Latine, BIPOC, underserved/unserved, and low-income youth, adults, and older adults with an approach that encompasses culturally competent strategies to support mental, physical, financial, and social wellbeing.	

LEAD ORGANIZATION	Molly's Angels
STRATEGY/PROGRAM NAME	Comprehensive Assistance and Resources for Elderly (CARE) Program
TARGET POPULATION(S)	Older Adults

STRATEGY/PROGRAM DESCRIPTION

The Comprehensive Assistance and Resources for Elderly (CARE) program seeks to improve health outcomes for Older Adults 60+ and reduce the risk of social isolation and geriatric depression through connections to consistent, caring adults and access to transportation and wrap-around supportive services. The CARE program will conduct outreach to older adults at risk of social isolation, depression, and who lack transportation to needed services, train program staff to use evidence-based screening tools, provide Hello Molly Care Calls and referrals to additional services, and conduct geriatric depression and social isolation screening for all Molly's Angels clients.

HIGHLIGHTED YEAR 1 OUTCOMES

715 bilingual referrals booklets produced and distributed.
84% of participants demonstrated improvement in well-being and access to care.

Behavioral Health

Goal 3: Support mental health and wellbeing of Napa County residents.	
Objective 3.1: Increase mental wellbeing among Latine, BIPOC, underserved/unserved, and low-income youth, adults, and older adults with an approach that encompasses culturally competent strategies to support mental, physical, financial, and social wellbeing.	

LEAD ORGANIZATION	On the Move
STRATEGY/PROGRAM NAME	Guaranteed Income for Foster Youth
TARGET POPULATION(S)	Youth and Young Adults who have been in the foster care system

STRATEGY/PROGRAM DESCRIPTION

VOICES Napa Guaranteed Income for Foster Youth program seeks to support youth enrolled in Extended Foster Care and improve mental health, education, employment, housing, and wellness status by both increasing and stabilizing young people's monthly income. Youth in the program receive monthly unconditional cash payments, life coaching, and financial education through their 22nd birthday. VOICES Guaranteed Income for Foster Youth Program serves youth participating in Extended Foster Care, who meet the income threshold and whose County of Origin is Napa.

HIGHLIGHTED YEAR 1 OUTCOMES

88% of youth enrolled in the program completed all components of this pilot program.

71% of youth demonstrated decreased income volatility as evidenced by their ability to cover unexpected expenses without going into debt.

64% of youth reported increased mental health and wellness as measured by increased self-determination and positive self-regard and/or decreased depression and anxiety.

78% of youth obtained and/or maintained stable, safe housing.

Goal 3: Support mental health and wellbeing of Napa County residents.	
Objective 3.1: Increase mental wellbeing among Latine, BIPOC, underserved/unserved, and low-income youth, adults, and older adults with an approach that encompasses culturally competent strategies to support mental, physical, financial, and social wellbeing.	

LEAD ORGANIZATION	ParentsCAN
STRATEGY/PROGRAM NAME	Parent Stress Intervention Program (PSIP)
TARGET POPULATION(S)	Families

STRATEGY/PROGRAM DESCRIPTION

The Parent Stress Intervention Program (PSIP) is an evidence-based prevention curriculum that teaches parents to manage and mitigate chronic stress and build coping skills and protective factors. ParentsCAN offers multiple sessions of PSIP Wellness Classes to its parent community, using evidence-based screening tools, as well as referrals from partner organizations and service providers, to identify parents with problematic stress levels who would benefit from the professional and social support structure of the program.

HIGHLIGHTED YEAR 1 OUTCOMES

283 new parents were screened using the Family Needs Assessment Tool to identify parents who need additional social and emotional support.

6 six-week long PSI Program Wellness Classes offered (English and Spanish).

89% of parents who attended PSI Program Classes reported lower levels of stress and anxiety, improved sleep and greater social wellbeing as indicated by their DASS scores.

Behavioral Health

Goal 3: Support mental health and wellbeing of Napa County residents.

Objective 3.2: Increase mental wellbeing and enhance access to mental health services, particularly bilingual and bicultural services, for children and their families, youth, adults, and older adults in Napa County.

LEAD ORGANIZATION	Aldea
STRATEGY/PROGRAM NAME	Supportive Outreach and Access to Resources (SOAR)
TARGET POPULATION(S)	Youth and Young Adults who require early intervention for psychosis

STRATEGY/PROGRAM DESCRIPTION

Aldea's Supportive Outreach and Access to Resources (SOAR) program uses the Coordinated Specialty Care model to provide evidence-based early intervention, assessment, and treatment services to children and transitional age youth experiencing or at high risk of developing psychosis. SOAR's team-based approach promotes shared decision-making among specialists, family members, and clients, empowering them to understand psychosis and engage fully in their recovery process. SOAR's goal is to intervene as early as possible to reduce symptoms and prevent illness-related impairments so clients may reach their personal, educational, and occupational goals while supporting long-term recovery and stability through client-centered care and psychoeducation.

HIGHLIGHTED YEAR 1 OUTCOMES

21 individuals enrolled in the SOAR program.

95% of program participants did not have a psychiatric hospitalization while in the SOAR Program.
100% of program participants received education, employment support, and referral services prior to discharge.
75% of program participants demonstrated improvement on the Compass 10 after having been in the SOAR Program for six months.
60% of program participants showed improvements from their initial assessment scores to their successful discharge scores on the Compass 10.

Goal 3: Support mental health and wellbeing of Napa County residents.

Objective 3.2: Increase mental wellbeing and enhance access to mental health services, particularly bilingual and bicultural services, for children and their families, youth, adults, and older adults in Napa County.

LEAD ORGANIZATION	Mentis
STRATEGY/PROGRAM NAME	Bridges Community Mental Health
TARGET POPULATION(S)	Uninsured/Underinsured Adults

STRATEGY/PROGRAM DESCRIPTION

The Bridges Community Mental Health (Bridges) program is an early-intervention, evidence-based bilingual mental health treatment program serving low income, uninsured/underinsured adults with no other access to mental health treatment. The Bridges program model typically offers 12-15 sessions on a weekly basis, bringing competent, trauma-informed care within reach for community members by removing typical barriers including ability to pay, language, culture, and accessibility.

HIGHLIGHTED YEAR 1 OUTCOMES

87% of clients, per the Emotional Rating Scale, reported decreased emotional distress and increased daily functioning.

82% of clients, per the PHQ9 (Patient Health Questionnaire-9) and the GAD7 (Generalized Anxiety Disorder 7 questionnaire), showed a reduction in symptoms of depression and anxiety.

78% of clients showed a reduction in symptoms of trauma per the PCL-PTSD (Post Traumatic Stress Disorder, PCL for short).

Behavioral Health

Goal 3: Support mental health and wellbeing of Napa County residents.

Objective 3.2: Increase mental wellbeing and enhance access to mental health services, particularly bilingual and bicultural services, for children and their families, youth, adults, and older adults in Napa County.

NAPA VALLEY EDUCATION FOUNDATION

LEAD ORGANIZATION	Napa Valley Education Foundation
STRATEGY/PROGRAM NAME	Middle School Access Program
TARGET POPULATION(S)	Youth

STRATEGY/PROGRAM DESCRIPTION

The Middle School Access Program seeks to support and enhance the wellbeing of Napa County youth and families through accessible, culturally responsive programming on 6 NVUSD campuses. Social workers provide screenings, access and linkage to treatment, prevention and early intervention services, trainings for middle school staff, and conduct evidence based El Joven Noble support groups for Latine students.

HIGHLIGHTED YEAR 1 OUTCOMES

100% of participants in the Joven Noble support groups built life skills, strengthened their cultural identity, and engaged as peer support for others in their groups.

69% of participants in the CBITS trauma support groups reported increased coping skills, resilience, self-regard, and understanding of available resources at their school sites.

72% of middle school students visited their Wellness Center for support at least once.
100% of students identified as needing Tier 3 mental health support offered services.
79% of middle school staff reported that they know how to identify, refer, and support a student with socio-emotional needs.

Goal 3: Support mental health and wellbeing of Napa County residents.

Objective 3.2: Increase mental wellbeing and enhance access to mental health services, particularly bilingual and bicultural services, for children and their families, youth, adults, and older adults in Napa County.

LEAD ORGANIZATION	Planned Parenthood Northern California
STRATEGY/PROGRAM NAME	Expanding Access to Equitable Behavioral Health Care in Napa Valley
TARGET POPULATION(S)	Teens and Young Adults

STRATEGY/PROGRAM DESCRIPTION

The Expanding Access to Equitable Behavioral Health Care in Napa Valley program offers accessible and affordable behavioral health care and wraparound services at the Napa Planned Parenthood Health Center. Staff provide crisis counseling and/or ongoing supportive therapy, and warm handoffs to wraparound services with assistance navigating the health care system. Services are provided via sliding scale fee or uncompensated.

HIGHLIGHTED YEAR 1 OUTCOMES

14 County residents provided with ongoing therapy.
114 County residents provided with crisis counseling and/or warm handoffs.

Behavioral Health

Goal 3: Support mental health and wellbeing of Napa County residents.

Objective 3.2: Increase mental wellbeing and enhance access to mental health services, particularly bilingual and bicultural services, for children and their families, youth, adults, and older adults in Napa County.

LEAD ORGANIZATION	Providence Queen of the Valley Medical Center
STRATEGY/PROGRAM NAME	Bilingual Behavioral Health Screening and Referrals in the Emergency Department
TARGET POPULATION(S)	Youth - Older Adults; Spanish speaking and Latine

STRATEGY/PROGRAM DESCRIPTION

The Bilingual Behavioral Health Screenings and Referrals in the Emergency Department program offers access and linkage to treatment by screening patients using validated tools, assessing behavioral health needs, and making referrals and connections to mental health and substance use disorder services in the community. This program aims to increase access to behavioral health care and prevent the development of serious mental illness among patients coming to the Emergency Department.

HIGHLIGHTED YEAR 1 OUTCOMES

306 total number of patients served.

100% of patients screened positive for social drivers of health concerns receive referrals, resources and/or connection to services while in ED.

100% of patients referred to behavioral health services receive follow-up outreach post discharge.

Goal 3: Support mental health and wellbeing of Napa County residents.

Objective 3.3: Identify and amplify non-traditional methods of mental wellness support, that address mental health needs and reduce stigma around accessing services.

LEAD ORGANIZATION	Mentis
STRATEGY/PROGRAM NAME	Middle School Foundations Wellness Initiative
TARGET POPULATION(S)	Youth

STRATEGY/PROGRAM DESCRIPTION

The Middle School Foundations of Wellness Initiative is a prevention/early intervention program that provides 8 monthly Wellness Cafes for 7th graders in six schools across NVUSD, incorporating the evidence based P2 curriculum. The program seeks to reduce isolation and increase positive social relationships that bolster wellness, increase students' knowledge of inclusivity, positive self-regard, coping skills, and other protective factors that bolster wellness and stability, increase students' awareness of resources available for additional support for themselves and their peers, and reduce use of more acute services in later teen years.

HIGHLIGHTED YEAR 1 OUTCOMES

820 Wellness Cafés held for 7th graders in six schools across NVUSD**.**

86% of Wellness Café participants reported increased coping skills**.**

93% of Wellness Café participants reported increased resilience.

93% of Wellness Café participants reported increased self-regard.

88% of Wellness Café participants reported increased understanding of available resources at their school site.

Behavioral Health

Goal 3: Support mental health and wellbeing of Napa County residents.

Objective 3.3: Identify and amplify non-traditional methods of mental wellness support, that address mental health needs and reduce stigma around accessing services.

LEAD ORGANIZATION	UpValley Family Centers
STRATEGY/PROGRAM NAME	Senior Wellness Program
TARGET POPULATION(S)	Older Adults

STRATEGY/PROGRAM DESCRIPTION

UpValley Family Centers' Senior Wellness Program delivers culturally competent, linguistically appropriate services for low-income and Latino/a seniors to promote wellness, foster mental health, reduce social isolation, and build a sense of community. The program launched Conversaciones con Los Abuelos (Conversations with the Grandfathers), a cross-generational pilot project to connect older Latino men with Latino youth through creative activities, and nutrition and line dancing classes for low-income older adults who live in Calistoga's age-restricted mobile home communities.

HIGHLIGHTED YEAR 1 OUTCOMES

802 connections made with older adults.
16 older Latina women recruited to participate in Latina Senior Women's Group.
78 Latino and Latina Senior groups conducted.
100% of older adult participants reported the groups helped them better understand how to manage stress and anxiety.
55% of older adult participants reported feeling more comfortable talking with others about seeking help for mental health concerns.

Access to Health Services

Our Vision: Everyone in Napa County has access to affordable health and social services, including primary, specialty, and dental care, without barriers to entering and navigating within the system.

Access to Health Services

Goal 1: Reduce health inequities and help ensure the wellbeing of individuals, including children and older adults, through programs and services.

Objective 1.1: Develop approaches to fall prevention education among older adults that reduce access barriers and increase opportunities for developing social supports.

LEAD ORGANIZATION	Share the Care
STRATEGY/PROGRAM NAME	Yvonne's Front Porch Resource Advocate Role and Transitional Fall Prevention
TARGET POPULATION(S)	Lower Income Older Adults

STRATEGY/PROGRAM DESCRIPTION

Share the Care's Yvonne's Front Porch Resource Advocate Role program accepts donations and provides distribution of new and gently used durable medical equipment and health supplies to those in need at no cost. The Transitional Fall Prevention program has expanded the current Fall Prevention Program, allowing caregivers to analyze and assess the home, and then revisit the client to offer a full Stop Falls Program assessment.

HIGHLIGHTED YEAR 1 OUTCOMES

104 clients served in the Fall Prevention Program.

37,328 new and gently used durable medical equipment and health supplies provided to Yvonne's Front Porch clients.

100% of clients reported feeling safer post Transitional Fall Prevention Program services.

Goal 1: Reduce health inequities and help ensure the wellbeing of individuals, including children and older adults, through programs and services.

Objective 1.2: Increase dental care access with a focus on low-income community members who identify as Black, Indigenous, People of Color (BIPOC), including children and older adults.

LEAD ORGANIZATION	CommuniCare+Ole
STRATEGY/PROGRAM NAME	Dental Access Program
TARGET POPULATION(S)	Lower Income Children - Older Adults who identify as BIPOC

STRATEGY/PROGRAM DESCRIPTION

The CommuniCare+Ole (CC+OLE) Dental Access Program provides culturally competent, bilingual dental services in three locations in Napa County. The CC+OLE program seeks to reduce barriers to care for patients with outstanding dental care plans, increase access to dental care for children by improving preventative dental health measures for expectant mothers, infants, and children including increasing the mothers' dental health awareness, maintain dentistry skill development enabling dentists to perform complex-level dental surgical procedures, and work with patients to identify and reduce barriers to wellness by providing resource referral assistance, warm handoffs to behavioral health and nutritionists, and assisting in scheduling appointments with internal and outside provider referrals.

HIGHLIGHTED YEAR 1 OUTCOMES

2,358 new pediatric patients aged 0-9 who had their first dental visit.

4,361 patients aged 18+ came in for a dental appointment.

1,642 additional/new low-income patients.

Access to Health Services

Goal 2: Reduce health inequities and help ensure the well-being of individuals, through system analysis and innovation.

Objective 2.1: Develop policies and programs that expand infrastructure to bring more medical professionals and related health services to Napa County.

LEAD ORGANIZATION	Partnership Health Plan
STRATEGY/PROGRAM NAME	Targeted Recruitment Campaign
TARGET POPULATION(S)	Pediatricians, Family Medicine Practitioners, and Pediatric Nurse Practitioners

STRATEGY/PROGRAM DESCRIPTION

Partnership HealthPlan's Provider Retention Initiative (PRI) and Provider Recruitment Program (PRP) aim to recruit and retain high-quality health professionals such as primary care clinicians, providers of perinatal services, and psychiatrists to serve the Northern California population. Through the incentives provided by these programs, Partnership HealthPlan enhances institutional knowledge, strengthens clinical leadership, and fosters mentorship opportunities for emerging providers throughout its network, enhancing access to care for Partnership HealthPlan members.

HIGHLIGHTED YEAR 1 OUTCOMES

Between June 2024 and June 2025, **8** Provider Recruitment Awards in Napa County.

Between June 2024 and June 2025, **1** Provider Retention Award in Napa County.

Goal 2: Reduce health inequities and help ensure the well-being of individuals, through system analysis and innovation.

Objective 2.2: Assess and identify transgender care service gaps, and specific service needs, in order to increase access to local transgender care.

LEAD ORGANIZATION	Providence QVMC
STRATEGY/PROGRAM NAME	Transgender Care Collaborative
TARGET POPULATION(S)	Youth - Older Adults seeking services related to gender identify

STRATEGY/PROGRAM DESCRIPTION

Plans for this program are still emerging, and Providence Queen of the Valley Medical Center will keep Napa County HHSA updated as they are developed.

HIGHLIGHTED YEAR 1 OUTCOMES

NA

Access to Health Services

Goal 2: Reduce health inequities and help ensure the well-being of individuals, through system analysis and innovation.		
Objective 2.3: Increase health and social service system navigation support, with a focus on undocumented individuals and mixed status households.		
	LEAD ORGANIZATION	Providence Community Health Foundation Napa Valley
	STRATEGY/PROGRAM NAME	Napa County Information and Access Program
	TARGET POPULATION(S)	Older Adults, including undocumented and mixed status households
STRATEGY/PROGRAM DESCRIPTION		
Providence Community Health Foundation Napa Valley's (Providence) Information & Assistance (I&A) program provides adults aged 60 and older information, resources and services that enable them to maintain their long-term independence. This includes providing housing support, caregiving resources, transportation services, and food access information. I&A also makes caregiver referrals, matching caregivers with older adults in the community in need of service.		
HIGHLIGHTED YEAR 1 OUTCOMES		
310 older adults provided Case Management so they could manage their daily tasks. **310** clients who had a documented, personalized plan of care. **58%** of older adults who received Information & Assistance referrals received a follow-up phone call within two months to confirm they connected with the referral. **70%** of older adults who receive case management reported an improved quality of life score via the OPQOL-Brief assessment tool which is administered pre- and post-management.		

Goal 2: Reduce health inequities and help ensure the well-being of individuals, through system analysis and innovation.		
Objective 2.3: Increase health and social service system navigation support, with a focus on undocumented individuals and mixed status households.		
	LEAD ORGANIZATION	HHSA
	STRATEGY/PROGRAM NAME	Be Well Mobile Services
	TARGET POPULATION(S)	Napa County residents aged 18+ who have Medi-Cal or Medicare, are without health insurance, or are underinsured
STRATEGY/PROGRAM DESCRIPTION		
HHSA BE WELL Mobile Services aims to provide an array of health and human services directly to community members in convenient locations across Napa County. The HHSA BE WELL team offers onsite Medi-Cal, CalFresh, and CalWORKs enrollment, helps with maintaining coverage and benefits, and provides screening and access to Behavioral Health Services (both Mental Health and Substance Use Disorders Treatment) among other services. Services are primarily for Napa County residents aged 18+ who have Medi-Cal or Medicare, are without health insurance, or are underinsured.		
HIGHLIGHTED YEAR 1 OUTCOMES		
BE WELL began operations in Fall 2025 and metrics are currently in development.		

Access to Health Services

Goal 2: Reduce health inequities and help ensure the well-being of individuals, through system analysis and innovation.

Objective 2.3: Increase health and social service system navigation support, with a focus on undocumented individuals and mixed status households.

LEAD ORGANIZATION	Napa Valley Education Foundation
STRATEGY/PROGRAM NAME	Newcomers Pathway Program
TARGET POPULATION(S)	Youth and families; Recent Immigrants

STRATEGY/PROGRAM DESCRIPTION

The Newcomers Pathway Program aims to reduce health inequities, increase system navigation for Newcomer students and their families, and promote the overall well-being and successful integration of these students into the school community. Newcomer students are identified and screened by social workers to assess any need for support services. Students and families are connected with community and school programs, and social workers identify and enroll students into the l0-week evidence-based STRONG program. Staff ensure each newcomer and their family have a case navigator, and work to establish trauma-informed, student-centered support systems at all three program pilot sites.

HIGHLIGHTED YEAR 1 OUTCOMES

72 students enrolled in STRONG program groups.

206 parents who participated in Newcomer Orientations, adult education, and/or were connected with partner programs/services.

100% of newcomer students demonstrated increased awareness of services and programs available within the school community, as well as improvement in coping skills, as measured by pre- and post-surveys.

100% of newcomer parents who are served reported increased knowledge about essential education, workforce, wellness, finance, technology, and/or parenting skills as measured by participant surveys.

90% of students demonstrated increased confidence, sense of belonging, resiliency and coping skills on STRONG post-tests.

Racial Equity and LGBTQ Inclusion

Our Vision: Napa County is a place where one's race, ethnicity, language, sexual orientation, and gender identify no longer predict opportunities, outcomes, or the distribution of resources.

Racial Equity and LGBTQ Inclusion

Goal 1: Implement changes to systems and structures that perpetuate white supremacy culture.

Objective 1.1: Increase access to information and services by reducing language and cultural barriers.

LEAD ORGANIZATION	Napa Valley Community Organizations Active in Disasters (COAD)
STRATEGY/PROGRAM NAME	Cultivating Connections: Creating a Community Liaison Program and Cultural Hubs to promote language inclusion and belonging
TARGET POPULATION(S)	Households with Limited English Proficiency; BIPOC community members

STRATEGY/PROGRAM DESCRIPTION

The Cultivating Connections program is creating a community liaison program, using human centered design to explore how trusted messengers and cultural hubs can promote language inclusion and belonging. The program is hiring and training community connectors to become system navigators and community advocates. This program will create Spanish-first events; support Spanish speaking liaisons in promoting COAD's language access and outreach work; and ensure communications are culturally and linguistically appropriate.

HIGHLIGHTED YEAR 1 OUTCOMES

73 individuals participated in design sessions.

3 trainings with COAD partners and agencies conducted.

30 COAD partners and agencies participated in trainings.

69 community events and workshops held/attended.

Goal 1: Implement changes to systems and structures that perpetuate white supremacy culture.

Objective 1.1: Increase access to information and services by reducing language and cultural barriers.

LEAD ORGANIZATION	Napa Valley Community Foundation, Immigration Institute of the Bay Area, On the Move, Puertas Abiertas Community Resource Center, UpValley Family Centers
STRATEGY/PROGRAM NAME	Napa Valley Together/One Napa Valley Initiative
TARGET POPULATION(S)	Immigrants in Napa County

STRATEGY/PROGRAM DESCRIPTION

The Napa Valley Together collaborative provides immigration legal services, citizenship support, and public education efforts to make sure immigrant families in Napa County have access to citizenship programs, due process, and accurate information. Although this strategy was not originally included in the 2024 CHIP, this work is partially funded by the Napa County Master Settlement Agreement.

HIGHLIGHTED YEAR 1 OUTCOMES

108 presentations and trainings were conducted for 7,888 individuals, including: Know Your Rights, Family Preparedness, Public Charge, immigration policy updates, Trusted Messenger.

15 volunteers provided 1,121 hours of assistance at naturalization workshops, at ESL for citizenship/civics classes, at one-on-one tutoring to help citizenship candidates prepare for their exam with USCIS and conducting community outreach for the program.

985 people received legal consultations for citizenship or other immigration benefits/remedies.

A total of **737** applications were filed for citizenship or other immigration benefits/remedies.

107 people naturalized, which included 4 children that derived citizenship from their parents’ applications.

Racial Equity and LGBTQ Inclusion

Goal 1: Implement changes to systems and structures that perpetuate white supremacy culture.

Objective 1.2: Identify and amplify opportunities for staff diversity training across sectors.

STRATEGY/PROGRAM DESCRIPTION

A strategy responsive to this objective has not been identified and will be an area of ongoing discussion among community partners.

HIGHLIGHTED YEAR 1 OUTCOMES

NA

Goal 2: Increase belonging and inclusion among systemically marginalized communities.

Objective 2.1: Increase inclusion and belonging among older adults who identify as low income and/or Black, Indigenous, People of Color (BIPOC).

LEAD ORGANIZATION	Providence Community Health Foundation Napa Valley
STRATEGY/PROGRAM NAME	Connections Napa County – Navigating resources for seniors and people with disabilities
TARGET POPULATION(S)	Older Adults

STRATEGY/PROGRAM DESCRIPTION

Connections Napa County seeks to become an emerging Aging and Disability Resource Connection (ADRC) with a resource directory that includes social activities and supports, including those targeted specifically toward BIPOC and LGBTQ older adults, and then apply to become a fully designated ADRC and ensure ADRC Designation Criteria are met, and person-centered practices and a 'No Wrong Door System' are implemented.

HIGHLIGHTED YEAR 1 OUTCOMES

Connections Napa County has been designated as an emerging ADRC and is in the process of applying for full designation. As of this publication, the online resource directory has had **1900** site visits.

Racial Equity and LGBTQ Inclusion

Goal 2: Increase belonging and inclusion among systemically marginalized communities.		
Objective 2.2: Increase inclusion and belonging among the Napa County LGBTQ Community.		
	LEAD ORGANIZATION	On The Move
	STRATEGY/PROGRAM NAME	LGBTQ School Support Program
	TARGET POPULATION(S)	Youth who identify as LGBTQ+; Spanish-speaking and BIPOC
STRATEGY/PROGRAM DESCRIPTION		
The LGBTQ School Support Program (LSSP) engages LGBTQ youth via Wellness Centers located at high schools across Napa County, utilizing a youth-led approach to community organizing in which young people find support and acceptance with other peers and discover their personal agency to make their community safer and more inclusive, while also strengthening their own wellbeing. The LSSP provides screening, peer support groups, and resource navigation to quickly connect young people to the mental health and other supportive services they need to lower distress and increase help-seeking, while also supporting youth-led advocacy projects that identify and prioritize community needs and facilitate a youth-led response.		
HIGHLIGHTED YEAR 1 OUTCOMES		
80% of identified high schools have collocated peer support inside Wellness Centers.		
65% of participating youths reported increased feelings of connectedness and inclusion, as measured by group interviews and/or retrospective survey data.		
65% of youth reported decreased risk factors including isolation, rejection and distress, as measured by group interviews and/or retrospective survey data.		

Goal 2: Increase belonging and inclusion among systemically marginalized communities.		
Objective 2.3: Identify and amplify tools for system analysis to determine if policies and programs result in disparate outcomes for community members who identify as Black, Indigenous, People of Color (BIPOC).		
	LEAD ORGANIZATION	Napa County
	STRATEGY/PROGRAM NAME	Promote and educate on policies that address the root causes of disparities, such as through a Health in All Policies (HiAP) approach.
	TARGET POPULATION(S)	People who are born, live, work, learn, play, and age in Napa County.
STRATEGY/PROGRAM DESCRIPTION		
This strategy is still emerging.		
HIGHLIGHTED YEAR 1 OUTCOMES		
NA		

Economic Stability

Our Vision: Everyone in Napa County has the means and resources to meet their basic needs, including access to affordable childcare, healthy food, and transportation options, and to achieve long term financial stability.

Economic Stability

Goal 1: Address economic stability among systemically marginalized populations in Napa County.

Objective 1.1: Increase economic stability for community members experiencing life transitions, such as those exiting foster care, transitioning to a fixed income, or becoming new parents.

	LEAD ORGANIZATION	ParentsCAN
	STRATEGY/PROGRAM NAME	Family Stability Program
	TARGET POPULATION(S)	Under-resourced Families of Children with Disabilities

STRATEGY/PROGRAM DESCRIPTION

The ParentsCAN Family Stability Program seeks to reduce the isolation, stress, and financial burden experienced by families transitioning to raising a child with a disability. ParentsCAN staff provide screenings, referrals, resources, application assistance, and follow-up support to ensure that families are connected to essential services that enhance their economic stability and well-being.

HIGHLIGHTED YEAR 1 OUTCOMES

142 families screened for needs.

49 families provided additional services.

67 Basic Safety Net service applications completed.

650 follow-up contacts to families navigating Safety Net systems.

Goal 1: Address economic stability among systemically marginalized populations in Napa County.

Objective 1.1: Increase economic stability for community members experiencing life transitions, such as those exiting foster care, transitioning to a fixed income, or becoming new parents.

	LEAD ORGANIZATION	Community Resources for Children (CRC)
	STRATEGY/PROGRAM NAME	Delivering Economic Stability for Childcare Providers and the Working Families they Serve
	TARGET POPULATION(S)	Lower Income Childcare Providers, with a focus on those who speak Spanish

STRATEGY/PROGRAM DESCRIPTION

Community Resources for Children (CRC) works to deliver economic stability for Napa County's childcare providers and working families by operating a culturally responsive and comprehensive job training program. The program will offer business training and coaching, connection to local resources and partners, assistance navigating childcare licensing regulations, and stipends to assist with childcare business-related expenses for prospective and existing licensed Family Childcare Home (FCCH) providers. The program serves low to moderate-income women childcare providers living in Napa County who are primarily Spanish speaking.

HIGHLIGHTED YEAR 1 OUTCOMES

31 Childcare providers enrolled.

90% of providers increased their knowledge of running a thriving childcare business.

90% of providers improved their understanding of business concepts such as expense tracking, tax deductions, and business insurance.

93% of providers feel more confident in their ability to open and sustain their childcare business.

86% of providers feel more connected to other resources in the community.

Economic Stability

Goal 2: All Napa County residents have regular access to affordable and nutritious food.		
Objective 2.1: Develop a food systems initiative with a backbone agency with authority and funding to connect resources.		
	LEAD ORGANIZATION	Downtown Napa Farmers Market
	STRATEGY/PROGRAM NAME	Nourishing Connections: Napa County Food Access Coalition
	TARGET POPULATION(S)	Children - Older Adults who are experiencing food insecurity
STRATEGY/PROGRAM DESCRIPTION		
Napa County Food Access Coalition Local Food Systems Initiative ("Nourishing Connections") supports economic stability by developing, implementing, and evaluating a local food access system communication initiative (with an authorized backbone organization to fund and connect resources) to ensure all Napa County residents have regular access to affordable and nutritious food.		
HIGHLIGHTED YEAR 1 OUTCOMES		
10 Napa County Food Access Coalition (NCFAC) meetings held.		
45% increase in the number of NCFSC partners, as measured by the number of new entities participating in NCFSC meetings.		

Goal 2: All Napa County residents have regular access to affordable and nutritious food.		
Objective 2.2: Increase access to fresh, nutritious, and culturally and/or medically appropriate food among low income and Latine residents of Napa County following recommendations from the 2018 Emergency Food System Study.		
	LEAD ORGANIZATION	Community Action of Napa Valley (CANV)
	STRATEGY/PROGRAM NAME	Food Bank and Meals on Wheels
	TARGET POPULATION(S)	Children - Older Adults who are experiencing food insecurity
STRATEGY/PROGRAM DESCRIPTION		
The CANV Food Bank will provide nutritious food to low-income individuals and families, and supports emergency food assistance efforts during disasters to ensure that the community's needs are met during crises. The CANV Food Bank purchased more fresh fruits and vegetables for distribution at its existing 7 food pantries, 12 free markets, and through community distribution partners. It also supports efforts to expand food access locations and minimize transportation challenges, ensuring all Napa County residents have regular access to affordable and nutritious food. The Meals on Wheels Program serves the senior population in Napa County, providing healthy food options to those who are unable to travel to food pantries or free markets due to health or transportation restrictions.		
HIGHLIGHTED YEAR 1 OUTCOMES		
879,256 lbs. of fresh, nutritious, and medically appropriate food purchased and provided to low-income individuals and families in Napa County.		
17,802 Meals on Wheels purchased and delivered, increasing more fresh meals for seniors.		

Economic Stability

Goal 2: All Napa County residents have regular access to affordable and nutritious food.

Objective 2.2: Increase access to fresh, nutritious, and culturally and/or medically appropriate food among low income and Latine residents of Napa County following recommendations from the 2018 Emergency Food System Study.

LEAD ORGANIZATION	Feeding it Forward
STRATEGY/PROGRAM NAME	Fighting Food Insecurity through Food Recovery
TARGET POPULATION(S)	Children - Older Adults who are experiencing food insecurity

STRATEGY/PROGRAM DESCRIPTION

Feeding It Forward Napa Valley (FIFNV) works with food generators to recover available excess prepared and highly perishable food, and coordinate food distribution to community-based organizations where the need for food is the greatest. FIFNV provides distributions at three senior living locations, and plans on expansion to more senior living locations. In addition, FIFNV distributes food weekly at multiple Abode locations, the Salvation Army hot meals program, Innovations Community Center, Serenity Homes, Farmworkers centers, and the Napa County Recovery Center.

HIGHLIGHTED YEAR 1 OUTCOMES

177,222 lbs. of food recovered and distributed to community members.
5,103 unduplicated individuals served.
43 CBO Partner Distribution locations served.

Goal 2: All Napa County residents have regular access to affordable and nutritious food.

Objective 2.2: Increase access to fresh, nutritious, and culturally and/or medically appropriate food among low income and Latine residents of Napa County following recommendations from the 2018 Emergency Food System Study.

LEAD ORGANIZATION	Puertas Abiertas
STRATEGY/PROGRAM NAME	Feeding Our Families: Napa Farmers Market Fruit and Veggies Bucks
TARGET POPULATION(S)	Lower income, Latine families

STRATEGY/PROGRAM DESCRIPTION

The Feeding our Families: Napa Farmers Market Fruit and Veggies Bucks (FVB) Program is a voucher distribution program, providing eligible, low-income Latine families with $300 in vouchers or "bucks" to be redeemed specifically for fruits and vegetables at the Napa Farmers Market. Services include an intake to assess and identify eligible Latine participants, and case management to provide participants with additional resources and referrals as needed. The FVB program also works to establish a community support network and extend outreach efforts to offer FVB as an essential community resource.

HIGHLIGHTED YEAR 1 OUTCOMES

150 unduplicated individuals and/or families served.
100% of participants reported an increase in their awareness of community food resources.
100% of participants reported an increase in access to nutritious food.
93% of participants reported they had improved dietary habits.

Economic Stability

Goal 2: All Napa County residents have regular access to affordable and nutritious food.
Objective 2.3: Identify and amplify non-traditional methods of consistent follow-up for community members accessing emergency food systems that allow for warm hand-offs to other services as needed**.**
STRATEGY/PROGRAM DESCRIPTION
A strategy responsive to this objective has not been identified and will be an area of ongoing discussion among community partners.
HIGHLIGHTED YEAR 1 OUTCOMES
NA

Goal 3: Transportation options in Napa County are accessible and affordable, allowing residents to meet their basic needs.		
Objective 3.1: Address transportation issues that create barriers to accessing food, healthcare, employment, education, and other basic needs, especially for older adults, youth, and community member who identify as low income, and/or Black, Indigenous, People of Color (BIPOC).		
	LEAD ORGANIZATION	Kaiser Permanente, Partnership Health Plan, and HHSA – Public Health Division
	STRATEGY/PROGRAM NAME	Managed Care Plan - DHCS SMART objective for Napa County
	TARGET POPULATION(S)	Older adults, individuals with a disability, families with children younger than 15 months, and those who identify as BIPOC.
STRATEGY/PROGRAM DESCRIPTION		
Managed Care Plan partners (MCP) are working with Napa County HHSA staff to increase the utilization of managed care plan transportation among Napa County community members with a focus on older adults, individuals with a disability, families with young children, and those who identify as BIPOC. MCP and HHSA staff are gathering transportation benefit utilization data and qualitative community data via listening sessions and will then develop an action plan to address identified gaps and barriers in the utilization of transportation benefits in Napa County.		
HIGHLIGHTED YEAR 1 OUTCOMES		
Managed Care plan partners have completed a transportation benefit landscape analysis, showing that people with young families, as well as people who identified as Hispanic, were underutilizing the transportation benefit in Napa County.		

Economic Stability

Goal 3: Transportation options in Napa County are accessible and affordable, allowing residents to meet their basic needs.		
Objective 3.1: Address transportation issues that create barriers to accessing food, healthcare, employment, education, and other basic needs, especially for older adults, youth, and community member who identify as low income, and/or Black, Indigenous, People of Color (BIPOC).		
	LEAD ORGANIZATION	Molly's Angels
	STRATEGY/PROGRAM NAME	Molly's Angel's Transportation Program
	TARGET POPULATION(S)	Older Adults, including those who identify as BIPOC
STRATEGY/PROGRAM DESCRIPTION		
Molly's Angels Transportation Program provides free transportation services for seniors 60+ and embark on a strategic expansion of services, including the addition of a Hispanic outreach worker to connect with Napa Valley's growing Latino population. Molly's Angels aims to ensure transportation options in Napa County are accessible and affordable by providing free door-to-door rides, participating in outreach events, and purchasing a 15-passenger van to expand program services.		
HIGHLIGHTED YEAR 1 OUTCOMES		
5,014 free door-to-door transportation rides provided for older adults (ages 60+). In Year 1, the number of rides **more than doubled.** **95** new clients enrolled in Molly's Angels services that identified as older adult BIPOC.		

Looking Forward Together

LHNC and CHIP partners meet on a quarterly basis to review strategy updates, share peer learning, and review community data. At each convening, Public Health staff provide opportunities for partners to provide feedback that shapes future LHNC work and meetings. During our pilot year, we focused on collecting feedback that would inform potential cohort-building and technical assistance opportunities in the next year of community convenings. Partner feedback themes include, but are not limited to:

- **System Navigation Support for Staff and Clients**
  - Partners consistently expressed a need for the “system to understand itself”. There is an opportunity to improve warm hand-offs, staff knowledge of available resources/services, and our ability to use data systems to track referrals from start to finish.

- **Data Collection and Analysis Support**
  - Partners expressed a desire to better understand how data can be analyzed and interpretated, and a need for better tools to collect and track data across diverse funders and programs. Many partners also emphasized that while they wanted to learn from data to improve their programming, there was often a lack of staff time to collect, track, and analyze that data.

- **Stronger Together**
  - Partners named strong connections between agencies, schools, hospitals, and coalitions as a key strength of their work. They feel their community’s trust and engagement, built from culturally competent services and trusted messengers, were crucial to their programs’ success. Finally, many partners found that our county’s adaptability, hard earned through many shifting emergencies and federal administration changes, is a central strength shared among our collaborative organizations.

In the coming year, LHNC partner meetings will focus on developing and building on these themes together. Reports providing updates on the 2024 CHIP will be published annually.

Questions on this report, the 2024 CHIP, or the work of the LHNC collaborative can be directed to LHNC@countyofnapa.org.