NUR 248 Syllabus

Nursing in Community Based Settings

Sandy Buckley, RN, MS
**COURSE NUMBER AND TITLE:** NURS 248 – Nursing in Community-Based Settings

**COURSE DESCRIPTION:** Focus is on the application of the nursing process in community-based settings. Teaching, systematized lifelong learning and collaboration will be highlighted.

**PREREQUISITES:** Completion of NURS 143 and NURS 144 or NURS 245 and NURS 144.

**NUMBER OF HOURS:**
- Credit: 1 Unit
- Class: 3 hours/everyother wk for 8 weeks
- Clinical/Lab: 6 hours/everyother wk 8 weeks

**FACULTY:** Sandra Buckley, RN, MS, Nursing Instructor. Room 814-2C. sbuckley@napavalley.edu; Office (707) 256-4511; FAX (707) 259-8933.

**TEACHING METHODS:** This class will be taught using a seminar format, audiovisuals, reading, case studies, community-based projects, and presentations.

**EVALUATION:**

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<tr>
<th>Component</th>
<th>Weight (%)</th>
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<tr>
<td>2 newspaper articles</td>
<td>5</td>
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<tr>
<td>4 seminars (Participation &amp; Preparedness)</td>
<td>10</td>
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<tr>
<td>Research/evidence based practice articles</td>
<td>10</td>
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<tr>
<td>Book/reading assignment</td>
<td>25</td>
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<tr>
<td>Presentation:</td>
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<td>Individual Teaching Plan</td>
<td>5</td>
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<td>Group</td>
<td>15</td>
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<td>Individual</td>
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<td>Group Collaboration</td>
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<td>Agency Evaluation (Group)</td>
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<td><strong>Total</strong></td>
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**REQUIRED TEXTS:**
- ADN Student Handbook
- Syllabus, NURS 248

**RECOMMENDED TEXTS:**
1. **News articles**-during the n248 rotation, students are expected to expose themselves to news media reports related to healthcare issues. Media information can be accessed via newspapers, internet news services, television or radio. The purpose of this requirement is to become familiar with media sources and to peruse, analyze and reflect upon current issues pertaining to healthcare. Students are required to come to class prepared to discuss the articles that have been analyzed. See Rubric for point distribution, calendar for due dates.

2. **Presentation**-The clinical activity for the community class is a community project. Students will utilize the nursing process to create and implement a project targeting a specific group in the community. The intent of the project is health promotion, disease prevention.

   There are multiple components to the project as described below:
   a. Establish a group of 3-5 students to participate in a community project.
   b. Identify a group within the community that would benefit from community nursing interventions.
   c. Utilize organizational skills, delegation, and communication skills to contact and meet with community agency director. Collaborate with agency and peers to determine appropriate topic for presentation. Determine dates, times and delegation of tasks amongst group members.
   d. Gather data to scientifically establish basis for teaching project. Include risk factors, internal and external environmental factors, research from scholarly journals, needs assessment, target audience, facility buy-in.
   e. Plan, implement and evaluate project.
   f. Present project in presentation to class. Include outcomes, research utilized, response of agency members, and evaluation by group members.
   g. See Rubric for point distribution, calendar for due dates.

3. **Reading assignment**-Students are required to read:
   *The Spirit Catches You and You Fall Down*, A Hmong Child, her American Doctors and the collision of two cultures, by Anne Fadiman (Farrar, Straus and Giroux, New York, 1997)

   It is suggested that the book be read, prior to the start of class. Students are required to answer 2 questions of your choice from the “questions and subjects for discussion” portion in the back of the book, and to answer the question, “Describe how nursing interventions might have impacted the outcomes of this story”. All
answers to the 3 questions should be submitted in essay form and should be at least 2 pages long. See Rubric for point distribution, calendar for due date.

4. **Class participation**-N248 is a seminar class. Students are required to participate in discussion in a knowledgeable manner. Review of discussion items prior to class is important to enhance one’s knowledge base and for utilization of critical thinking skills. Students may receive extra points (up to 5 points) for actively participating in discussion topics.
THE ESSENTIAL “C’s” of COMMUNITY-BASED NURSING PRACTICE

To prepare graduates of AND programs to meet local nursing needs (HEALTH PROMOTION-DISEASE PREVENTION) in community-based settings.

COMMUNICATION/TEACHING – students, agency staff, clients, groups

COLLABORATION

CLIENT/FAMILY ADVOCACY

CARE, CASE & SYMPTOM MANAGEMENT

COMMUNITY INVOLVEMENT

COPING WITH AMBIGUITY

CULTURAL COMPETENCY

CRITICAL THINKING/REASONING

COMMUNITY SERVICE LEARNING

COMMUNITY NEEDS & RESOURCES
SOME RECOMMENDED WEBSITES:

*County Health Rankings  www.countyhealthrankings.org
American Academy of Pediatrics  www.aap.org
American College Health Association  www.acha.org/projects_programs
American Health Association  www.apha.org
Bilingual health education materials for children  www.childrenshealthfund.org/healthybasics
Brainpop.com (for kids, health teaching, lots of fun)  www.5/nut2el45/index.asp  http://www.brainpop.com
Canadian Healthy People 2000  http://www.hc-sc.gc.ca/hppb/phdd/determinants/e_determinants.html
CDC – Advisory committee on Immunization Practices  www.cdc.gov/hip/acip
Center for Disease Control  http://www.cdc.gov/  CDC Website - full of useful information. You can even subscribe to Morbidity and Mortality Weekly.
Centers for Disease Control & Prevention – Chronic Diseases Prevention & Health Promotion  www.cdc.gov/nccdphp/dah
Drug Identification  http://www.drugs.com/xg/cfm/pageID_1152/qx/index.htm  This web site can be used to help identify medications when no labels are available.
Healthteacher.com  www.healthteacher.com/lesson guides/nutrition/4-
Healthy People 2010  http://www.health.gov/healthypeople/default.htm
Healthy People 2010 Information [http://nnlm.gov/partners/hp](http://nnlm.gov/partners/hp) This site searches PubMed for journal articles related to achieving selected Healthy People 2010 objectives. A single click retrieves articles geared to 32 objectives on the following topics: Access to Quality Health Services, Disability and Secondary Conditions, Food Safety, Public Health Infrastructure, Respiratory Diseases, and Environmental Health. The site also includes links to relevant community and clinical preventive service guidelines and MEDLINEplus topics. This site is designed to make information needed for the planning and implementation of HP 2010 objectives more easily available to public health professionals, the public health workforce, students, and researchers.

Home Care Online [http://www.nahc.org](http://www.nahc.org) National Association of Home Care Website Lots of links and resources.

Kaiser family foundation [www.statehealthfacts.kff.org](http://www.statehealthfacts.kff.org)


Multicultural Links [http://www.iun.edu/~libemb/trannurs/trannurs.htm](http://www.iun.edu/~libemb/trannurs/trannurs.htm) Links to a variety of multicultural health sites.

National Coalition to End Homelessness [http://www.naeh.org](http://www.naeh.org) Of particular interest are the “Best Practices” profile and the section on what you can do.

National Guidelines [http://www.guidelines.gov](http://www.guidelines.gov) This is a great site to browse. You will find national guidelines on numerous health care concerns.

National Healthcare for the Homeless Coalition [http://www.nhchc.org/basics.html](http://www.nhchc.org/basics.html) The National Healthcare for the Homeless Council is a membership organization of healthcare providers working with homeless people across the United States. The Council exists to help bring about reform of the health care system to best serve the needs of people who are homeless. The National Council home page contains reports, policy papers, clinical information, two newsletters, links to health and homelessness sites, and a forum for members.

National Homeless Coalition [http://www.nationalhomeless.org](http://www.nationalhomeless.org) Information on activities on behalf of the homeless at the national level.

National Institute of Mental Health [http://www.medscape.com/govmt/NIMH.html](http://www.medscape.com/govmt/NIMH.html) This is a good site for information on mental illnesses. You can download booklets on individual diagnoses.


Nutrition Navigator [http://navigator.tufts.edu](http://navigator.tufts.edu) Tufts University site. Provides links to a huge variety of nutrition sites that are rated by professionals for currency, credibility and user friendliness. Go to the Professionals section. This is the best and most comprehensive source of nutritional information I have found.

NVUSD website (windshield survey-lowdown on demographics, district, etc.) [www.nvusd.k12.ca.us](http://www.nvusd.k12.ca.us)


Patient teaching materials for low literacy clients [http://itsa.ucsf.edu/~hclinic](http://itsa.ucsf.edu/~hclinic) Materials created at the UCSF Homeless clinic for teaching clients with low literacy. Click on the "Resources" link for materials.

Priority Home Care [http://www.priorityhomecare.com](http://www.priorityhomecare.com) Provides information about elder care, nursing care, home infusion therapy, certified home health aides, companions and homemakers, home therapies, etc.

Public Health Interventions Wheel [http://www.health.state.mn.us/divs/chs/phn/compete.html](http://www.health.state.mn.us/divs/chs/phn/compete.html) Scroll to near the bottom of the page and click on "Public Health Interventions Wheel" to locate and print a copy of the wheel.


World Health Organization [http://www.who.int](http://www.who.int)
PROGRAM OUTCOMES

At the completion of the program, the graduate will:

I. Use the nursing process to individualize care in order to assist patients to promote, maintain and restore health.

II. Assume responsibility to actively participate with individuals, families and healthcare team members in accordance with the legal and ethical standards of the nursing profession.

III. Maintain effective communication with individuals, families, and members of the healthcare team.

IV. Makes sound clinical decisions and evaluates outcome based on scientific principles, diversity and growth and development.

V. Manage care for a group of patients with multiple complex health alterations in hospital or community setting.

VI. Demonstrate commitment to professional growth and self-development.

VII. Qualify to take the NCLEX-RN.

COURSE OBJECTIVES

1. *Apply* the nursing process to a wellness/health promotion activity in the community.

2. *Awareness* of legal and ethical principles as applied in the community.

3. *Use communication* effectively with classmates, agency personnel and client groups.

4. *Apply theory-based knowledge* to nursing practice in the community.

5. *Collaborative involvement* with students and agency personnel.

6. Demonstrate responsibly for *continued personal growth* and development.

7. *Awareness* of diversity in community settings and how those diversities may correlate to social, political, and environmental issues that impact health disparities in groups.
Community-Based Clinical Experiences

During community-based clinical experiences, the student will:

1. Develop an understanding of the characteristics of health and human service resources in the Napa Valley College service area.

2. Develop service learning projects with selected community agencies that provide health promotion and disease prevention services to individuals, families and groups, across the lifespan in the Napa Valley College service area.

3. Become familiar with the process and strategies for assessing a community and factors influencing the health of individuals and families in selected community agencies.

4. Explore the many factors, which affect the health status of individuals and families in a community through collection of data for targeted groups in selected agencies.

5. Collaborate with teams and agency personnel to manage time and maximize community resources.

6. Discuss the implications for nursing practice in home, community and institutional settings.

At the conclusion of community-based experiences, the student will have met the following clinical objectives:

1. Use a collaborative approach to assessment by working with peers, faculty, community agency staff, individuals and families in the community to access, plan, implement and evaluate a health education program.

2. Prepare an individual teaching plan for selected community health promotion project.

3. Provide a health promotion, health education program to a targeted group in a selected community agency.

4. Complete a cultural assessment of an individual client or staff member of selected agency/community.

5. Prepare for and actively participate in four (4) seminars on Tuesdays from 1:30-4:00 pm.

6. Identify issues (with 2 or more points of view) that present themselves in the selected community and read articles and write abstracts addressing those issues.

7. Practice effective communication skills with team members, agency personnel and groups to meet course objectives.

8. Organize and present a presentation to classmates and faculty summarizing your community teaching project and “lessons learned - that should be shared” regarding Nursing in Community-Based Settings.
Objectives for Napa-Solano Head Start as a Community-Based Clinical Experience

NURS 248 – Nursing in Community-Based Settings

The following objectives, from Healthy People 2010, correspond with student activities at the preschool centers:

1. Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children (14-22).
2. Increase the proportion of preschool children aged 5 years and younger who receive vision screening (28.2).
3. Increase use of child restraints (15.20).

The following objectives relate to the nursing student's experience at the pre-school centers:

In collaboration with the agency staff, the student will:

1. Assist agency staff to conduct vision and hearing screenings, complete intake assessment on children and their families and utilize the Brigantz Scale or the Denver Developmental Scale (per agency preference) to assess growth and development milestones.
2. Plan and teach health promotion, health education classes to children, age 3 – 5.
3. Discuss issues related to delivery of culturally sensitive healthcare within the pre-school setting.
4. Explore the role of the nurse in the pre-school setting where the emphasis is on risk management and health promotion/disease prevention.
5. Plan and teach health promotion, health education classes to teachers, staff and/or parents on topics to include, but not limited to, asthmas, lead poisoning, nutrition, stress in children and immunizations (if indicated).
Objectives for Schools as a Community-Based Clinical Experience

NURS 248 – Nursing in Community-Based Settings

The following objectives, from Healthy People 2010, correspond with student activities at the schools:

1. Increase the proportion of middle, junior high and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: violence; suicide; tobacco use and addiction; alcohol and other drug use; unhealthy dietary patterns; inadequate physical activity; and environmental health (7.2).

2. Increase smoke-free and tobacco-free environments in schools, including all school facilities, property vehicles, and school events (27.11).

3. Increase the proportion of the nation's elementary, middle, junior high and senior high schools that have a nurse-to-student ration of at least 1:750 (7.4).

The following objectives relate to the nursing student’s experience at the schools:

In collaboration with the school counselor and the school nurse, the student will:

1. Plan and teach health promotion, health education classes to include (but not limited to) nutrition, sexual behavior, effects of smoking, hygiene and age appropriate HIV education.

2. Participate in health screening activities in collaboration with the school nurse.

3. Participate in interdisciplinary conferences to discuss individual student progress and to plan health education classes.

4. Discuss issues related to delivery of culturally sensitive healthcare within the school setting.

5. Explore the role the nurse in the school setting where the emphasis is on health promotion and health education.

6. If indicated, plan and implement workshops for teachers and/or parents on health promotion, health education topics.
Objectives for Projects with Elders
Community-Based Clinical Experience

The following objectives, from Healthy People 2010, correspond to activities initiated at senior apartment complexes and senior centers:

1. Increase the proportion of primary care provider, pharmacists and other healthcare professionals who routinely review with their patients aged 65 and older and patients with chronic illnesses or disabilities all new prescribed and over-the-counter medicines (17.3).

2. Increase the proportion of persons who have had a hearing examination on schedule (28.14).

3. Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease (14.29).

The following objectives relate to the nursing student’s learning experiences at the senior apartment complexes:

In collaboration with the agency staff, the student will:

1. Assess the healthcare needs of residents who live at the agency.

2. Plan and implement health promotion, health education services for elders to include classes on nutrition, exercise, medication management or other issues related to risk management.

3. Collaborate with agency personnel to assist residents to develop effective coping mechanisms and adequate support systems to maintain independence and optimal functional ability.

4. Discuss issues related to delivery of culturally sensitive healthcare within a supervised community living environment.

5. Explore the potential role of a nurse in a residential community to provide coordination of primary care services and to provide health promotion, health education services.
Objectives for Napa Valley College Health Services as a Community-Based Clinical Experience

NURS 248 – Nursing in Community-Based Settings

The following objectives, from Healthy People 2010, correspond to health promotion/disease prevention activities initiated at the College:

1. Increase to at least 50% the proportion of college and university students who receive information from their institution on each of the six priority health risk behavior areas (7.3).

2. Increase to at least 50% the proportion of worksites with 50 or more employees that offer nutrition education and/or weight management, smoking cessation and stress reduction programs for employees (2.20) (3.11) (6.11).

3. Increase to at least 75% the proportion of healthcare providers who provide age-appropriate counseling on the prevention of HIV, other sexually transmitted diseases and family planning options (19.14).

In collaboration with nursing staff in the College Health Center, the student will:

1. Assess the healthcare needs of students/faculty in the college community and plan appropriate health promotion, health education services.

2. Participate in planning, implementing and evaluating health promotion, health education services with the health services staff, to include, but not limited to, National Depression Day, March of Dimes Prevention Program and The Great American Smoke-Out.

3. Discuss issues related to delivery of culturally sensitive healthcare within the college setting.

4. Explore the role of the nurse in a college health center where the emphasis is on triage services, crisis intervention and health promotion/disease prevention.

5. Plan and teach health promotion, health education classes to student/faculty and family members on topics to include, but not limited to, asthma, lead poisoning, nutrition, contraception, drug abuse, immunizations, depression and Well-Baby and Well-Mom Care (if indicated).
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<thead>
<tr>
<th>Maternal-Infant Clients in the Community</th>
<th>Pediatric Clients in the Community</th>
<th>Adolescent Clients in the Community</th>
<th>Adult Clients in the Community</th>
<th>Adults and Families</th>
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<td>New Beginnings</td>
<td>Napa-Solano Child Start</td>
<td>Rainbow House &amp; Home Base</td>
<td>Napa Valley College Health Service</td>
<td>Progress Foundation at Bella House</td>
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<td>CalSAFE &amp; Teen Parent Center</td>
<td>Jacklyn Nielsen</td>
<td>Patty Catalino</td>
<td>Charlene Reilly, RN, NP</td>
<td>(Mental Health Residential Program)</td>
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<tr>
<td>Karen Valentine, MA Coordinator</td>
<td>707-252-8931 Ext. 2858</td>
<td>707-224-4403</td>
<td>707-253-8005 Health Fairs</td>
<td>Susan Thomas</td>
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<td><a href="mailto:kvalentine@nvusd.k12.ca.us">kvalentine@nvusd.k12.ca.us</a></td>
<td><a href="mailto:jnielsen@childstart.inc.org">jnielsen@childstart.inc.org</a></td>
<td>Jefferson St, Napa, CA</td>
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<td>707-257-7755</td>
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<td>1600 Lincoln Ave, Napa 94558</td>
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<td>Napa Valley College</td>
<td>Boys &amp; Girls Club</td>
<td>The Springs of Napa Valley College</td>
<td>Hope Resource Center</td>
<td>Clinic Olie</td>
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<td>Child Developmental Center</td>
<td>Lana Brackin 7072558866 Ext. 114</td>
<td>Loretta Gomez: 707-224-7835</td>
<td>Napa Valley Shelter Project</td>
<td>Arturo Fernandez</td>
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<tr>
<td>Dianna Chiabotti: 707-253-3048</td>
<td>1515 Pueblo Avenue, Napa, CA 94558</td>
<td>3460 Villa Lane Napa, CA 94558</td>
<td>(Methodist Church)</td>
<td>707-254-1774</td>
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<td>Cynthia Painter: 707-259-8133</td>
<td><a href="mailto:fernandez@clinicole.org">fernandez@clinicole.org</a></td>
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<td><a href="mailto:proyer@can-v.org">proyer@can-v.org</a></td>
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<td>Family Homeless Shelter</td>
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<td>Charlene Horton 707-253-6145</td>
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<td>Old Sonoma Rd</td>
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<td>Napa Creek Manor Senior Living</td>
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<td>Susan Gragg: 707-257-1878</td>
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<td>Susan Thomas 707-257-7755</td>
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**COMMUNITY-BASED CLINICAL SITES**
SEMINAR I

RELATED ACTIVITIES – ASSIGNMENTS

READ OR REVIEW – THE CHAPTERS WERE ASSIGNED IN NURS 141


READ


-Silent Suffering – North Bay Farm Workers Face a Healthcare Crisis, pp. 82-83.

ACTIVITIES

-Course Orientation

-Video – Bringing Nursing Care to the Community

-Discuss – Community Health Issues in Napa Valley

-Select a community based setting with two or three other students, where you can provide health promotion services within the next 3 weeks.

CLINICAL PRACTICE

-Visit your selected setting with your team to meet the agency staff and assess and plan a health promotion service.

-Plan to spend 6 hours at the agency, each week. This can be all at once or in segments.
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<th>SEMINAR II</th>
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<td>RELATED ACTIVITES – ASSIGNMENTS</td>
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**Seminar II** will be **held** at **Clinic Ole** – 1141 Pear Tree Lane – Napa (off Beard Road & Villa Lane)

Clinic Ole is Napa’s Community Health Center and the primary source of healthcare for low income residents.

Read article on Clinic Ole in (A Home for Health) Appendix C.

### READ OR REVIEW

-Potter, P. A., and Perry, A. G., 2001. *Fundamentals of Nursing: Concepts, Process & Practice*. 5th ed. Mosby, Chapter 1 (Health & Wellness); Chapter 3 (Community-Based Nursing Practice); Chapter 6 (Nursing Healing and Caring); Chapter 8 (Caring in Families); and Chapter 10 – Unit 2 (Caring Throughout the Lifespan); and other chapters/texts that relate to your selected project-age group.

One news article related to; community, world health, new health research, changing roles of RNs, Any healthcare issue.

### BE PREPARED TO DISCUSS

-Napa’s Community Health Center

-Communication Skills Needed in the Community

-Share Cultural Assessments & Issues Assignment

-Writing the Individual Teaching Plan

### CLINICAL PRACTICE

-Work with your project group to plan and begin implementation of health promotion project. Spend 6 hours this week to familiarize yourselves with the clients served in your agency.

-Share with seminar group the time/place of your planned project and two or more learning objectives.

-Preparation of Teaching Plans.
### Seminar III

#### Related Activities – Assignments

**Read**

- ANA Code of Ethics for Nurses (next page)
- Values & Ethical Decision Making p. 7

**Activities**

Discussion of *The Spirit Catches you and you fall down*. Answers to questions due, discussion of answers.

- Complete Critical Thinking Exercise – Values & Ethical Decision Making p. 11
- BE PREPARED TO DISCUSS – Legal & Ethical Issues Faced in Community-Based Settings and current news articles

**Clinical Practice**

- Community-Based health promotion project should be accomplished this week.

**Turn In (No later than week 3 seminar)**

- Individual Teaching Plan
ACTIVITIES

Presentation of Group Project
All assignments due at this time
Annotated Bibliography Assignment

Individual Teaching Guide
ANNOTATED BIBLIOGRAPHY ASSIGNMENT

Student will analyze issues in articles related to their project (issues such as financial, legal, ethical, prevention, health promotion methods, practice trends, client and worker safety, workgroup psychology, assumptions made by workers in the area, biases of workers in the area, assumptions made by clients. The student is expected to reflect individually and with her/his group and instructor about these issues, and potentially work them into the group presentation.

Annotated Bibliography

Student name, reference (APA bibliography format – see next page) for resource used.

Points are earned by:

- Using separate Annotated Bibliography Form for each selected “full text” article.
- Analyzing the 11 questions for each article.
- Reviewing and writing on 2 full-text articles related to one or more issues associated with your project.
  - Full-text articles must be primarily from nursing or medical journals (lay journal articles must be approved by the instructor). Articles must be current (later than 2005) and relevant to your community project.
- Attach a copy of each article reviewed to its annotated bibliography form.
- If student reviews 1 article, he/she can additionally ask questions of one agency staff in their delivery setting. Write a one paragraph synopsis of beliefs stated by the staff member related to the issue selected to discuss and another paragraph reflecting your ideas and reactions.
  - The staff member can only be interviewed AFTER the articles are read. The idea is that you will go into the interview with some good current background on some related issue. Write the issue discussed at the top of the synopsis page.
Assignment:
Research Article/evidence based practice article
Students will analyze issues in articles related to their project (issues such as: economic, legal, ethical, social, professional, practice trends, health promotion methods, client and/or worker safety, new evidence-based practices, psychological, cultural and ethnic issues, epidemiology, nutrition, pharmacology, political, etc).
Students will then chose 2 research based articles to analyze and implement for their teaching project.
One article may be solely research on the topic to be presented. The other article should be an evidence-based practice article, preferably related to your topic.
The articles are to be research-based. They must be credible; that refers to the reliability of the information presented. Is the author(s) affiliated with a reputable facility? Is the conclusion based on data and research methodology? Does the evidence-based practice feasible and established by scientific methodology?
Articles from sources that are not credible, backed by research or data, or who have no professional affiliation will not be accepted. Internet sources must be research based (not opinion only) with a credible author. Please utilize “full-text” article, not abstract.
The student is expected to reflect individually and discuss with her/his group the findings of the articles. The articles should be utilized in the group presentation to provide credibility and science-backed evidence to your teachings and recommendations.
ANOTATED BIBLIOGRAPHY – GUIDELINES FOR CRITICAL THINKING

RESPOND TO THE FOLLOWING 11 QUESTIONS WHEN ANNOTATING A “FULL-TEXT” ARTICLE FOR THE ISSUES ASSIGNMENT. Such analysis will improve your critical thinking skills.

Citation for the selected article:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

1. WHO IS THE AUTHOR? What is the author’s occupation, position, titles, education, experience, etc.? Is the author qualified to write on the subject?

2. WHAT IS THE PURPOSE FOR WRITING THE ARTICLE OR DOING THE RESEARCH?

3. TO WHAT AUDIENCE IS THE AUTHOR WRITING? Is it intended for the general public, scholars, policymakers, teachers, professionals, practitioners, etc.? Is this reflected in the author’s style of writing or presentation? How so?

4. DOES THE AUTHOR HAVE A BIAS OR MAKE ASSUMPTIONS UPON WHICH THE RATIONALE OF THE PUBLICATION OR RESEARCH RESTS?
5. WHAT METHOD OF OBTAINING DATA OR CONDUCTING RESEARCH WAS EMPLOYED BY THE AUTHOR? Is the article based on personal opinion or experience, interviews, library research, questionnaires, laboratory experiments, case studies, standardized tests, etc.?

6. SUMMARIZE IN THE SPACE BELOW THE MAJOR IDEAS IN THE ARTICLE.

7. AT WHAT CONCLUSIONS DOES THE AUTHOR ARRIVE?

8. DOES THE AUTHOR SATISFACTORILY JUSTIFY THE CONCLUSIONS FROM THE RESEARCH OR EXPERIENCE? Why or why not?

9. HOW DOES THE STUDY COMPARE WITH SIMILAR STUDIES? Is it in tune with or in opposition to conventional wisdom, established scholarship, professional practice, government policy, etc.? Are there specific studies, writings, schools of thought, philosophies, etc., with which this one agrees or disagrees and of which one should be aware?

10. ARE THERE SIGNIFICANT ATTACHMENTS OR APPENDIXES SUCH AS CHARTS, MAPS, BIBLIOGRAPHIES, PHOTOS, DOCUMENTS TESTS OR QUESTIONNAIRES? If not, should there be? (EVALUATE THE UTILITY OF THE CHARTS & DOCUMENTS)

11. WHAT IS THE APPLICATION OF THIS RESOURCE TO YOUR CURRENT COURSE OBJECTIVES? How can you incorporate this article into your project and presentation?
RESPOND TO THE FOLLOWING 11 QUESTIONS WHEN ANNOTATING A “FULL-TEXT” ARTICLE FOR THE ISSUES ASSIGNMENT. Such analysis will improve your critical thinking skills.

Citation for the selected article:

1. WHO IS THE AUTHOR? What is the author’s occupation, position, titles, education, experience, etc.? Is the author qualified to write on the subject?

2. WHAT IS THE PURPOSE FOR WRITING THE ARTICLE OR DOING THE RESEARCH?

3. TO WHAT AUDIENCE IS THE AUTHOR WRITING? Is it intended for the general public, scholars, policymakers, teachers, professionals, practitioners, etc.? Is this reflected in the author’s style of writing or presentation? How so?

4. DOES THE AUTHOR HAVE A BIAS OR MAKE ASSUMPTIONS UPON WHICH THE RATIONALE OF THE PUBLICATION OR RESEARCH RESTS?
5. WHAT METHOD OF OBTAINING DATA OR CONDUCTING RESEARCH WAS EMPLOYED BY THE AUTHOR? Is the article based on personal opinion or experience, interviews, library research, questionnaires, laboratory experiments, case studies, standardized tests, etc.?
6. SUMMARIZE IN THE SPACE BELOW THE MAJOR IDEAS IN THE ARTICLE.

7. AT WHAT CONCLUSIONS DOES THE AUTHOR ARRIVE?

8. DOES THE AUTHOR SATISFACTORILY JUSTIFY THE CONCLUSIONS FROM THE RESEARCH OR EXPERIENCE? Why or why not?

9. HOW DOES THE STUDY COMPARE WITH SIMILAR STUDIES? Is it in tune with or in opposition to conventional wisdom, established scholarship, professional practice, government policy, etc.? Are there specific studies, writings, schools of thought, philosophies, etc., with which this one agrees or disagrees and of which one should be aware?

10. ARE THERE SIGNIFICANT ATTACHMENTS OR APPENDIXES SUCH AS CHARTS, MAPS, BIBLIOGRAPHIES, PHOTOS, DOCUMENTS TESTS OR QUESTIONNAIRES? If not, should there be? (EVALUATE THE UTILITY OF THE CHARTS & DOCUMENTS)

11. WHAT IS THE APPLICATION OF THIS RESOURCE TO YOUR CURRENT COURSE OBJECTIVES? How can you incorporate this article into your project and presentation?
### Bibliography or Citation of Readings Format

**American Psychiatric Association Bibliography Style**

**JOURNAL:**
- Last names(s) of author(s), followed by the first initials, separated by commas and ending with a period
- Year of publication in parenthesis followed by a period
- Title of article followed by a period. Only capitalize the first letter of the article title except when followed by a semi-colon
- Name of journal underlined, comma, then the volume followed by the journal number listed in parenthesis followed by a comma
- Then list the article’s page numbers followed by a period

**Note:** If no author, start with the journal title and go from there.

**EXAMPLE OF A JOURNAL**


**BOOK:**
- Last name(s) of author(s), followed by the first initials
- Year of publication, title of book (underlined) and edition
- City of publishing company followed by the name of the company
- Please note that two spaces should be inserted between each character
- Only capitalize the first letter of the book title except when followed by a semi-colon

**EXAMPLE OF A BOOK**

INTERNET CITATIONS

Articles from Electronic Databases: Cite article and then the following:

- Identify date of retrieval (omitted for CD-ROMs)
- Identify source (e.g., DIALOG, WESTLAW, SIRS, Electric Library)
- Followed in parentheses by the name of the specific database used and any additional information needed to retrieve a particular item
- For Web sources, a URL should be given that points to an “entry page” for the database

→ Basic retrieval statement for CD-ROM databases is:
  Retrieved from (source) database (name of database), CD-ROM, (release date), (Item no. – if applicable)

→ Basic retrieval statement for online databases is:
  Retrieved (month, day, year) from (source) online database (name of database), (item no. – if applicable)

→ Basic retrieval statement for databases accessed via the Web is:
  Retrieved (month, day, year) from (source) database (name of database), (item no. – if applicable) on the World Wide Web: (URL)

EXAMPLES


TITLE: ____________________________________________________________

TOPIC: ____________________________________________________________

Date(s) and Time(s) of Presentation(s): ________________________________

Nursing Students Who Are Presenting: _________________________________

________________________________

Describe the segment of the presentations you are individually responsible for: _______

________________________________

Age of Participants: ___________   Number of Participants: ________________

Location of Presentation: ____________________________________________

PLANNING:

How did you research this topic (include articles, journal articles and bib)?

________________________________

________________________________

What format are you going to use? ____________________________

________________________________

Structured presentation(s); support group; health promotions fair; other: _____________

________________________________

________________________________
Number of planned sessions? ________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Describe your instructional strategy (see page 29): ______________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

What have you done to make the teaching age appropriate? _________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Supplies/Resources to be used and source: ________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
<table>
<thead>
<tr>
<th>Expected Learning Objectives (ELO) or Outcomes</th>
<th>Topical Outlines Content Outline for ELO</th>
<th>Learning Activity</th>
<th>Time Frame (Number of minutes you plan for segments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The clients will:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>1.</td>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
<td>3.</td>
<td>3.</td>
</tr>
</tbody>
</table>
PLANNING EVALUATION

How do you plan to evaluate the effectiveness of your teaching project (feedback from participants; agency personnel; tools)?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
EVALUATION

Explain how objectives were met or not met or not met (section cannot be completed until after your project is completed. Turn this page in at the time of your presentation at week 4. Include evaluation information, findings in your presentation.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Comments on things you would do differently the next time. Consider including this information in your presentation in week 4.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Presentation Guidelines and Evaluation Forms
Presentation Guidelines

“Lessons Learned – That Should Be Shared”

Group presentations will be offered by each project group at the week 4 Seminar.

The group (3 – 4 students) must select content for their group presentations that address “Lessons Learned – That Should Be Shared” that relate to the course and Community-Based Clinical Experience Objectives.

Carefully review the criteria for evaluation forms for the group presentations. Note: engaged audience; start/end on time; content clear & understandable; eye contact; time for questions; visual aids; etc.

Each group will have 30 minutes for their group presentation and 10 minutes for questions and answers. Each member of the project team has to have a relatively equal degree of participation in the presentation.

The presentation must share with the class, the following critical elements:

- The project that the group conducted in the community
- Information about the agency/or community setting
- Interesting reflections on the issues and Annotated Bibliography Assignment selected by individuals relating to their targeted community
- “Lessons Learned-That Should Be Shared” related to course & clinical objectives—be specific, as to the course & clinical objectives being addressed
# AGENCY EVALUATION FORM

This section to be completed by student group and provided to community agency contact person during or before week II.

Name of Agency: ___________________  Dates for Group Participation: _______________

Contact Person: ___________________  Location of Group Project: ___________________

Names of Participating Students: __________________________________________________________

Title of proposed health promotion activity: _____________________________________________

**Evaluation by Agency Contact Person:** Circle one number as your response to each question using the following scale in each separate area.

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>3</th>
<th>6</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all</td>
<td>Some of the time</td>
<td>Most of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>1.</td>
<td>The project group collaborated effectively together?</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>2.</td>
<td>The project group collaborated effectively with agency personnel?</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>3.</td>
<td>The project group collaborated effectively with community clients?</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>4.</td>
<td>The project group established realistic goals &amp; objectives for their health promotion activity?</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>5.</td>
<td>The group assessed the need for a health promotion activity?</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>6.</td>
<td>The group’s health promotion activity was?</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>7.</td>
<td>The group evaluated the effectiveness of their activity?</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

Please return this form by fax during week III to:
Sandra Buckley, Professor, Nursing – Napa Valley College
FAX (707) 259-8933 or e-mail me at sbuckley@napavalley.edu
If you have questions or comments please call (707) 256-4511

Signature of Agency Contact Person: ___________________________________________________

Printed Name: __________________________  Phone Number: ___________________________
EVALUATION FORM for COLLABORATION

WORK GROUP performance and INDIVIDUAL performance within work group

Each student evaluates group’s members and the group itself. Turn form in to your instructor at 4th seminar.

Circle Your Group: A   B   C   D          Month, Day, Year ______________________

Topic for Presentation _______________________________  Faculty Member ______________________

Objectively evaluate how well the group performed on the following questions. Circle one number as your response to each question using the following scale.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>Below Average</td>
<td>Average</td>
<td>Above Average</td>
<td>Outstanding</td>
</tr>
</tbody>
</table>

**How effectively did members of the group work:**

1. Make individual contributions that helped the group accomplish its goals?  
   1  2  3  4  5

2. Maintain an atmosphere in which each member could contribute to the group?  
   1  2  3  4  5

3. Remain focused on important issues during presentation planning?  
   1  2  3  4  5

4. Search for alternative points of view or compromise within the group?  
   1  2  3  4  5

5. Deal with and resolve conflict within the group?  
   1  2  3  4  5

6. Contribute to the overall plan for the class presentation?  
   1  2  3  4  5

7. Utilize resources and literature?  
   1  2  3  4  5
Average of above numbers is (add all your #s and divide by 7): __________

How could your group have been more effective? How could you make that happen better in future work groups?

In the space below, list the names of each member in your work group, including yourself. Using the following scale rate each member (including yourself) on how effectively each contributed to the assignments.

*Use the following scale: circle a number between one and five beside each name.*

<table>
<thead>
<tr>
<th>Name</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
### Individual Presentation

Member name:

Presentation/group Topic:

Student's Name:

<table>
<thead>
<tr>
<th>criteria</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Individual student</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical appearance</strong></td>
<td>Casual, street clothes, nervous, poor eye contact, only looks at instructor</td>
<td>Professional clothes, some eye contact with audience,</td>
<td>Appropriate dress, confident, eye contact with audience and instructor</td>
<td></td>
</tr>
<tr>
<td><strong>COMPREHENSIBILITY OF PRESENTATION</strong></td>
<td>Use of opinion, rather than science, Unstructured, no rationale for information, Much of the presentation out of logical order. Goes over time limit</td>
<td>Use of research apparent but not stated, logical, organized approach, new information given</td>
<td>Research discussed and utilized, logical explanation of approach and information, able to answer questions from audience brings new information to audience.</td>
<td></td>
</tr>
<tr>
<td><strong>Overall approach</strong></td>
<td>Lacks enthusiasm, no new information, unable to hear presenters, difficulty understanding presenters concept or communication style</td>
<td>Enthusiastic, utilized and communicated new ideas, approach or information, gained new insight and expressed analysis of experience</td>
<td>Enthusiastic, gained from experience and able to express what was learned and it’s value, teamwork and collaboration evident. presentation materials match to measurable objectives in ITP</td>
<td></td>
</tr>
</tbody>
</table>
### Reading/Paper Rubric-N248

**Student’s Name:**

<table>
<thead>
<tr>
<th>criteria</th>
<th>2</th>
<th>5</th>
<th>8</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Less than one paragraph, poor grammar, illegible, very little analysis, no reflection or acknowledges of challenges Ms. Lee</td>
<td>Content of paper is well organized, easy to follow. No grammar or spelling errors. Analysis of question, adequate answer, shows understanding of cultural challenges</td>
<td>Free of grammatical and spelling errors, answer question analytically, use of reflective or critical thinking, gained insight and stated such, paper flows smoothly</td>
<td></td>
</tr>
</tbody>
</table>

(1)Question one

(2)Question two

(3)Question three

Assignment: Read, analyze and respond to: The Spirit Catches you and you Fall Down†, Anne Fadiman. (15 points)

1. Answer 2 questions from back of book. (1, 2)
2. Identify one healthcare issue that impacted the family of Lia Lee. Utilize nursing process to formulate a plan that could potentially improve on the issues or problems the family and or healthcare providers experienced. (3)
# Group Presentation

**Member's names:**

**Presentation/group Topic:**

**Student's Name:**

<table>
<thead>
<tr>
<th>criteria</th>
<th>1</th>
<th>3</th>
<th>3</th>
<th>group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical appearance</strong></td>
<td>Casual, street clothes, nervous, poor eye contact, only looks at instructor</td>
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<td>.</td>
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<td>Lacks enthusiasm, no new information, unable to hear presenters, difficulty understanding presenters concept or communication style</td>
<td>Enthusiastic, utilized and communicated new ideas, approach or information, gained new insight and expressed analysis of experience</td>
<td>Enthusiastic, gained from experience and able to express what was learned and it's value, teamwork and collaboration evident. presentation materials match to measurable objectives in ITP</td>
<td>.</td>
</tr>
<tr>
<td><strong>USE AND VARIETY OF PRESENTATION MATERIALS</strong></td>
<td>No presentation materials or material that was inadequate or too small to see.</td>
<td>Identified target audience needs, utilized multiple sources of information (visual, auditory, tactile), involves audience</td>
<td>Engages audience, multiple media sources, identified target audience needs, motivates audience to ask questions</td>
<td>.</td>
</tr>
<tr>
<td><strong>TEAM COVERAGE OF REQUIRED TOPICS</strong></td>
<td>Individuals presented without reference to team members. Did not equally divide tasks. Not all team members knowledgeable regarding topic issues.</td>
<td>Group worked as a team; all members were knowledgeable regarding presentation information, most members presented during presentation</td>
<td>All members presented a portion, or roles were explained, all group members knowledgeable and able to answer questions from audience, expresses interest and understanding of other team members topic.</td>
<td>.</td>
</tr>
</tbody>
</table>
Articles
And
Report Excerpts

(Queen of the Valley Medical Center, WHO, SF Chronicle)
Primary Prevention
Health Promotion
Health Education
Good standard of nutrition adjusted to
developmental phases of life
Attention to personality development
Provision of adequate housing and recreation, as
well as agreeable working conditions
Marriage counseling and sex education
Genetic screening
Periodic selective examinations

Specific Protection
Use of specific immunizations
Attention for personal hygiene
Use of environmental sanitation
Protection against occupational hazards
Protection from accidents
Use of specific Nutrients
Protection from carcinogens
Avoidance of allergens

Leavell and Clark's
Three Levels of Prevention

Secondary Prevention
Early Diagnosis and Prompt Treatment
Case-finding measures: individual and mass
screening surveys
Selective examinations to
- Cure and prevent disease process
- Prevent spread of communicable disease
- Prevent complications and sequelae
- Shorten period of disability

Disability Limitations
Adequate treatment to arrest disease process and
prevent further complications and sequelae
Provision of facilities to limit disability and prevent
death

Tertiary Prevention
Restoration and Rehabilitation
Provision of hospital and community facilities for
retraining and education to maximize use of
remaining capacities
Education of public and industry to use
rehabilitated persons to the fullest possible
extent
Selective placement
Work therapy in hospitals
Use of sheltered colonies

Figure 6-4 The three levels of prevention developed by Leavell and Clark. (Data from Leavell H, Clark AE: Preventive
medicine for the doctors in his community, ed 3, New York, 1965, McGraw-Hill; and modified from Edelman CL, Mandle CL:
Health promotion throughout the life span, ed 5, St. Louis, 2002, Mosby.)
Key Findings

Napa County has many quality programs serving the health and other needs of low-income members of the community. Despite these good efforts, however, the findings from this assessment indicate a great need for expanded access to health care for low-income individuals in Napa County, as evidenced by the following survey results.

From Survey Respondents:

Inadequate Healthcare

- Over one in five respondents (21.7%) reported they or a family member were unable to get adequate treatment for a medical condition or problem during the past year.

- More than 50% of adults and one in four children have not had a physical exam during the past year.

- Over 70% of all respondents said they would be likely to use one or more of the following services: free or low-cost health screenings, immunization clinics, health education, community case management and a neighborhood mobile health van.

Inadequate or No Health Insurance

- 59% of adults reported a lack of health insurance for one or more adults in the past year.

- 44% of children did not have health insurance sometime during the past year.

- 35% of the respondents reported that their income was insufficient to make ends meet.

ER Visits

- Approximately 40% of both the low-income general and senior populations went to the hospital emergency room the last time they or a family member were sick.
Women's Health and Prenatal Care

- More than 50% of the women responding to the survey reported a need for women's health care.

- Nearly one-fifth of female respondents that gave birth during the past year received no prenatal care during the first trimester of pregnancy.

Senior Citizens

- Over half of non-senior respondents reported a lack of health insurance for one or more adults in their household during the past year.

- Only a third (33.0%) of senior respondents have seen a dentist in the past year; and yet one in four seniors reported dental problems that make it difficult for them to eat.

- Only half (51.7%) of senior respondents have had a physical during the last year.

- The principal health conditions reported by seniors are arthritis, high blood pressure, and heart disease.

- Senior citizens expressed greatest interest in home visits by nurses and social workers for the chronically ill.

Dental and Vision Care

- More than 50% of both adults and children have not seen a dentist during the past year.

- More than 50% of all adults reported a need for vision care, while one-fifth reported a need for mental health services.

- Families participating in focus groups identified dental care and access to after-hour and weekend health care as their top priorities.
From Secondary Data:

Secondary data reveal that Napa County health indicators are significantly worse than U.S. Department of Health Services, Healthy People 2010 Objectives in several areas, including the following:

• The rates of all cancers are more than two times higher.

• Deaths due to heart disease are over one and a half times higher.

• The percentage of women receiving early prenatal care is significantly lower than state and national rates.

• We have a high prevalence of communicable diseases such as hepatitis and tuberculosis.

It is also interesting to note that:

• Nearly 50% of babies born at QVH in 2000, and approximately one in three of all children born in Napa County, are born into poverty, i.e. their low-income mothers receive Medi-Cal.

• Over 70% of all Medi-Cal discharges in Napa County during 1999 were from Queen of the Valley Hospital.

• Up to one in five Napa County residents (20%, or 25,000 people), are believed to be uninsured. According to *Hunger in Napa County: A Comprehensive Study of the People Seeking Food Assistance, November 2000*, 34% of respondents had no health insurance, and 42% were forced to put off medical or dental care because they could not afford it.
IMPROVING ACCESS TO HEALTHCARE

Common themes appeared among survey participants, key informants, and focus group participants regarding areas of greatest concern in improving health care access, including:

Late Night and Weekend Urgent Care

Research findings indicate that many low-income people use the emergency room (ER) for routine health care due to a lack of access to same day or evening and weekend urgent care facilities. As focus group participants pointed out, they, and particularly their children, often seem to get sick late at night or on weekends, resulting in a trip to the ER. Many parents also noted that they go to the ER because their children are very ill and they cannot get an appointment to see their primary care physician for several days or weeks. It is clear that people prefer not to use the ER for routine health care. There are long waits and the cost can be prohibitive. However, given the lack of timely access to non-emergency primary care, even for those with health insurance, many respondents claimed they have no choice but to go to the emergency room.

Clinic Ole', the only clinic in Napa County exclusively serving low-income residents, cannot currently meet the demand for regular and urgent care services.

Affordable Dental and Vision Healthcare

Over half of survey respondents have not been to the dentist during the past year, while a significant number have never been to the dentist. Most low-income individuals do not have health coverage for dental or vision care, both of which are very expensive. Sister Anni's Community Dental Clinic is unable to meet the current demand for its services.

Health Screenings, Immunizations and Education

More than 90% of survey respondents would be likely to use low-cost or free health screenings, while a similar number would use low-cost immunization clinics for adults and children, even though nearly all survey respondents report their children have received all required immunizations.

Information and Assistance with Programs and Services

The most obvious need with respect to improving access to health care is to improve access to information about health care benefits that low-income individuals are eligible for, such as Healthy Families. In addition to information about available programs and services, many low-income people find it difficult to fill out complicated paperwork. This is particularly daunting for non-English speakers as well as many seniors. Focus group participants cited confusion regarding diagnoses and treatment options, e.g., why antibiotics are not offered to treat viral and other non-bacterial infections.
Language and Paperwork Assistance

Language is a barrier to accessing health care for non-English speaking and illiterate individuals. Latino participants cited a need for providing more trained medical interpreters and assistance filling out forms in English.

Focus group respondents reported a need for more Spanish-speaking providers and particularly for improved interpreting services in the ER. Many noted that they often use their children as interpreters, and that the hospital emergency room has had to use non-medical personnel to provide medical interpretation services.

Home Care and Case Management

Key informants expressed a need for more resources for home visits, follow-up care and case management for people with chronic illnesses. These services are vital in ensuring that patients comply with preventive and treatment regimens and receive the care they need to avoid getting worse. In addition to improving an individual’s health, case management, follow-up and home health care are considered cost-effective mechanisms for providing access to quality health care, particularly in light of the high cost of treating advanced health problems.

Specialized Healthcare

In addition to primary health care, there is a clear need for increased access to specialized health care for low-income residents. Clinic Ole’ and Sister Ann’s Community Dental Clinic are currently unable to provide many specialized services. In those cases, patients are referred to other providers, including Queen of the Valley, or even out of Napa County. Many of those patients do not subsequently access needed care, given the cost and/or complexity of doing so. Undocumented individuals with chronic illnesses or specialized needs are at a particular disadvantage, since Clinic Ole’ cannot provide them with specialized care, and they are often unable to access specialized care elsewhere.

Early Prenatal Care

As noted previously, nearly 50% of babies born at QVH in 2000, and approximately one in three of all children born in Napa County, are born into poverty, i.e., their low-income mothers receive Medi-Cal. The high rate of women receiving late prenatal care, as well as the high percentage of children born to low-income mothers are cause for concern. These findings point to the need for continued efforts to target these high-risk populations and ensure that they receive the services they need.
Mental Health Services

Nearly one fourth of survey respondents (22.6%) indicated an interest in mental health services. There are currently waiting lists for some mental health services, particularly for Spanish-speakers.

Reduce Health Care Costs

The cost of health care is clearly one of the greatest barriers to accessing health care for low-income residents, including those with health insurance.

Many respondents reported the inability to obtain routine health care due to the high cost of co-pays, sliding fees which they cannot afford, high ambulance costs, and the high cost of medicine. Reducing out-of-pocket health care costs will require significant coordination among all health care providers to synergize financial and administrative resources, seek innovative, creative solutions for addressing the numerous issues, and advocate for changes in public policy and support.

Address Racial and Cultural Variances

Some health indicators in the assessment are significantly worse for Caucasian as compared to Latino respondents, even though secondary data reveals a high proportion of Caucasians who are poor and under- or uninsured. For example, over one in five respondents with children reported the inability to obtain needed health care for one or more of their children in the last year. However, this was true for twice as many Caucasians as Latinos. Latinos more frequently cited lack of insurance or a regular doctor, and difficulties getting to the clinic during office hours, while lack of transportation was cited by over one-third of Caucasians and virtually no Latinos.

Survey results reveal discrepancies between secondary health indicators and the survey respondents’ self-reports regarding the prevalence of health conditions. Latino survey respondents, for example, report “never being sick” at much higher rates than Caucasian respondents. While many social service agencies conduct extensive outreach in the Latino community, the relatively low proportion of Caucasian clients may indicate a need for more outreach among that population.

Improve Communication and Outreach

Health Access Task Force members cited a need for improved mechanisms for notifying health care providers and case managers when individuals are no longer receiving benefits. They also cited a need for employers to provide increased opportunities to conduct outreach at job sites, to educate employees about programs and services for which they might be eligible.
Reduce Administrative Barriers to the Provision of Health Care

There are a number of administrative, bureaucratic and logistical barriers which have limited the availability and provision of health care services to low-income people in Napa County. Reducing or eliminating these barriers would also lead to improved access to health care.

- A number of key informants noted that increased support from the County would vastly increase their ability to provide improved access to quality health care for low-income residents.

- Members of the Health Access Task Force cited the need for improved coordination of health care provider efforts throughout the County which would eliminate the duplication of efforts and tailor the provision of health care services to ensure adequate access to health care for all County residents.

- Some key informants cited administrative hurdles that provide disincentives to the provision of health care for low-income people, particularly with respect to payment. Some physicians are reluctant to provide uncompensated health and dental care for indigent patients due to low reimbursement rates and insufficient funding for uncompensated care. Additionally, many providers are unwilling to offer services to Medi-Cal patients due to costly and time-consuming billing mechanisms.

- Some key informants also cited a need for increased funding for uncompensated care, as well as more flexible and innovative approaches for compensating physicians providing care for Medi-Cal patients, in order to provide them with greater incentives to serve low-income patients.
OVERVIEW: DEMOGRAPHIC CHARACTERISTICS OF NAPA COUNTY RESIDENTS

Section Highlights

Napa County's population increased by 12.2% between 1990 and 2000.

The mean age of all residents is 37 years. Latinos, with a mean age of 25, are the County's youngest residents.

Napa County is becoming increasingly ethnically diverse.

The Latino population increased from 14.4% to 23.7% between 1990-2000.

Napa County has many low-income residents—8.8% of all residents, and 14.4% of children under the age of 18 lived in poverty in 1997.

Low-paying jobs in the service and retail sectors account for nearly half of all jobs in Napa County.

GEOGRAPHIC BREAKDOWN

Queen of the Valley Hospital's community is defined by the geographic boundaries of Napa County and is divided into five regions: American Canyon, Calistoga, the City of Napa, St. Helena and Yountville. With a 2000 population of 72,585, the City of Napa comprises 58% of the County's population, followed by American Canyon, St. Helena, Calistoga and Yountville. Unincorporated areas account for 22% of the County’s population. Napa County's growth rate was 12.2% between 1990-2000.

Exhibit 1: Geographic Breakdown of Napa County Residents, 1990 and 2000

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Napa</td>
<td>61,842</td>
<td>72,585</td>
<td>10,743</td>
<td>17.4%</td>
</tr>
<tr>
<td>American Canyon</td>
<td>N/A</td>
<td>9,774</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>St. Helena</td>
<td>4,990</td>
<td>5,950</td>
<td>960</td>
<td>19.2%</td>
</tr>
<tr>
<td>Calistoga</td>
<td>4,468</td>
<td>5,190</td>
<td>722</td>
<td>16.2%</td>
</tr>
<tr>
<td>Yountville</td>
<td>3,259</td>
<td>2,916</td>
<td>-343</td>
<td>-10.5%</td>
</tr>
<tr>
<td>Unincorporated</td>
<td>36,206</td>
<td>27,864</td>
<td>-8,342</td>
<td>-23.0%</td>
</tr>
<tr>
<td>County Total</td>
<td>107,765</td>
<td>124,279</td>
<td>16,514</td>
<td>12.2%</td>
</tr>
</tbody>
</table>

Source: 1990, 2000 U.S. Census

1 American Canyon's rate of growth cannot be calculated, since it was unincorporated in 1990.
AGE

With 15.5% of all residents over the age of 65, Napa County has a higher proportion of older residents than the State of California as a whole (11.3%). The highest proportions of senior citizens are found in Yountville (46.8%), Calistoga (26.9%) and St. Helena (23.9%). Whereas the mean age of all residents is 37 years, the white population has a mean age of 41, while Latinos, with a mean age of 25, are the County’s youngest residents.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 18 years of age</td>
<td>23.5%</td>
</tr>
<tr>
<td>18-64</td>
<td>59.6%</td>
</tr>
<tr>
<td>65-74</td>
<td>7.3%</td>
</tr>
<tr>
<td>75-84</td>
<td>5.8%</td>
</tr>
<tr>
<td>85+</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Source: California Department of Finance, Demographic Research Unit

RACE/ETHNICITY

In keeping with state and nationwide trends, Napa County is becoming increasingly ethnically diverse. The county’s 2000 population was 69.1% white, down from 80.8% in 1990. Conversely, the Latino population increased from 14.4% to 23.7% during the same period. The proportion of Latino residents is highest in Calistoga (34.0%), St. Helena (28.6%) and the City of Napa (23.5%)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>2000</th>
<th>1990</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>69.1%</td>
<td>80.8%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>23.7%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>3.1%</td>
<td>3.1%</td>
</tr>
<tr>
<td>African American</td>
<td>1.2%</td>
<td>1.1%</td>
</tr>
<tr>
<td>American Indian, Eskimo, or Aleut</td>
<td>0.5%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other, mixed race</td>
<td>2.3%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: 1990, 2000 U.S. Census

2 The high proportion of senior citizens in Yountville is largely due to the presence of the California Veteran’s Home.

Harder+Company Community Research/April 11, 2001
OVERVIEW OF HEALTH SERVICES IN NAPA COUNTY

The principal health care providers serving low-income individuals in Napa County are Queen of the Valley Hospital, St. Helena Hospital, and Kaiser Permanente. There are two freestanding walk-in clinics as well, Community Clinic Olé and Planned Parenthood (which provides reproductive health care services for low-income women). Emergency services are provided at Queen of the Valley Hospital and St. Helena Hospital. Low-cost dental care is provided at Sister Ann Community Dental Clinic.

Most recent reports available note that there were 3.4 primary care physicians per 1,000 Napa County residents (1998), which compares favorably with the 2.4 per 1,000 rate for the State of California as a whole (Medical Board of California). However, physicians providing primary care make up only 29.7% of all doctors, compared to 40% statewide. The remaining 70.3% of physicians in Napa County are specialists, to whom uninsured individuals have reduced access (Building a Healthier Napa, Northern California Council for the Community, 2000). A recent, but important, development with respect to access to physicians is the dissolution of Napa County’s only physician IPA. It remains to be seen what impact that will have on access to physicians (February 2001).

According to the Office of Statewide Health Planning and Development (OSHPD), there were 189 primary care clinic encounters at Clinic Olé and Planned Parenthood per 1,000 population in 1998. That is significantly lower than the 281 rate of primary care clinic encounters for the State of California. However Clinic Olé has recently increased its outreach efforts with new satellite programs, which will likely increase that rate.

There were 1.17 dentists per 100,000 population in Napa County in 1998 (State Dental Board, Department of Consumer Affairs). The 1998 rate of Medi-Cal eligible individuals using dentists was 4.9%, slightly lower than the statewide rate of 5.3% for the same period (California Medical Assistance Program, Annual Statistical Report, Medical Care Statistics Section, Department of Health Services).
PARTICIPATION IN GOVERNMENT HEALTH PROGRAMS

Medi-Cal

Medi-Cal is California's version of Medicaid. It pays the cost of medical care for low-income persons such as the elderly, disabled, those receiving public assistance and others with limited resources and high medical bills. Medi-Cal is a need-based program, that is, eligibility primarily depends on the income and resources a person has. Eligibility is limited to U.S. citizens, nationals and qualified immigrants.

There were 8,556 individuals enrolled in Medi-Cal in Napa County as of October, 2000 (California Department of Health Services, Medical Care Statistics Section). However, even individuals with Medi-Cal often have difficulties accessing health care, as some providers are reluctant to serve Medi-Cal and CMSP patients because of lower compensation for health care services and complex billing arrangements. Due to a lack of consistent primary care, low-income Napa County residents make greater usage of the emergency room and minor emergency center at Queen of the Valley Hospital in the City of Napa. In addition, depending on their income level, Medi-Cal recipients must often pay a "share of cost," or co-pay, which is prohibitively expensive for many low-income people, as reported by focus group participants.

Medicare

Medicare is the nation's largest health insurance program, covering approximately 39 million Americans. Medicare provides health insurance to people age 65 and over, and those with certain disabilities. There were a total of 21,676 Medicare recipients in Napa County in 1999, of whom 18,906 (87.2%) were elderly, while 2,770 (12.8%) were disabled (Health Care Financing Administration).

Healthy Families

The Healthy Families Program is a state and federal funded health coverage program providing health, dental and vision coverage for uninsured children with family incomes above the level eligible for no-cost Medi-Cal and below 250% of federal income guidelines. Eligibility is limited to children who are U.S. citizens, nationals or eligible qualified immigrants. As of February 26, 2001, there were a total of 1,158 subscribers enrolled in Healthy Families in Napa County. Of those, 19.5% are White, while 77.1% are Latino (Managed Risk Medical Insurance Board).
**HOSPITAL UTILIZATION**

There are three principal health care facilities in Napa County — Queen of the Valley Hospital in Napa, St. Helena Hospital in Deer Park, and a Kaiser Clinic in Napa. Queen of the Valley and St. Helena hospitals reported a total of 13,210 discharges during calendar year 1999, the majority of which (84%) were for general acute care services (*Office of Statewide Health Planning and Development*). Since Napa County does not have a County hospital, Queen of the Valley Hospital serves a large number of the low income people in the County — 72.3% of all Medi-Cal hospital discharges were from Queen of the Valley during fiscal year 2000.

**Emergency Room Utilization**

QVH had a total of 21,151 Emergency Medical Services (ER) admissions during 1999. Of those, 22.10% were considered non-urgent visits; i.e., visits that did not require emergency attention, and could likely have been prevented given the availability of access to a primary care physician (*Office of Statewide Health Planning and Development, 1999*). Calendar year 2000 data for the Queen of the Valley emergency room indicates that approximately half of all ER admissions were to low income individuals. Of those, over 40% were "self-pay," i.e., individuals who for the most part have no insurance.

**Exhibit 12: Queen of the Valley Hospital, Emergency Room Discharges for CMSP, Medi-Cal, Medi-Cal Pending, Partnership and Self-Pay Patients, 2000**

<table>
<thead>
<tr>
<th>Payment Method</th>
<th>Number of Discharges</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Pay</td>
<td>4,109</td>
<td>41.6%</td>
</tr>
<tr>
<td>Partnership Health Plan (Medi-Cal)</td>
<td>3,828</td>
<td>38.8%</td>
</tr>
<tr>
<td>CMSP</td>
<td>1,259</td>
<td>12.8%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>601</td>
<td>6.1%</td>
</tr>
<tr>
<td>Medi-Cal Pending</td>
<td>71</td>
<td>0.7%</td>
</tr>
<tr>
<td>Total</td>
<td>9,868</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Source: Queen of the Valley Hospital, February 2001.*

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5 Although Kaiser’s closest acute care hospital is in Vallejo, there is a freestanding clinic in Napa.
CLINIC UTILIZATION

Community Health Clinic Olé is the only freestanding clinic in Napa County exclusively serving low-income populations. Clinic Olé has a bilingual and bicultural staff of three full-time physicians and the equivalent of three full-time nurse practitioners. Clinic Olé has a major clinic and four limited satellite sites throughout Napa County. The major clinic is in Napa, as well as a satellite site which serves the homeless. Other sites are in St. Helena, Lake Berryessa and Calistoga. However, some clinics are small and offer limited hours. Though evening hours are offered at several locations, no weekend hours are available at any of the sites. In the City of Napa, the clinic operates Monday through Friday from nine to five and offers evening hours until nine o'clock three days a week. However, the clinic is closed from 12-1 PM each day. The St. Helena facility is open weekday afternoons and three evenings a week. Services are available in Calistoga two evenings a week. Hours vary at the Eastern Napa County/Lake Berryessa site, which is open two half-days every week.

Clinic Olé is unable to provide many specialist services and must refer patients to QVH or other providers. Most referrals are made to private practices that will accept Medi-Cal or self-pay patients. The most common referrals are to specialists for treatment of congestive heart failure and diabetes, though hepatitis C and hearing loss are also frequently referred out.

During fiscal year 1999-2000, Clinic Olé saw a total of 9,801 unduplicated patients, with a total of 19,694 visits. Over two-thirds (69%) of Clinic Olé's patients are Latino, while 35% are white and 3% identify as other. Clinic Olé's patient population is poor — 59% have incomes below the federal poverty line and 38% have incomes between 100-200% of the federal poverty line. Only 16% of the clinic's patients have Medi-Cal and 5% have some type of private insurance, including Healthy Families. While over one-third (35%) of the patients received sliding fee services, Clinic Olé staff and focus group participants report that the lowest rate is $30 per visit, which is still very high for many individuals with limited incomes. While Clinic Olé provides a vital service to the community, it needs additional resources to be able to meet the extent of the demand for its services, according to clinic staff and reports from focus group participants.

Sister Ann Community Dental Clinic provides a range of dental services to low-income residents of Napa County. The clinic serves approximately 7,500-8,000 clients each year (10,000 patient visits), two-thirds of whom are children. Denti-Cal patients account for 50% of Sister Ann's clientele, 15% are covered under the Healthy Families program and Children's Treatment Program patients represent another 20%. Self-pay patients account for the remaining 15%. Clinic staff report that it is very rare for the clinic to see a totally uncompensated patient. Self-pay patients pay on a sliding-fee scale modeled after Clinic Olé's. However, individuals earning

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6 The Children's Treatment Program is for children under 18 who have had a CHDP physical. CHDP refers these children to Sister Ann's for routine dental care or to treat a pre-existing problem.
over 250% of poverty are not eligible for services at the clinic, which makes it difficult for the working poor to access affordable dental care.

There is a large demand for Sister Ann Community Dental Clinic’s services, which the clinic is currently unable to meet. The clinic’s director notes that, given its limited resources, “I really don’t see any sign that we’ve met the dental care needs of the community.”

Sister Ann Community Dental Clinic foresees rapid growth over the next five years, with an estimated 15,000 patient visits. That growth will clearly require additional resources. The clinic cannot currently meet demand for a number of specialized services, including operative dental care, pediatric dental specialty care and periodontic services, dentures, dental health education and outreach, after hours care and eligibility information to help clients access Medical, Healthy Families or CHDP. Patients must often travel out of Napa County for specialized services, which many are unable to do, thus foregoing access to needed dental care. Furthermore, although Sister Ann charges low-income clients on a sliding fee scale, the cost is still prohibitive for many clients, as reported by focus group participants.
CONCLUSIONS

Napa County has many quality programs serving the health and other needs of low-income members of the community. Despite these efforts, however, the findings from this assessment indicate a great need for expanded access to health care for low-income individuals in Napa County, as evidenced by the following survey results:

✔ Over one in five respondents (21.7%) reported they or a family member were unable to get adequate treatment for a medical condition or problem during the past year.

✔ 59% of adults reported a lack of health insurance for one or more adults in the past year.

✔ 44% of children did not have health insurance sometime during the past year.

✔ Approximately 40% of both the low-income general and senior populations went to the hospital emergency room the last time they or a family member were sick.

✔ More than 50% of the women responding to the survey reported a need for women’s health care.

✔ One-fifth of female respondents that gave birth during the past year received no prenatal care during the first trimester of pregnancy.

✔ 35% of the respondents reported that their income was insufficient to make ends meet.

✔ More than 50% of adults and one in four children have not had a physical exam during the past year.

✔ More than 50% of both adults and children have not seen a dentist during the past year.

✔ One in four seniors reported dental problems that make it difficult for them to eat.

✔ More than 50% of all adults reported a need for vision care, while one-fifth reported a need for mental health services.

✔ Over 70% of all respondents said they would be likely to use one or more of the following services: free or low-cost health screenings, immunization clinics, health education, community case management and a neighborhood mobile health van.

Secondary data reveal that Napa County health indicators are significantly worse than U.S. Department of Health Services, Healthy People 2010 Objectives in several areas, including the following:
✓ The rates of all cancers are more than two times higher.

✓ Deaths due to heart disease are over one and half times higher.

✓ The percentage of women receiving early prenatal care is significantly lower than state and national rates.

It is also interesting to note that:

✓ Nearly 50% of babies born at QVH in 2000, and approximately one in three of all children born in Napa County, are born into poverty, i.e. their low-income mothers receive Medi-Cal.

✓ Over 70% of all Medi-Cal discharges in Napa County during 1999 were from Queen of the Valley Hospital.
Silent Suffering
North Bay farm workers face a healthcare crisis
By Joy Lanzendorfer

Efran Castillo was in pain. For some days, the vineyard worker had been hobbling around. He had stepped in a hole, fallen, and hurt his ankle. Since he spoke no English, had no healthcare insurance, and didn’t know how to get help, he simply tried to live with the pain.

His supervisor, noticing his problem, told Castillo that his injury was covered by workers’ compensation and took him to the nearest emergency room. There, no one spoke Spanish, and even with the supervisor translating for him, Castillo found the hospital intimidating and confusing. Nearly illiterate, he had trouble filling out the required forms. After waiting hours and being shuffled from room to room, his ankle, which was broken, was put in a cast.

Castillo was assigned no doctor, and follow-up care was not clearly explained to him; when it came time for the cast to be removed, he naturally went back to the emergency room. Since federal law dictates that hospitals cannot turn away people seeking care at an emergency room, the hospital had no choice but to devote emergency resources to a nonemergency situation.

Farm workers tend to have more health problems than most other groups of workers in Sonoma and Napa counties but less access to care. As a result, they often misuse the already overtaxed emergency departments or let problems get to the breaking point before finally seeking help. And because the issue has not been tracked, no one really knows how big the problem is. One thing is clear, though: as the number of migrant and farm workers increases and the cost of health insurance continues to go up, this issue will weigh more and more heavily on the North Bay’s sagging healthcare system.

Uninsured, Uniformed

The exact number of both regular and migrant farm workers in Sonoma and Napa counties is unknown. The 2000 census showed that Latinos made up 23.7 percent and 17.3 percent of Napa and Sonoma counties’ population, respectively. And few of the farm workers have health insurance, though again the numbers are sketchy. In Sonoma County, 60,000 people are estimated to be uninsured, but experts have called that number low, and no one knows how many are farm workers. Napa’s Queen of the Valley Hospital estimated that 64 percent of Latinos in Napa County are uninsured.

"No one has hard numbers on how many uninsured farm workers are in our area,” says Jeff Meckler, M.D., medical director of Alliance Medical Center in Healdsburg, which primarily serves the Hispanic population. "It depends on what type of worker you’re talking about. The undocumented workers rarely have insurance. With the documented workers, it depends on whether or not their employers offer insurance."

But whether insured or not, Hispanic workers often have health problems related to their lifestyles. Farm workers tend to eat a lot of fast food, loaded with fat and sugar, which puts them at a greater risk of obesity and high cholesterol and in turn ups their chances of getting chronic conditions such as diabetes and high blood pressure. Though immediate injuries such as Efran Castillo’s broken ankle are covered by workers’ comp, other kinds of work problems can be ignored, such as ongoing back pain or foot injuries.

"We primarily see a lot of untreated chronic conditions, especially diabetes, high blood pressure, and hypertension,” says Beatrice Bostick, head of Community Health Clinic Ole, the main source of healthcare for Hispanic workers in Napa County. "Chronic illnesses are troubling to treat, because even when we diagnose a problem, it is difficult to get the workers to come back for follow-up care."

The effect of pesticides on farm workers is also becoming a concern. A study published last year in the American Journal of Industrial Medicine showed that Hispanic farm workers in California have much higher incidents of leukemia, as well as brain, stomach, and skin cancers. The study did not, however, establish a clear link between the cancer rates and pesticide exposure.

Local doctors haven’t seen as many cases of cancer as the study suggests they would. Some speculate that this may be because pesticides used in vineyards are somewhat gentler than those used on other kinds of crops; others believe it may be because very ill workers tend to return to Mexico for treatment.

But some doctors are seeing other disturbing trends that may be linked to pesticides. Meckler, for example, has seen several cases of birth defects in the last five years. One baby was born without eyes and several others with abdominal wall closures.

"I have no idea if the birth defects we’ve seen have anything to do with pesticides or not,” he says. "It just seems like we’ve seen more than you would expect. It would be good if there was some reporting system to collect hard evidence on whether this is at all linked to pesticide exposure."

Because migrant workers often leave family behind in Mexico when they come to the United States for economic reasons, they are often socially and emotionally isolated, which leads to high incidents of depression and other mental illnesses, some experts believe. And though there are a considerable number of programs directed at children of farm workers, a lot more could be done to ensure the children’s care.

With a lack of numbers on how few North Bay farm workers are getting the care they need, the problem may be worse than many realize. A study of 971 California farm workers (including those in the North Bay) by the California Institute of Rural Studies revealed that more than a third of the men had never been to a doctor in their lives. Even fewer people had dental and eye care. More than half the men and two-fifths of the
women had never been to a dentist, and two-thirds of both sexes had never been to an eye doctor. Nor, surprisingly, nearly 70 percent of those surveyed lacked any form of health insurance, and only 7 percent were covered by a government-funded program. But poor healthcare access for farm workers is more complicated than the fact that many employers don't offer insurance, though that is part of the problem. In fact, some vineyards and farms do offer health insurance. Alliance Medical, for example, estimates that roughly one-quarter of its Hispanic patients are insured through their employers. Queen of the Valley Hospital estimated that nearly one-third of Napa County's farm workers have health insurance through their employers. "Some vineyard owners do provide insurance for their workers," says Andy Demsky, spokesperson for the Napa Valley Vintner's Association. "There is even seasonal coverage for temporary workers. It just depends on the vineyard." But even those employers who do offer insurance, many workers can't afford the co-payments. Because migrant workers can earn less than $10,000 a year, co-payments must compete with other more immediate needs such as food and housing. Though nearly 17 percent of those surveyed in the CIRS study said their employers offered health insurance, one-third of that amount didn't participate in the plan because they couldn't afford the payments. When employees don't have healthcare insurance, their options are greatly reduced. Legal aliens can apply for government programs such as Medi-Cal, which will cover some of their needs. Clinics like Community Health Clinic Ole and Alliance Medical will work with patients to develop a sliding-scale fee based on their income and whatever insurance they have. As in Castillo's case, the misuse of emergency rooms is also a common path for the poor. Patients must often wait for care regardless of the patient's ability to pay, many uninsured people use ERs as their primary care providers. Because of this and other factors, the majority of emergency rooms in the nation are losing money and have no way to recoup costs. And misuse adds to overcrowding in the emergency room, so that severely ill or dying patients are often turned away because the beds and resources are already in use.

Greek to Me

When it comes to dealing with being uninsured, farm workers are no worse off than other low-income workers who can't afford healthcare. However, Mexican workers have extra obstacles that other working poor don't have, according to Rick Mines, Ph.D., one of the researchers who worked on the CIRS study. "The farm workers are similar to other working poor in terms of healthcare access, except they have additional cultural barriers," he says. "These barriers are a huge problem. We found that because they don't have these barriers, the working poor can utilize the healthcare system much better than the farm workers. All such barriers are secondary to illegal aliens, who often fear that seeking healthcare will put them at risk for deportation. As a result, many will not get help unless they are very sick. But beyond this, the most obvious cultural barrier is language. In Sonoma and Napa counties, many healthcare providers have bilingual people on staff, but they are usually in the minority. And even if there is a large bilingual staff, few specialists and doctors are bilingual. Without someone there to translate, farm workers have trouble explaining symptoms, may feel sick enough to seek care when they typically avoid doing so—and it's easy to see why language would be a huge issue for the worker to contend with. And language barriers are even when workers don't understand what healthcare resources are available to them in the first place. Transportation is also an issue, especially when cash-strapped workers can't afford to take much time off work, according to Kathy Ficco, executive director of the Medical Access Program at St. Joseph Health System, Greater Sonoma County. "We have one woman who needed to go from Roseland to Southwest Community Health Center on Lombardi Court in Santa Rosa, a 10-minute drive for you and me," she says. "On the bus, it was an hour and a half to get to the clinic. In her case, she usually has three sick children with her. It's very difficult for them to travel without a car." But perhaps more than anything else, it is the cultural strangeness of our healthcare system that keeps many workers from seeking care. To be unable to get to a healthcare provider and then explain yourself once there are both deterrents. Patients feel that cultural sensitivity of the system is nonexistent and that nothing compared to not knowing where to go and how the system works to begin with. In Efarn Castillo's case, uncertainty of how the local healthcare system works kept him from getting help for his ankle and made the experience confusing and intimidating when he finally did. The California Institute of Rural Studies found that most farm workers prefer Mexican healthcare, which is quite different from U.S. healthcare. Though not as accurate and careful, Mexican healthcare means less bureaucracy and waiting, fewer laboratory tests, quicker diagnosis, and immediate issuance of medicine, all by someone who, of course, speaks Spanish and shares the same cultural background as the patient. Maria Matsen, who worked with migrant and farm workers in Napa County for 12 years and is a member of the Latina Advisory Board, feels that sensitivity is the first step to reaching the throngs of unknown health problems among the farm workers.

"Yes, we have Health Clinic Ole and some other healthcare resources in Napa County, but workers don't do a lot better," she says. "Cultural sensitivity is the key to understanding how this group of people works. We can't expect them to change to our way of doing things. We would be better off teaching them how to incorporate healthier thinking into their habits. I think a lot of people in charge of some of these programs don't understand that." Some providers are beginning to reach out to the silent population. Alliance Medical Center received a grant to go into the farm worker community where they plan to do health screening and educate the population on the existence of the clinic. St. Joseph's Medical Access Program received a $500,000 grant from the California Endowment to fund a dental clinic van, which will go out into the community to offer dental care and education. The program also runs a medical unit that supplies the community with some medicine, and education on issues such as cooking and prevention of diseases. According to Ficco, St. Joseph's Medical Access Program supplies the only vans in the North Bay that directly reach the farm worker community. "I think that Queen of the Valley would like to have a van, and the community has told them that a van would help," she says. "But many feel that the needs of the Hispanic population have been met. What they don't seem to understand is that the van reaches the population the clinics aren't reaching. We can provide newcomers with links to the clinics." Sick Days

Healthcare rates are still rising. Insurance rates are expected to increase for the fourth year in a row to the highest amount yet—early numbers are indicating a 25 percent increase for HMOs in 2003. As rates continue to rise, fewer employers will be able to afford healthcare insurance, and those who continue to maintain insurance are likely to pass more of the burden on to the employees. Southwest Community Health Center is already seeing 200 to 300 more patients a month as more people without insurance seek care. Next year, the clinic expects to see more patients, including middle-class patients who can no longer afford premiums. While rates are increasing, evidence suggests that the number of migrant workers coming into the two counties is increasing as well. The Press Democrat recently reported that the number of day laborers has increased to 120 in Graton and 200 in Fulton. What does all this mean for the farm worker? As more Mexicans come in to the area and jobs remain tighter compared to earlier years, there will be more competition for jobs, lower wages, and less health insurance. "The problem is likely to get worse for the migrant workers before it gets better," says Mecklenburgh.
Years of healthy life can be increased 5-10 years, WHO says

30 October 2002 -- Worldwide, healthy life expectancy can be increased by 5-10 years if governments and individuals make combined efforts against the major health risks in each region, the World Health Organization (WHO) says in its new yearly report.

The World Health Report 2002 -- Reducing Risks, Promoting Healthy Life - breaks new ground by identifying some major principal global risks to disease, disability and death in the world today, quantifying their actual impact from region to region, and then providing examples of cost-effective ways to reduce those risks, applicable even in poor countries.

“This report provides a road map for how societies can tackle a wide range of preventable conditions that are killing millions of people prematurely and robbing tens of millions of healthy life,” says WHO Director-General Gro Harlem Brundtland, MD. “WHO will take this report and focus on the interventions that would work best in each region and on getting the information out to Member States.”

From more than 25 major preventable risks selected for in-depth study, the report finds that the top 10 globally are: childhood and maternal underweight; unsafe sex; high blood pressure; tobacco; alcohol; unsafe water, sanitation and hygiene; high cholesterol; indoor smoke from solid fuels; iron deficiency and overweight/obesity. Together, they account for about 40 per cent of the 56 million deaths that occur worldwide annually and one-third of global loss of healthy life years.

These leading risks are comparatively much more important than widely believed. WHO calls the contrast between rich and poor people “shocking.” The burden from many of the risks is borne almost exclusively by the developing world, while other risks have already become global. Some 170 million children in poor countries are underweight, mainly from lack of food, while more than one billion adults worldwide – in middle income and high income countries alike are overweight or obese. About half a million people in North America and Western Europe die from overweight/obesity-related diseases every year.

WHO warns that the “cost of inaction is serious.” The report predicts that unless action is taken, by the year 2020 there will be nine million deaths caused by tobacco, compared to almost five million a year now; five million deaths attributable to overweight and obesity, compared to three million now; that the number of healthy life years lost by underweight children will be 110 million, which, although lower than 130 million now, is still unacceptably high.

If all of these preventable risks could be addressed as WHO recommends (which WHO acknowledges is a highly ambitious goal), healthy life spans could increase as much as 16 plus years in parts of Africa, where healthy life expectancy now falls as low as just 37 years (in Malawi). Even in the richer developing countries, such as Europe, the United States, Australia, New Zealand and Japan, healthy life spans would increase by about five years.

“Globally, we need to achieve a much better balance between preventing disease and merely treating its consequences,” says Christopher Murray, M.D., Ph.D., Executive Director of WHO’s Global Programme on Evidence for Health Policy and overall director of World Health Report 2002. “This can only come about with concerted action to identify and reduce major risks to health.”

WHO has developed a unique framework for using a wide body of scientific evidence to comparably assess the impact of different risks in a ‘common currency’ of lost healthy life years, called the DALY (disability-adjusted life year). This takes into account the impact of the different risks on mortality and on morbidity. A DALY is equal to the loss of one healthy year of life.

Risks that result in death reduce life expectancy. Risks that result in short or long term morbidity mean that people stay alive, but not in full health. Healthy life expectancy (HALE) is, therefore, lower than life expectancy. For example, overall life expectancy in Japan is 84.7 years for women and 77.5 for men, versus a healthy life expectancy of 73.6 years for men and women.

The report divides the world into 14 different regions on the basis of geography and health development (see Annex), then analyzes the risks most important in each area and the gains in healthy life span that can be achieved. The top risks vary widely, from being underweight and unsafe sex in most of Africa to tobacco use and high blood pressure in North America, Western Europe and developed countries in the Western Pacific such as Japan.

The major risks reviewed in the report are responsible for a substantial loss in healthy life expectancy – on average about five years in developed countries and 10 years in developing countries. The amount of lost healthy life years...
due to these leading risks varies by region. In Canada, the United States and Cuba (highest ranked group in the Western Hemisphere), healthy life expectancy can increase by 6.5 years, from their current healthy life expectancy of Canada, 69.9 years; Cuba, 66.6 years, U.S., 67.6 years. In the wealthiest countries of Europe, including Germany, France, Italy, Spain and the United Kingdom, healthy life expectancy can grow by 5.4 years; in most of Latin America, including Argentina, Brazil and Mexico, 6.9 years; in an Asian group including China, 6 years; in another Asian group including India, 8.9 years. (WHO estimates apply to each region as a whole and may not apply to any given country.)

A considerable part of this burden could be reduced by a set of cost-effective interventions identified in the report. WHO has developed a first-ever system of identifying and reporting cost-effective health interventions consistently across different regions that it calls CHOICE (CHOosing Interventions that are Cost-Effective). Various CHOICE options are contained in a new statistical database that is also a part of the World Health Report 2002, one of the largest research projects ever undertaken by the World Health Organization. These interventions can be implemented on an à la carte basis, depending on each country's individual circumstances.

“Although the report carries some ominous warnings, it also opens the door to a healthier future for all countries - if they’re prepared to act boldly now,” says Dr. Murray. “In order to know which interventions and strategies to use, governments must first be able to assess and compare the magnitude of risks accurately. Our report gives assessments for each of the major risks.”

Selected Major Risk Factors and What to Do About Them

The report shows that a relatively small number of risks cause a huge number of premature deaths and account for a very large share of the global burden of disease. For example, at least 30 per cent of all disease burden occurring in the highest mortality developing countries, such as those in sub-Saharan Africa and south-east Asia, results from underweight and deficiencies in micronutrients like iron and zinc, unsafe sex, unsafe water, sanitation, and hygiene and indoor smoke from solid fuels, the leading risks examined in those countries.

“We have established effective, but often underused, interventions.”

The report also breaks new ground by assessing avoidable death and disability at a global scale. By incorporating current knowledge in risk factor, demographic and mortality trends, an intriguing picture emerges - an increasingly ageing world facing some major risks globally (such as tobacco), as well as remaining very high mortality regions, particularly sub-Saharan Africa.

“This report brings out for the first time that 40 per cent of global deaths are due to just the 10 biggest risk factors, while the next 10 risk factors add less than 10 per cent,” says Alan Lopez, Ph.D., WHO Senior Science Advisor and co-director of the Report. “This means we need to concentrate on the major risks if we are to improve healthy life expectancy by about 10 years, and life expectancy by even more.”

Given the risks measured in this Report and other known major risks, current scientific knowledge has clearly identified causes for most death and disability globally. For example, more than three-quarters of major diseases such as ischaemic heart disease, stroke, HIV/AIDS and diarrhoea were due to the combined effects of risks assessed in the Report. WHO emphasizes that each risk is also a prevention opportunity, and the potential for prevention from tackling major known risks is clearly substantial, and much greater than commonly thought. “Since many of these risks are continuous, without a threshold, the most cost-effective interventions are often those that move the entire population to a lower risk zone,” says Dr. Rodgers. “A good example would be government- and industry-led reductions of salt in processed foods, which would have major population-wide benefits.”

Underweight/under-nutrition -- Childhood and maternal underweight was estimated to cause 3.4 million deaths in 2000, about 1.8 million in Africa. This accounted for about one in 14 deaths globally. Under-nutrition was a contributing factor in more than half of all child deaths in developing countries. Since deaths from under-nutrition all occur among young children, the loss of healthy life years is even more substantial: about 138 million DALYs, 9.5 per cent of the global total.

Under-nutrition is mainly a consequence of inadequate diet and frequent infection, leading to deficiencies in calories, protein, vitamins and minerals. Underweight remains a pervasive problem in developing countries, where poverty is a strong underlying cause, contributing to household food insecurity, poor childcare, maternal under-nutrition, unhealthy environments, and poor health care.
Interventions -- The most cost effective strategy to reduce under-nutrition and its consequences combines a mix of preventive and curative interventions. Micronutrient supplementation and fortification - Vitamin A, zinc and iron -- is very cost-effective. It should be combined with maternal counselling to continue breast feeding, and targeted provision of complimentary food as necessary. In addition, routine treatment of diarrhoea and pneumonia, major consequences of under-nutrition, should be part of any health improvement strategy for children.

Unsafe sex -- HIV/AIDS caused 2.9 million deaths in 2000, or 5.2 per cent of total. It also causes the loss of 92 million DALYs (6.3 per cent of all) annually. Life expectancy at birth in sub-Saharan Africa is currently estimated at 47 years; without AIDS it is estimated that it would be around 62 years. Current estimates suggest that 95 per cent of the HIV infections prevalent in Africa in 2001 are attributable to unsafe sex. In the rest of the world the estimated percentage of HIV infections prevalent in 2001 that are attributable to unsafe sex ranges from 25 per cent in Eastern Europe to 90 per cent or more in parts of South America and the developed countries of Western Pacific. Interventions -- Most people infected with HIV do not know they are infected, making prevention and control more difficult. Various sexual practices contribute to the risk of sexually transmitted infections. High-risk sex practices include multiple partners, together with lack of condom use and the type of sex acts involved. Treatments include:

- Population-wide mass media health promotion using the combination of television, radio and printed media.
- Voluntary counselling and testing.
- School-based AIDS education targeted at youths aged 10-18 years.
- Peer counselling for sex workers.
- Peer outreach for men who have sex with men.
- Treatment of sexually transmitted infections as a way of reducing transmission of HIV infections.
- Treatment of mothers with HIV infection to prevent maternal to child transmission.
- Anti-retroviral therapy has also been evaluated.
- Intervention combinations: WHO says that the best way to address the problem is to apply a combination of the above interventions at a population-wide level.

High blood pressure and cholesterol -- Worldwide, high blood pressure is estimated to cause 7.1 million deaths, about 13 per cent of the global fatality total. Across WHO regions, research indicates that about 62 per cent of strokes and 49 per cent of heart attacks are caused by high blood pressure.

High cholesterol is estimated to cause about 4.4 million deaths (7.9 per cent of total) and a loss of 40.4 million DALYs (2.8 per cent of total), although its effects often overlap with high blood pressure. This amounts to 18 per cent of strokes and 56 per cent of global ischemic heart disease.

Blood pressure is a measure of the force that the circulating blood exerts on artery walls. High blood pressure levels damage the arteries that supply blood to the brain, heart, kidneys and elsewhere. Cholesterol is a fat-like substance found in the bloodstream that is a key component in the development of atherosclerosis, the accumulation of fatty deposits on the inner lining of arteries of the heart and brain.

Interventions -- The World Health Report 2002 urges countries to adopt policies and programs to promote population-wide interventions like reducing salt in processed foods, cutting dietary fat, encouraging exercise and higher consumption of fruits and vegetables and lowering smoking. These are the most cost-effective interventions identified to reduce cardiovascular disease. This reflects recent evidence that such therapy benefits all groups at elevated risk, even those with average or below average blood pressure or cholesterol.

When added to this base, a combination of drugs -- statins (cholesterol lowering), low-dose blood pressure lowering medications and low-dose aspirin (blood-thinning) -- given daily to people at elevated risk of heart attack and stroke, would achieve very substantial additional benefits. This highly effective drug combination is likely to more than halve stroke and heart disease incidence and could be widely used in the developed world, and is increasingly affordable in the developing world.

"Our new research finds that many established approaches to cutting CV disease risk factors are very inexpensive, so that even countries with limited health budgets can implement them and cut their CV disease rate by 50 per cent," says Derek Yach, M.D., Executive Director of the Cluster on Non-communicable Diseases and Mental Health. "In addition, drug treatments are increasingly affordable in middle and low-income countries, as effective drugs come off patent."

Tobacco Use -- WHO estimates that tobacco caused about 4.9 million deaths worldwide in 2000, or 8.8 per cent of the total, and was responsible for 4.1 per cent of lost DALYs (59.1 million). In 1990, it was estimated that tobacco caused just 3.9 million deaths, demonstrating the rapid evolution of the tobacco epidemic and new evidence of the size of its hazard, with most of the increase in developing countries.
Interventions -- Countries that have adopted comprehensive tobacco control programs involving a mix of interventions including a ban on tobacco advertising, strong warnings on packages, controls on the use of tobacco in indoor locations, high taxes on tobacco products and health education and smoking cessation programs have had considerable success. WHO found that for every 10 per cent real rise in price due to tobacco taxes, tobacco consumption generally falls by between 2 per cent and 10 per cent. In addition to national programs, an effective Framework Convention on Tobacco Control will address transnational aspects of the issues.

Nicotine replacement therapy (NRT) targeting all current smokers was less cost-effective than the other strategies, but affordable in higher income countries. NRT includes nicotine patches, nicotine chewing gum, nicotine nasal sprays, lozenges, aerosol inhalers and some classes of anti-depressants.

Unsafe Water and Sanitation -- Approximately 3.1 per cent of deaths (1.7 million) and 3.7 per cent of DALYs (54.2 million) worldwide are attributable to unsafe water, sanitation and hygiene. Of this burden, about one-third occurred in Africa and one-third in south-east Asia. Overall, 99.8 per cent of deaths associated with these risk factors are in developing countries, and 90 per cent are deaths of children. Various forms of infectious diarrhoea make up the main burden of disease associated with unsafe water, sanitation and hygiene.

Interventions -- The United Nations has adopted a goal of halving the number of people with no access to safe water and sanitation by 2015. Improved water supply and basic sanitation, if extended globally, could prevent 1.8 billion cases of diarrhoea (a 17 per cent reduction of the current number of cases) annually. If universal piped and regulated water supply were achieved, 7.6 billion cases of diarrhoea (69.5 per cent reduction) would be prevented annually. Universal piped water is the ideal, but is high cost. In the short term, the most cost-effective strategy evaluated was disinfection of unsafe water at the point of use. This is a simple technology, is of very low cost, and would achieve substantial health benefits.

Iron deficiency -- Iron deficiency is one of the most prevalent nutrient deficiencies in the world, affecting an estimated two billion people with consequences for maternal and perinatal health and child development. In total, 800,000 (1.5 per cent) of deaths worldwide are attributable to iron deficiency, 1.3 per cent of all male deaths and 1.8 per cent of all female deaths. Attributable DALYs are even greater, amounting to the loss of about 25.9 million healthy life years (2.5 per cent of global DALYs) because of the non-fatall outcomes like cognitive impairment.

Interventions -- Iron fortification is very cost-effective in areas of iron deficiency. It involves the addition of iron usually combined with folic acid, to the appropriate food vehicle made available to the population as a whole. Cereal flours are the most common food vehicle, but there is also some experience with introducing iron to other vehicles such as noodles, rice, and various sauces.

“We surprised even ourselves in how far-reaching the health benefits can be if governments and health systems adopt our recommendations,” says Dr. Murray. “WHO believes that the wide distribution of this report should become a prime goal of all Member States.”

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The charts and maps contained in this media kit show in which parts of the world some of the selected leading risks to health have their biggest impact. This impact is measured in disability-adjusted life years, or DALYs.

One DALY can be interpreted as equalling one year of healthy life lost. For the purposes of analyses in The World Health Report, countries have been grouped into “subregions” which serve only to reflect their levels of child and adult mortality and have no other basis.

The 12 risks shown in these maps are divided into four groups. The first group, childhood and maternal undernutrition, contains underweight, iron deficiency and vitamin A deficiency. The second group, diet-related risk factors and physical inactivity, contains blood pressure, cholesterol and overweight. The third group contains tobacco, alcohol and illicit drugs. The fourth group, environmental risks, contains unsafe water, indoor smoke from solid fuels, and urban air pollution.

Figure 4.5 Global distribution of burden of disease attributable to 20 leading selected risk factors:

One DALY (disability-adjusted life year) is equal to the loss of one year of healthy life. For example, a person who lives to age 70, but suffers an incapacitating stroke at age 60, has had five DALYs.
Figure 4.3  Burden of disease attributable to diet-related risk factors and physical inactivity (% DALYs in each subregion)

A. Blood pressure

B. Cholesterol

C. Overweight (high body mass index)
Figure 4.6: Burden of disease attributable to tobacco, alcohol and illicit drugs (% DALYs in each subregion)

A. Tobacco

B. Alcohol

C. Illicit drugs
