HEALTHY YOLO

Our Community Our Future

Community Health Assessment

August 20, 2014

YOLO COUNTY
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INTRODUCTION

BACKGROUND

Health is affected by a wide range of components including social and economic circumstances, physical environment, behavior, and clinical care. Individual and community health are the byproducts of these components interacting in complex ways with each other that vary in their impact depending upon individual traits and circumstances operating both on the individual and societal level. Understanding these components and how they influence health is critical to efforts aimed at improving the health of our community.

Healthy Yolo was created as a public health effort to describe health characteristics of our community, analyze causal factors of health, and devise and implement programs to maintain or improve the health and well-being of all Yolo County residents. Healthy Yolo recognizes the interconnectedness of our community – what affects people in one part of our county affects us all. We cannot truly succeed until all parts of our county are in good shape.

Healthy Yolo fully supports the Institute of Medicine's definition of a healthy community:

> ***"A healthy community is a place where people provide leadership in assessing their own resources and needs, where public health and social infrastructure and policies support health, and where essential public health services, including quality health care, are available. In a healthy community, communication and collaboration among various sectors of the community and the contributions of ethnically, socially, and economically diverse community members are valued. In addition, the broad array of determinants of health is considered and addressed, and individuals make informed, positive choices in the context of health-protective and supportive environments, policies, and systems."*** *(p. 206)*[1]

This Community Health Assessment plays a fundamental role in identifying strategic issues and consequently evaluating and developing policies and programs for improving the health and well-being of Yolo County. Further, the information provided is intended to be a community resource that may be used by community members and organizations in a variety of ways. This information will help prioritize health issues and identify strengths and assets in our community that will be incorporated into the development of goals and strategies to address these health issues, thus providing a better understanding of these components so efforts to improve community health are more effective.

The Community Health Assessment includes four comprehensive assessment reports: Community Health Status; Community Themes and Strengths; Local Public Health System; and Forces of Change.

The **Community Health Status Assessment** provides a comprehensive look at the health status and contributing factors within Yolo County as portrayed through secondary data. By gathering and comparing our community's data to trend information and state data, specific health issues and contributing factors are identified.

The **Community Themes and Strengths Assessment** provides valuable insight into the health issues community members feel are important, perceptions of the quality of life in our community, and community strengths and assets. The information collected helps identify themes that residents are interested in, concerned about, and would support.

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[1] Institute of Medicine. The Future of the Public's Health in the 21st Century. http://www.iom.edu/~/media/Files/Report%20Files/2002/The-Future-of-the-Publics-Health-in-the-21st-Century/Future%20of%20Publics%20Health%202002%20Report%20Brief.pdf (November 2002)

The **Local Public Health System Assessment** measures how well the local public health system performs its roles and responsibilities.

The **Forces of Change Assessment** is a simple, comprehensive assessment of the positive and negative forces within and outside our county, so we can better prepare to act effectively.

To complete these four assessments, Healthy Yolo established several planning groups that worked in concert, the Healthy Yolo Core Team, Steering Committee, and three Assessment Subcommittees. The Core Team consisted of Health Department staff and interns; and the Steering Committee and subcommittee members were made up of community members and local public health system representatives.

Healthy Yolo Planning Group Responsibilities

Planning Group	Responsibilities
Healthy Yolo Core Team	Organize and manage the project processes, activities, and collaborations. Establish resources and provide support.
Steering Committee	Provides guidance throughout the entire project. Involved in the review and approval of key deliverables. Provide input and information on specific phases.
Assessment Subcommittees	Plan, conduct, and oversee the necessary activities according to the assessment.

MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS

Healthy Yolo has adapted the Mobilizing for Action through Planning and Partnership (MAPP) model for community health improvement in Yolo County. MAPP is a community-wide strategic planning tool for improving community health that helps communities prioritize public health issues and identify resources for addressing them. MAPP focuses on strengthening the whole system rather than separate pieces, thus bringing together diverse interests to collaboratively determine the most effective way to conduct public health activities.

The MAPP model is a nationally recognized process for improving community health that was developed by the National Association of County and City Health Officials (NACCHO), in cooperation with the Public Health Practice Program Office, Centers for Disease Control and Prevention (CDC). The MAPP model is comprised of six phases:

- **Phase 1:** The **Organize for Success and Partnership Development** phase identifies who should be involved in the process and how the partnership will approach and organize the process.
- **Phase 2:** The **Visioning** phase is a collaborative and creative approach that leads to a shared community vision and common values.
- **Phase 3:** The **Four Assessments** inform the entire MAPP process. The assessment phase provides a comprehensive picture of a community in its current state using both qualitative and quantitative methods.
- **Phase 4: Identify Strategic Issues** uses the information gathered from the four assessments to determine the strategic issues a community must address in order to reach its vision.
- **Phase 5:** The **Formulate Goals and Strategies** phase involves specifying goals for each of the strategic issues identified in the previous phase.
- **Phase 6:** The **Action Cycle** includes planning, implementation, and evaluation of a community's strategic plan.

PUBLIC HEALTH

Public health uses a proactive, preventive approach that focuses on the entire community. Overall, public health is concerned with protecting and promoting the health of entire populations through population-based strategies. The goals of population-based strategies are to address the community as a whole; maintain and improve the health status of entire populations; and to reduce inequities in health status between population groups.

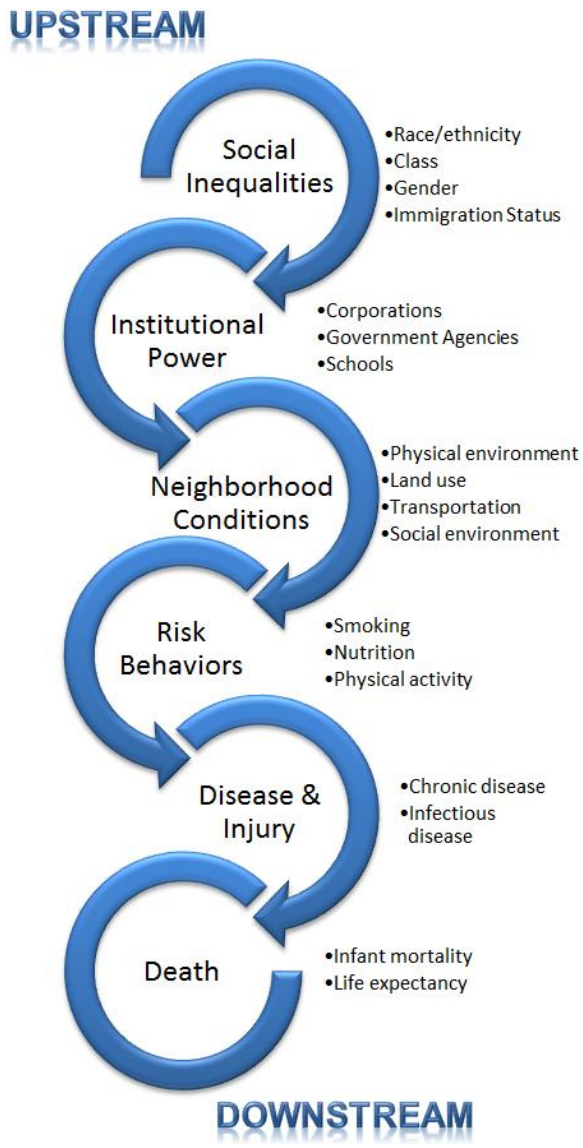
Public health professionals try to prevent problems from happening or re-occurring through implementing educational programs, developing policies, administering services, and conducting research, in contrast to clinical professionals such as doctors and nurses, who focus primarily on treating individuals after they become sick or injured[1]. Public health relies on a combination of scientific and social strategies to protect and improve the health of families and communities through the promotion of healthy lifestyles, research for disease and injury prevention, and detection and control of infectious diseases[2].

Individual and community health is affected by many factors that operate at a societal level, which necessitate strategies that span many levels of community. The aim of public health is to move further upstream to better identify root causes, as well as the policies that might productively address such causes.

Thinking upstream means making smarter decisions based on long-term thinking. Upstream thinking deals with the root causes of health issues whereas downstream thinking deals with the consequences. It is about reducing the conditions that give rise to and sustain disease and promoting the conditions that give rise to and sustain health. It makes more sense to prevent people from becoming sick or injured rather than trying to treat people one by one after they have become sick or injured.

Public health is about preventing disease and disability and promoting health. This requires changing the conditions in which people live, improving the quality of the environment, and reforming public policy in order to create conditions in which people can be healthy.

Public Health Upstream/Downstream Model



METHODOLOGY

DATA SOURCES

HEALTH INDICATOR DATA

A Community Health Status Assessment (CHSA) Subcommittee was established consisting of three members of our community in professional fields of healthcare delivery, epidemiology, and a Health Council member. The CHSA

[2] Centers for Disease Control and Prevention (CDC), What is Public Health? http://www.cdcfoundation.org/content/what-public-health

subcommittee was tasked to identify the health indicators to be reviewed. The health indicators were selected primarily from the recommended list provided by the MAPP model. The subcommittee also reviewed health indicators from the Life Course Metrics Project and Community Commons. Health indicators were chosen due to their relevance to Yolo County, standard use, availability, reliability of data, and the ability to track the health indicators over time. A list of the data sources and definitions is available in Appendix A.

Data are reported at the county level and where available the data are reported at the city, region, or school district level. Additionally, where possible, the data are stratified by sex, age, race/ethnicity, and/or income level. Looking at data at these levels allows for the identification of unique issues to facilitate targeted interventions. Appendix B provides data notes regarding proportions and rates, suppression of data, etc. For data provided in tables, all figures in red indicate a percentage or rate that exceeds that of the county's rate.

The quantitative data consist of more than 130 health indicators over 11 broad-based categories. These categories include:

- Demographics
- Social and Economic Circumstances
- Quality of Life
- Social and Mental Health
- Physical Environment
- Health Care and Preventive Services
- Maternal and Child Health
- Health Behaviors
- Communicable Diseases
- Health Outcomes
- Mortality

COMMUNITY THEMES AND STRENGTHS SURVEY

The Community Themes and Strengths Assessment (CTSA) engaged community members by asking them to voice their thoughts, experiences, opinions, and concerns. Thus, the CTSA provides valuable insight into the health issues residents feel are important, perceptions of the quality of life in our community, and community strengths and assets. The information collected helps identify themes that residents are interested in, concerned about, and would support. Communicating with the members of our community is essential to the effectiveness and overall success of future public health initiatives.

Community Open House Event

A CTSA subcommittee was established consisting of six members of our community in professional fields of healthcare delivery and senior care. The CTSA subcommittee was tasked to identify resources, approaches, and events; refine the survey tool used; assist in the design of community events; participate in community events; and provide ongoing overview. Several interns were involved in the design of the survey and community events, and participated in the community events. In Addition, the Healthy Yolo Steering Committee provided insight to the design of the community events and provided potential community events for participation.

The CTSA survey relied on previous CTSA surveys from other counties. The Healthy Yolo core team identified, modified, and drafted questions concerning community perceptions and assets. The final CTSA survey consisted of 21 questions for categories of health issues and contributing factors; perceptions of quality of life; strengths and assets; and demographics (see Appendix C for the complete survey).

Community events served as an opportunity for Healthy Yolo to present the CTSA survey to community members. In order to provide an opportunity to review health data prior to respondents filling out the survey, information was presented in booth set-ups, with preliminary health data (i.e., demographics, contributing factors, and health outcomes) and project information in both English and Spanish. In addition to the CTSA survey, respondents were asked to contribute to a health issues wall chart. In this exercise, they placed a sticker next to three health issues they felt needed to be addressed in their community.

Healthy Yolo attended 20 community events from July 24, 2013 to November 17, 2013.

Healthy Yolo Community Event Participation

Date	Event	City
July 24, 2013	Farmers' Market	Davis
August 17, 2013	Yolo County Fair	Woodland
September 15, 2013	Mexican Independence Celebration	Knights Landing
September 19, 2013	Food Distribution	Winters
September 19, 2013	Let's Get Healthy Fair	West Sacramento
September 21, 2013	Farmers' Market	Woodland
September 22, 2013	Latino Health Fair	Woodland
September 23, 2013	Food Distribution	Esparto
September 28, 2013	Festival de la Comunidad	Winters
October 1, 2013	Food Distribution	Clarksburg
October 2, 2013	Food Distribution	Arbuckle/Dunnigan
October 2, 2013	Community Fair	Esparto
October 5, 2013	Multi-Cultural Event	West Sacramento
October 12, 2013	International Festival	Davis
October 15, 2013	Flu Clinic	Davis
October 17, 2013	Flu Clinic	Woodland
October 18, 2013	Community Health Fair	West Sacramento
October 18, 2013	Community Resource Fair	Woodland
October 19, 2013	Flu Clinic	Davis
November 17, 2013	Elementary School Event	West Sacramento

The CTSA survey was also available online from July 24, 2013 to December 1, 2013 in three languages English, Spanish, and Russian. Hard copies of the CTSA survey were distributed to the rural county libraries, senior centers, and community-based organization offices.

Nine hundred surveys were completed (723 hard copies and 177 online) and nearly 500 people placed over 1,400 stickers on the health issues wall charts.

Furthermore, Healthy Yolo compared the survey respondent demographics with the U.S. Census American Community Survey data; respondents were proportionally representative of the county in terms of age and race/ethnicity. However, higher than Census proportions of females and individuals with annual household income of less than $15,000 were represented among the respondents. A possible explanation for this discrepancy is the number of community events held at food distributions sites.

LOCAL PUBLIC HEALTH SYSTEM WORK SESSION

On November 15, 2013, Healthy Yolo conducted a half-day work session to assess the local public health system (LPHS) in Yolo County and address the issues that affect health in our community. Twenty-six representatives from health care institutions, government and policy agencies, community groups, and service providers gathered at the Yolo County Health Department (see Appendix D for a list of the attendees and their agency or organization). As each LPHS work session participant arrived, they were provided with an event packet that consisted of an agenda, background materials, guidelines, scoring definitions, and voting cards. Each participant was assigned to a specific work group based on their area of essential public health service (Essential Service) involvement.

Five work groups focused on two Essential Services each based on the Local Implementation Guide suggested groupings. Each Essential Service includes two to four Model Standards that describe the key aspects of an optimally performing public health system. Each Model Standard was followed by assessment questions that served as measures of performance. There are 108 Performance Measures that indicate how well the LPHS is meeting the Model Standard. A facilitator and recorder were assigned to each work group to ensure the discussion principles were followed and to document the discussion.

FORCES OF CHANGE WORK SESSION

On January 30, 2014, Healthy Yolo conducted a half-day work session to identify the forces of change within our community. Twenty-one community members attended the work session (see Appendix E for a list of the attendees). Prior to the work session, each attendee received a forces of change brainstorming worksheet. The worksheet provided a definition of forces of change, tips on how to identify forces of change, and a table to list the forces with the associated threats and opportunities.

A consensus workshop was conducted during the first half of the work session. Attendees were posed with the workshop focus question, "What are the forces of change that are occurring or may occur that affect the health and quality of life in our community?" Attendees individually brainstormed and wrote down all of the forces of change they could think of on individual cards. They then paired up and shared the cards with one another. Three cards were collected from each pair and read aloud as they were posted at the front of the room.

The work group paired similar cards together to form clusters based on similar intent, action, accomplishment, etc. Each pair selected two more cards, which were read aloud and posted. Consensus was reached on the appropriateness for each cluster and for the cards within that cluster. The work group decided on a word or phrase that was most descriptive of all the cards in that cluster. The title card for each cluster was read aloud and the work group confirmed that it answered the workshop focus question.

The second half of the work session focused on the threats and opportunities. The attendees selected a force of change that interested them the most and then broke into groups. In each group, threats and opportunities were identified for each card or force within that group. The results of the threats and opportunities were read back to the entire work group.

YOLO COUNTY REGIONS

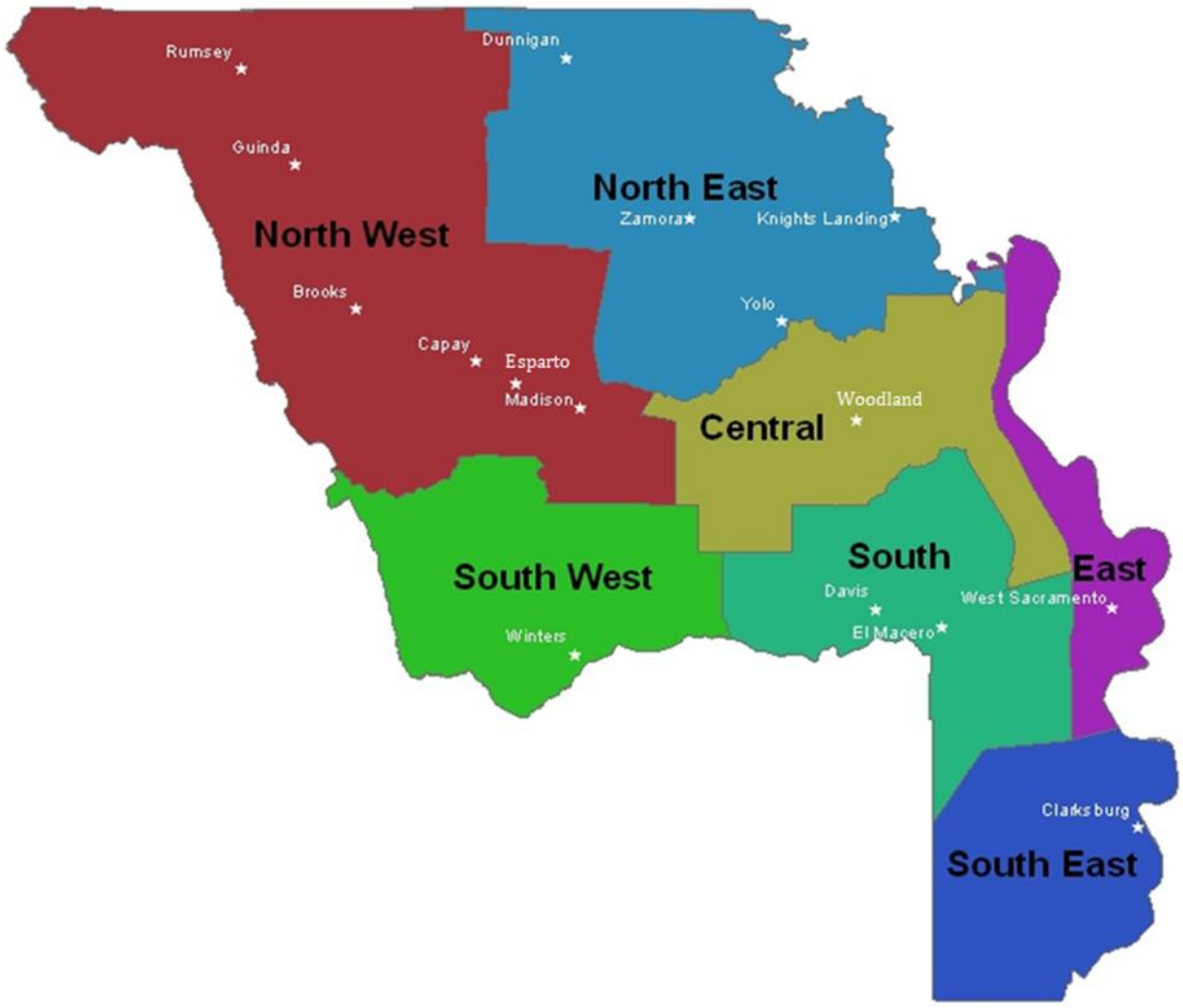
In order to address the geographic and demographic diversity of Yolo County, Healthy Yolo divided the county into seven regions based on the U.S. Census subdivisions, allowing perspective that is more comprehensive on individual communities.

The seven regions are as follows:

- The **Central** region includes the city of Woodland and the surrounding areas.
- The **East** Region includes West Sacramento and the area running north along the Sacramento River.
- The **North East** region includes the towns of Dunnigan, Zamora, Yolo, and Knights Landing.

- The **North West** region stretches up the Capay Valley and includes all of the towns therein.
- The **South** region includes the city of Davis and El Macero.
- The **South East** region includes Clarksburg and the surrounding areas.
- The **South West** region includes the city of Winters and surrounding areas.

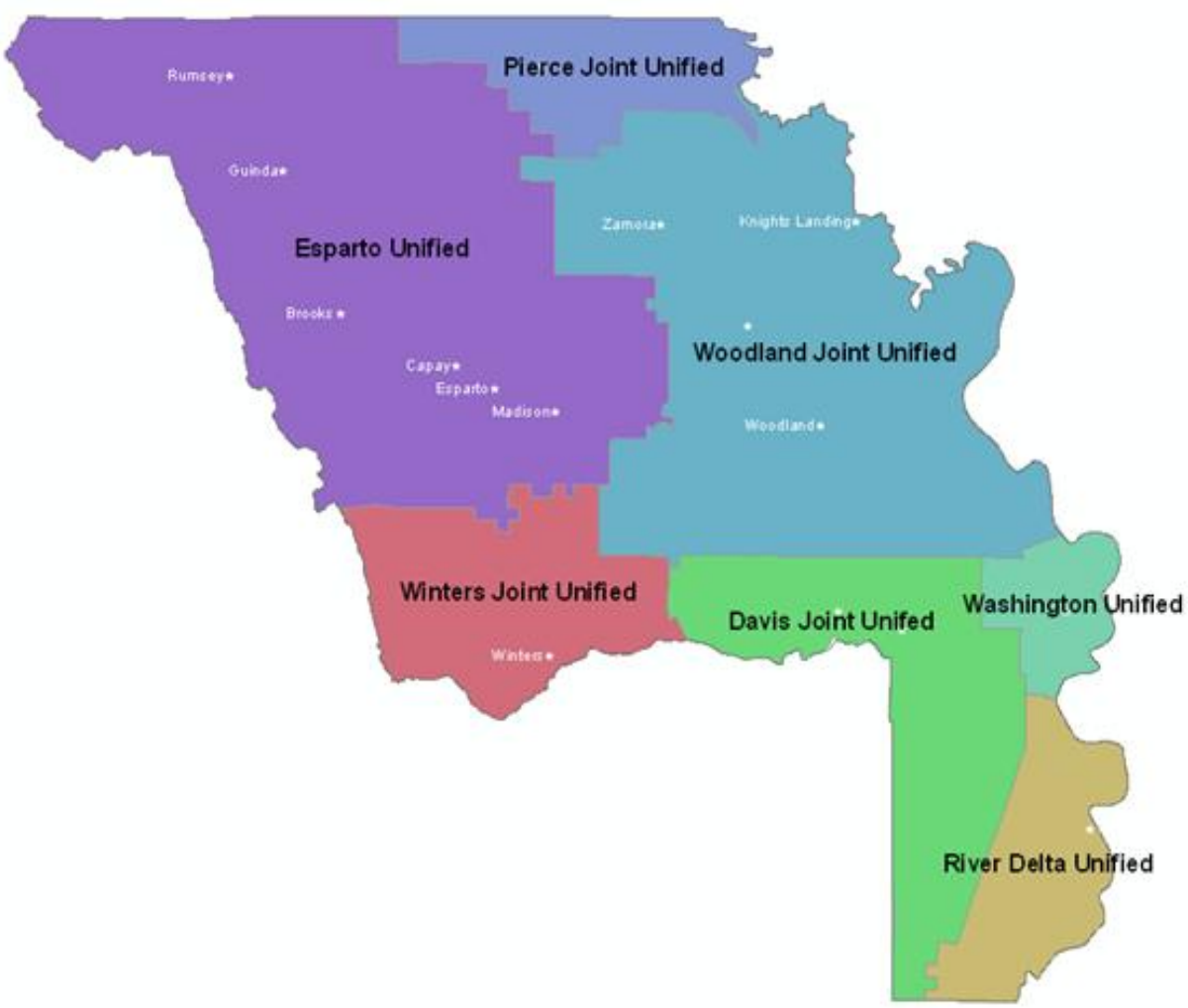
Yolo County Regions



YOLO COUNTY SCHOOL DISTRICTS

The health indicator data that refers to students are subdivided by school district. There are seven school districts in Yolo County: Esparto Unified; Winters Joint Unified; Woodland Joint Unified; Davis Joint Unified; Washington Unified; River Delta Unified; and Pierce Joint Unified. The school districts roughly align with the regional boundaries, though there are some slight differences. Woodland Joint Unified covers both the Central and North East Regions.

The school districts of Pierce Joint Unified and River Delta Unified overlap several county lines. The students of Dunnigan attend the Pierce Joint Unified where the schools are located in Colusa County. River Delta Unified encompasses Solano, Yolo, and Sacramento Counties, though there are schools in Clarksburg. Data for health indicators at the school district level do not include students who attend Pierce Joint Unified and River Delta Unified. Whenever possible, data from schools in the Clarksburg area were used.



DEMOGRAPHICS

Current population demographics provide a snapshot of who we are as a community, which provide a better understanding of cultural aspects of a community in order to develop appropriate and effective community-based public health relationships and efforts. Changes in demographic structures over time play a determining role in the types of health and social services needed by communities. A significant positive or negative shift in total population over time affects healthcare and the utilization of community resources. Commonly examined demographic data include age, sex, race, ethnicity, language, and even location.

POPULATION CHANGE

According to the U.S. Census Bureau Decennial Census, between 2000 and 2010 the population in Yolo County grew by 32,189 persons, a change of 19%. In comparison, the population change for the state of California increased by 10% during the same period.

The region to experience the most population growth was the East region accounting for more than half of the population change for the entire county during this time span. The South East region was the only region with a negative change in population.

Population Change from 2000 to 2010				
Report Area	2000 Population	2010 Population	Change	% Change
Yolo County	168,660	200,849	32,189	19%
Regions				
East	31,799	48,921	17,122	54%
North West	4,552	5,325	773	17%
Central	51,641	58,695	7,054	14%
North East	3,784	4,193	409	11%
South	67,939	74,334	6,395	9%
South West	7,572	8,106	534	7%
South East	1,373	1,275	-98	-7%

CHANGE IN POPULATION BY AGE GROUP

Changes in the population of specific age groups in our community is important to understand because specific age groups (e.g., children and seniors) have unique health needs that need to be considered separately from other age groups.

The age groups with the largest population change over the past decade are the young adults aged 20 to 24 years, and the older adults aged 55 to 64 years.

Population Change by Age Group from 2000 to 2010				
Age Group	2000 Population	2010 Population	Change	% Change from 2000 to 2010
under 5	10,964	12,577	1,613	15%
5 - 9	12,363	12,258	-105	-1%
10 - 19	29,605	31,638	2,033	7%
20 - 24	20,797	27,185	6,388	31%
25 - 34	23,677	28,168	4,491	19%
35 - 44	23,866	23,913	47	0.2%
45 - 54	20,301	24,830	4,529	22%
55 - 64	11,613	20,159	8,546	74%
65 - 74	8,056	10,570	2,514	31%
75 - 84	5,753	6,227	474	8%
85 +	1,973	2,974	1,001	51%

POPULATION DENSITY

A total of 200,849 people live in the 1,014 square miles of Yolo County according to the U.S. Census Bureau Decennial Census 2010. The population density, the number of persons per square mile, is estimated at 198 persons per square mile. This is greater than the national average of 87 persons per square mile and less than the state average of 239 persons.

Population Density: 2010			
Report Area	Total Population 2010	Total Land Area (Sq. Miles)	Population Density (Per Sq. Mile)
Yolo County	200,849	1,014	198
California	37,253,956	155,738	239
United States	308,745,538	3,530,998	87

AGE AND SEX

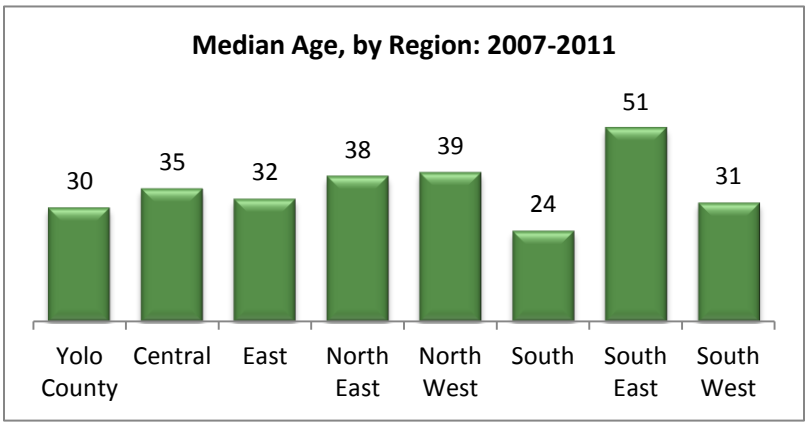
The following population estimates are based on the U.S. Census Bureau American Community Survey, 5-year Estimate from 2007-2011. This estimate differs slightly from the Decennial Census 2010. Table 6 provides a breakdown of Yolo County's population by sex and region. Overall, females slightly outnumber males 51% to 49% of the population.

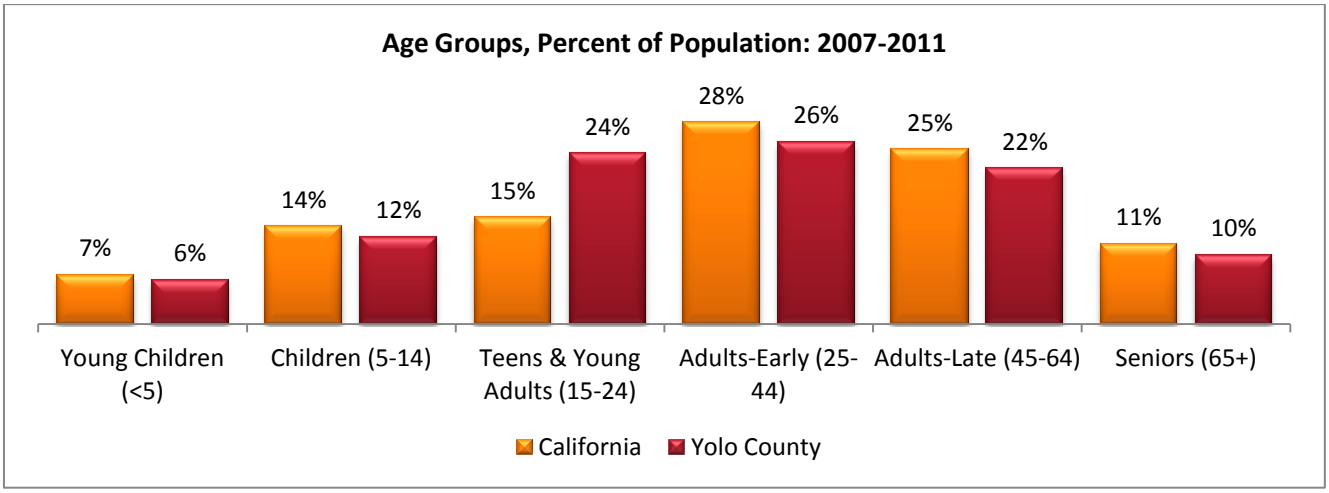
Population by Sex: 2007-2011

Report Area	Male	Female	Total Population
Yolo County	96,986	101,903	198,889
Regions			
Central	28,817	29,268	58,085
East	22,740	24,609	47,349
North East	2,080	1,774	3,854
North West	2,448	2,552	5,000
South	36,206	38,958	75,164
South East	575	663	1,238
South West	4,120	4,079	8,199

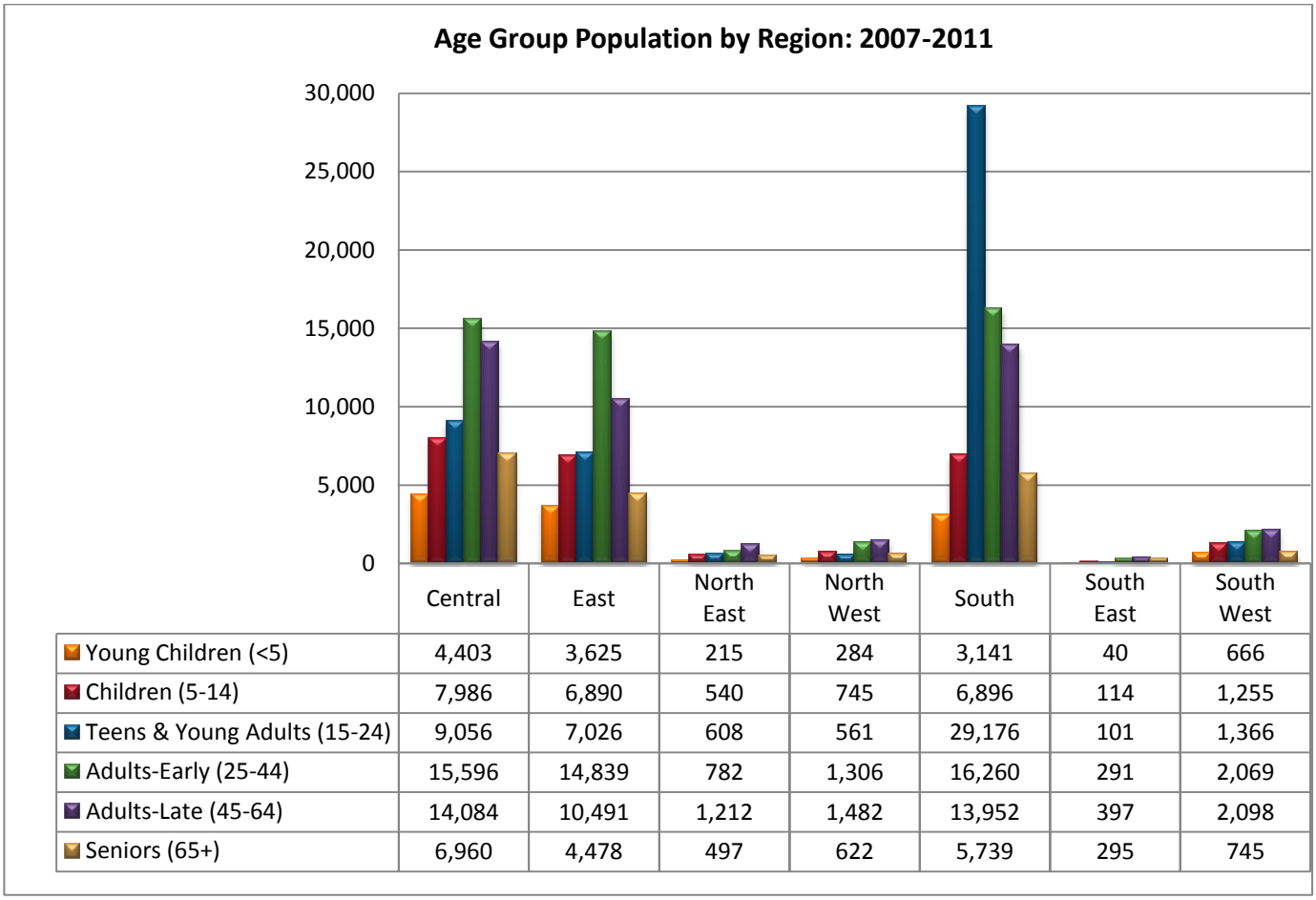
The median age for Yolo County is 30 years of age. The median age of the regions ranged from a low of 24 years in the South region to a high of 51 years in the South East region.

Yolo County has a higher percentage of teens and young adults (24%) compared to the state (15%). The South region has the highest percentage of teens and young adults at 39%. This is primarily due to the student population at the University of California, Davis. The number of students enrolled in the fall of 2011 was 31,732.





The South East region has the smallest number of seniors, but has the highest percentage of its population as seniors, 24%. The regions of North East, North West, and South East have nearly one third of their population between the ages of 45 to 64 years. Services and social supports to promote healthy aging will be important in these regions to maintain the best possible levels of health and function.



	Central	East	North East	North West	South	South East	South West
Young Children (<5)	4,403	3,625	215	284	3,141	40	666
Children (5-14)	7,986	6,890	540	745	6,896	114	1,255
Teens & Young Adults (15-24)	9,056	7,026	608	561	29,176	101	1,366
Adults-Early (25-44)	15,596	14,839	782	1,306	16,260	291	2,069
Adults-Late (45-64)	14,084	10,491	1,212	1,482	13,952	397	2,098
Seniors (65+)	6,960	4,478	497	622	5,739	295	745

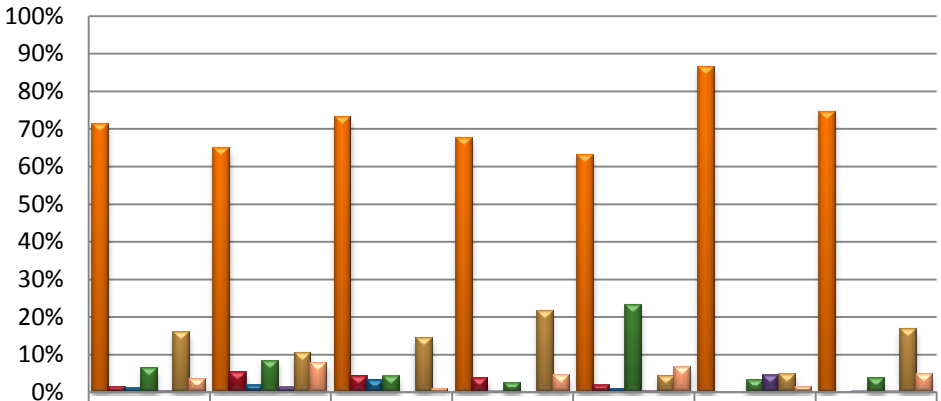
RACE AND ETHNICITY

Race and ethnicity play an important role on the health of individuals and communities. It is not entirely understood how race and ethnicity interplay with other factors that lead to disparities in health status, quality of life, access to care, etc. The U.S. Census Bureau states that racial categories reflect a social definition and are based on self-identification.

Generally, Yolo County mirrors the racial makeup of the state of California, with exception that Yolo County has a slightly higher White population percentage and slightly lower Black/African American population percentage.

Population by Race: 2007-2011

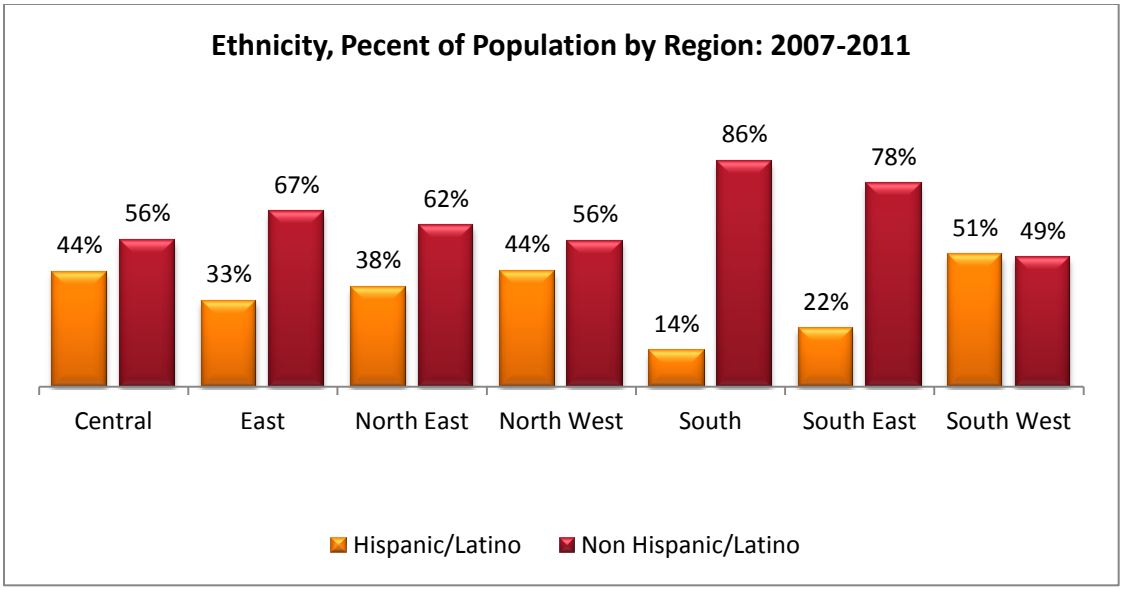
Race	California		Yolo County	
	Number	Percent	Number	Percent
White	22,860,341	62%	132,734	67%
Black/African American	2,252,129	6%	5,006	3%
American Indian/Alaska Native	287,712	1%	2,485	1%
Asian	4,825,271	13%	25,626	13%
Native Hawaiian/Other Pacific Islander	141,382	0.4%	1,112	1%
Some Other Race	5,142,478	14%	20,510	10%
Two or More Races	1,459,887	4%	11,416	6%



	Central	East	North East	North West	South	South East	South West
White	71%	65%	73%	68%	63%	86%	74%
Black/African American	1%	5%	4%	4%	2%	0%	0%
American Indian/Alaska Native	1%	2%	3%	0%	1%	0%	0%
Asian	6%	8%	4%	3%	23%	3%	4%
Native Hawaiian/other Pacific Islander	0%	1%	0%	0%	0%	4%	0%
Some Other Race	16%	10%	15%	22%	4%	5%	17%
Two or More Races	4%	8%	1%	4%	7%	2%	5%

The estimated population of residents of Hispanic, Latino, or Spanish origin in Yolo County is 59,340. This represents nearly 30% of the total population, which is less than the state rate of 37%. Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

The South and South East regions have the lowest percentage of Hispanic/Latino population, 14% and 22% respectively. The South West region has a slight majority of its population as Hispanic/Latino, 51%.



FOREIGN-BORN

The foreign-born population includes anyone who was not a U.S. citizen or U.S. national at birth. This includes any non-citizens, as well as persons born outside of the U.S. who have become naturalized citizens. The native U.S. population includes any person born in the U.S., Puerto Rico, a U.S. Island Area, or abroad of U.S. citizen parent or parents.

In Yolo County, there are 42,089 persons of foreign birth, which represents 21% of the population. This percentage is less than the state rate of 27%. The East, North West, North East, and South West regions exceed Yolo County's rate with 23%, 28%, 26%, and 26%. For data provided in tables, all figures in red indicate a percentage or rate that exceeds that of the county's rate.

Percentage of Native and Foreign-Born by Region: 2007-2011

Region	Native	Foreign-Born
Central	79%	21%
East	77%	**23%**
North East	74%	**26%**
North West	73%	**28%**
South	81%	19%
South East	88%	12%
South West	74%	**26%**

LANGUAGE

An inability to speak English may create barriers to access, provider communications, outreach efforts, and health literacy/education.

LANGUAGE SPOKEN AT HOME

In Yolo County, the population aged 5 and older who speak a language other than English at home is 64,337 persons, which represents 35% of the population aged 5 and older. This rate is less than the state rate of 43%. The percentage of Yolo County residents aged 5 and older that speaks English less than "very well" is at 15%. Of these languages other than English spoken at home, Spanish represents nearly 60%.

Language Other than English Spoken at Home, Aged 5 and Older: 2007-2011

Language	Percent
Spanish	59%
Indo-European	18%
Asian & Pacific Islander	21%
Other	2%

Speaks English less than "Very Well", Aged 5 and Older: 2007-2011

Region	Percent
Central	**17%**
East	**18%**
North East	**18%**
North West	**24%**
South	9%
South East	11%
South West	**29%**

ENGLISH LANGUAGE LEARNERS

In Yolo County's public school system, English Learners are those students with a primary language other than English and who lack the defined English skills of listening comprehension, speaking, reading, and writing necessary to succeed in regular school instructional programs. English Learners face difficult challenges in learning a new language as well as the school curriculum and are less likely to obtain future educational and economic success.

In 2012, Yolo County had 20% of the public school population as English Learners, which is slightly less than the state rate of 22%. Spanish is the most predominant language spoken among English Learners at 81%. Of the school districts in Yolo County, the Winters Joint Unified School District has one-third of its student population as English Learners.

English Language Learners, Davis JUSD	
Student	**Percent**
English Learner (Spanish)	5%
English Learner (Other Language)	4%
Not an English Learner	91%

English Language Learners, Winters JUSD	
Student	**Percent**
English Learner (Spanish)	**34%**
English Learner (Other Language)	0.3%
Not an English Learner	66%

English Language Learners, Esparto USD	
Student	**Percent**
English Learner (Spanish)	**26%**
English Learner (Other Language)	1%
Not an English Learner	73%

English Language Learners, Woodland JUSD	
Student	**Percent**
English Learner (Spanish)	**25%**
English Learner (Other Language)	2%
Not an English Learner	73%

English Language Learners, Washington USD	
Student	**Percent**
English Learner (Spanish)	13%
English Learner (Other Language)	7%
Not an English Learner	80%

English Language Learners, Yolo County Office of Education	
Student	**Percent**
English Learner (Spanish)	15%
English Learner (Other Language)	3%
Not an English Learner	82%

HOUSEHOLD COMPOSITION

A house, apartment, single room, or group of rooms is regarded as a household. There are 69,860 households in Yolo County. Slightly over 21,775 of these households have at least one child under the age of 18. Nearly 27% of these family households are led by single parents. There are also nearly 5,400 households where a senior is living alone.

OTHER POPULATIONS

It is estimated that there are 500 homeless persons in Yolo County representing 0.2% of the population. In addition, there are 23,445 undocumented immigrants living in Yolo County.

SOCIAL AND ECONOMIC CIRCUMSTANCES

Social and economic circumstances are the experiences and realities that help mold one's personality, attitudes, and lifestyle. Social and economic insecurity are often associated with poor health.

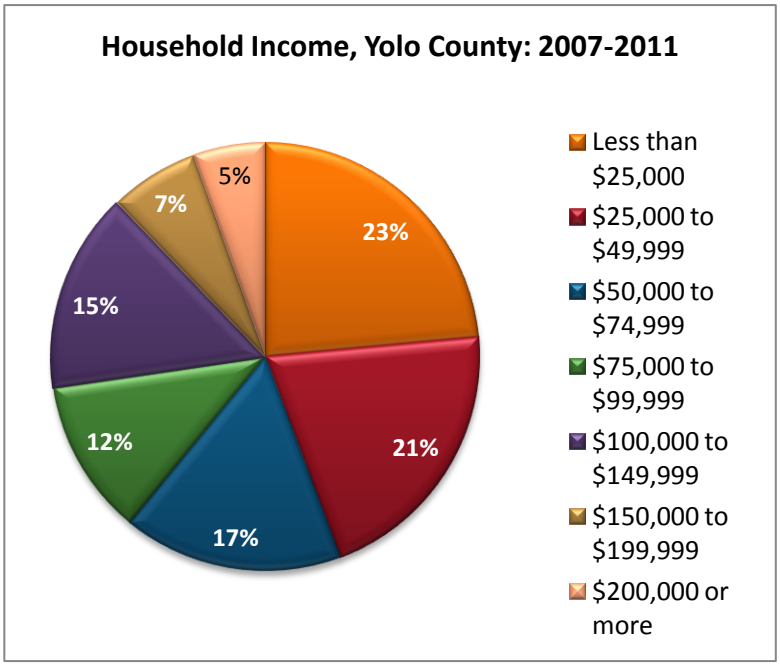
Poverty, unemployment, and lack of educational attainment affect the ability of an individual or community to engage in healthy behaviors. Ensuring access to social and economic resources provides a foundation for a healthy community. For data provided in tables, all figures in red indicate a percentage or rate that exceeds that of the county's rate.

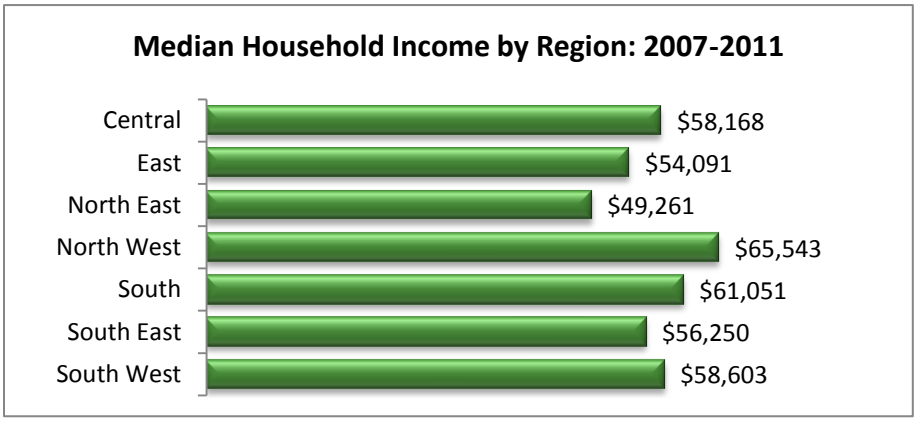
INCOME

Personal income is one of the major determinants of individual and community health. Lower household income is directly related to an increased risk for chronic conditions in children[3].

Household income includes all reported income from wages and salaries as well as income from self-employment, interest or dividends, public assistance, retirement, and other sources. The following data describe the household income levels and those living below the federal poverty level by county region.

For the period from 2007 to 2011, the median household income for the state of California was $61,632, which was slightly higher than the Yolo County median household income of $57,920. The county regions range from a low of $49,261 in the North East region to $65,543 in the North West region.





For Yolo County, 12% of the households had incomes greater than $150,000.

The South region tops the list with 17% of households, while the North East region has only 6% of households with incomes greater than $150,000.

Household Income Greater than $150k: 2007-2011	
Region	**Percent**
Central	10%
East	9%
North East	6%
North West	13%
South	17%
South East	9%
South West	10%

[3] American Public Health Association. Health Disparities: The Basics. http://www.apha.org/NR/rdonlyres/54C4CC4D-E86D-479A-BABB-5D42B3FDC8BD/0/HlthDisparty_Primer_FINAL.pdf

POVERTY

Within Yolo County, 19% or 36,993 individuals are living in households with incomes below the Federal Poverty Level, which is slightly higher than the state at 14%.

The table on the right displays the 2012 federal poverty guidelines. To determine if a household is below the federal poverty level, the family/household size is compared to the poverty guidelines. For example, if a family of four has a household income of less than $23,050, then that household and its members are considered below the Federal Poverty Level.

Those living below the poverty level in Yolo County, include 11,038 households, 4,330 families, and 7,863 children. The percentages of the different populations living below the federal poverty level are listed below.

The South region has the highest percentage of people and households below the poverty level, 26% and 21% respectively. However, the percentage of families and children living below the poverty level is among the lowest in the county at 9% and 11%. Although poverty status is not determined for those who are living in college residence halls, there is still a large student population in Davis not living in college residence halls, which could account for the high percentages of people and households below the poverty level and the low percentages among families and children.

Federal Poverty Level Guidelines

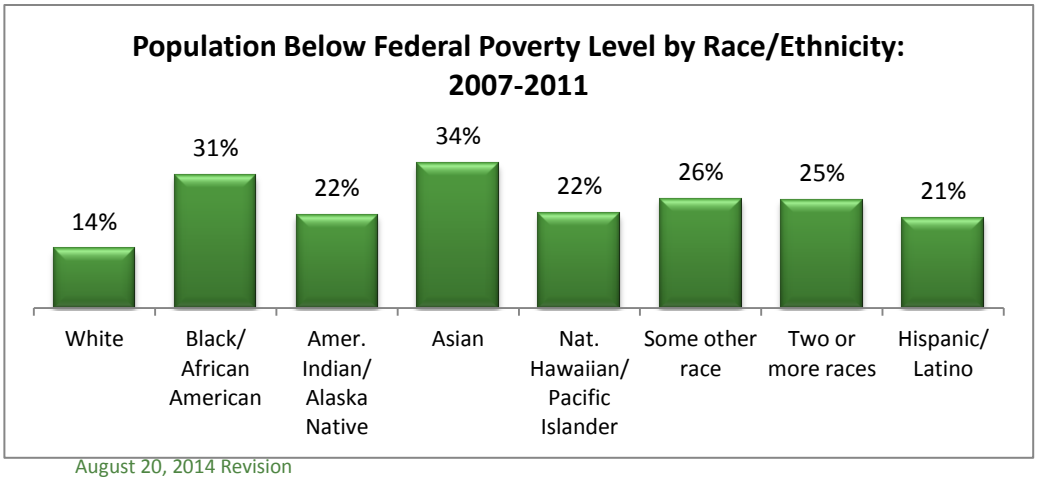
Family/ Household Size	Poverty Guideline
1	$11,170
2	$15,130
3	$19,090
4	$23,050
5	$27,010
6	$30,970
7	$34,930
8	$38,890

For families/households with more than 8 persons, add $3,960 for each additional person.

Populations Living Below the Federal Poverty Level: 2007-2011

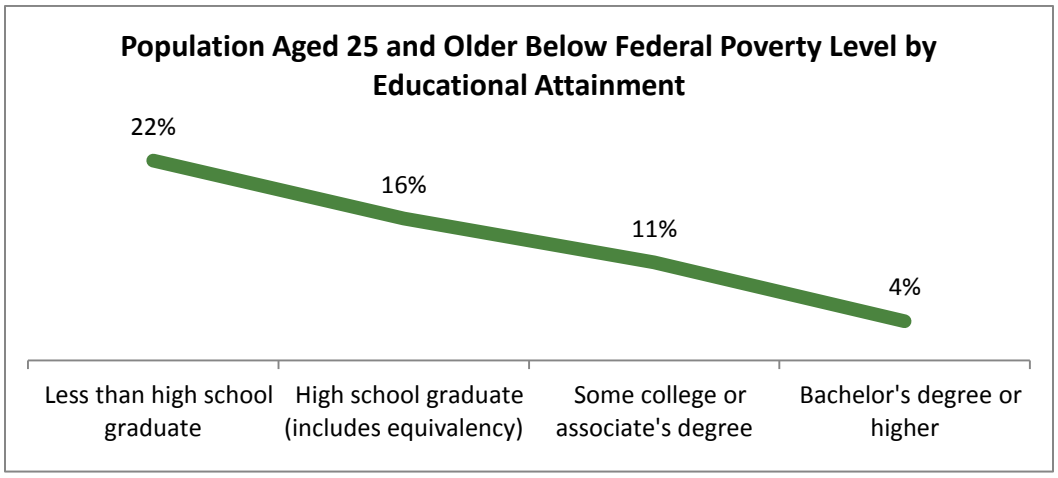
Report Area	All People	Households	Families	Children
Yolo County	19%	16%	10%	18%
Regions				
Central	11%	11%	8%	14%
East	**19%**	15%	**14%**	**27%**
North East	**22%**	**18%**	**17%**	**41%**
North West	10%	8%	5%	15%
South	**26%**	**21%**	9%	11%
South East	10%	4%	6%	**37%**
South West	15%	16%	**11%**	**19%**

The burden of poverty falls heavy on us all, but even more so on children. Those regions that exceed the county's rate for children below the poverty level include the North East (41%), South East (37%), East (27%), and South West (19%) regions. The North East region exceeds the county rate for all categories of those living below the poverty level.



Poverty is not experienced equally among all populations. Among the different races in Yolo County, Asians, and Black/African Americans experience poverty more than Whites do.

One's educational attainment has a dramatic effect on the likelihood one will experience poverty. For those aged 25 years and older In Yolo County, 22% of those who have less than a high school diploma live in poverty. Conversely, only 4% of those with a bachelor's degree or higher live in poverty.



HOUSEHOLD COSTS

Median Value of Owner-Occupied Housing Unit: 2007-2011

Region	Amount
Central	$326,400
East	$275,600
North East	$304,000
North West	$293,800
South	$574,000
South East	$494,000
South West	$313,300

There are 69,860 occupied housing units in Yolo County with 54% owner-occupied and 46% renter-occupied. The median value of an owner-occupied housing unit in Yolo County is $365,500, which is far lower than the state median value of $421,600.

The median value of owner-occupied housing units ranges from a low of $275,000 in the East region to a high of $574,000 in the South region.

Monthly Owner Costs as a Percentage of Household Income: 2007-2011

Report Area	Percent
Yolo County	43%
Regions	
Central	**45%**
East	**52%**
North East	**63%**
North West	**52%**
South	31%
South East	42%
South West	**50%**

The U.S. Department of Housing and Urban Development considers households to be burdened if they spend more than 30% of their income on housing costs. Some examples of owner costs include mortgages, real estate taxes, various insurances, utilities, fuels, mobile home costs, and condominium fees. A housing unit may be a house, an apartment, a mobile home, a single room or group of rooms. The number of households burdened by housing costs provides a measure of the cost of living and a proxy for evaluating disposable income levels in a community.

The percentage of housing units with a mortgage whose owner expenses exceed 30% of their monthly gross household income is 43% for Yolo County.

The economic burden of owner costs exceeds the county rate in all regions except for the South and South East regions.

Gross Rent as a Percentage of Household Income: 2007-2011	
Report Area	**Percent**
Yolo County	50%
Regions	
Central	42%
East	44%
North East	20%
North West	40%
South	**59%**
South East	**65%**
South West	37%

The percentage of renter households whose gross rent (contracted rent amount plus estimated average monthly utility costs) is 30% or more of their household income is half of the renter households in Yolo County.

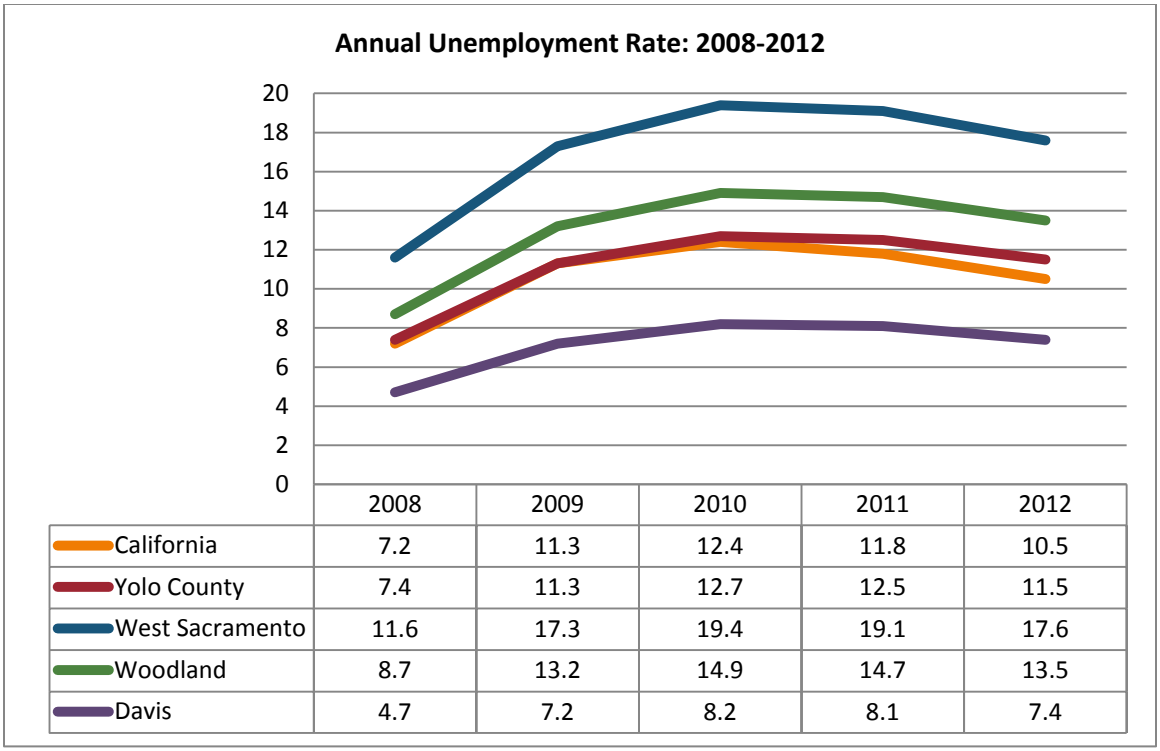
The economic burden of renter households exceeds the county rate in only the South and South East regions.

EMPLOYMENT

Steady employment in safe working conditions often means a steady paycheck, income benefits, and stability necessary for good health. Unemployment creates financial instability and barriers to insurance coverage, health services, healthy food, and other necessities that affect health. Furthermore, long-term unemployment has large negative effects on mental health due to elevated levels of anxiety, frustration, disappointment, alienation, and/or depression[4].

The unemployment rate from 2008 to 2012 of the civilian non-institutionalized population age 16 and over (non-seasonally adjusted) peaked in 2010 and has gradually declined over the past two years in Yolo County. Generally, the unemployment rate in Yolo County mirrored that of the state, but has not recovered as quickly. Unemployment rates were collected for the three metropolitan areas in Yolo County: West Sacramento, Woodland, and Davis. All three resemble the curvature represented in the unemployment rates of the state and Yolo County. However, West Sacramento has experienced unemployment rates roughly six points higher than the county. Woodland has also experienced unemployment rates higher than the county, typically being two points higher, and Davis has experienced unemployment rates four points lower than the county.

[4] Arthur Goldsmith and Timothy Diette' "Exploring the Link Between Unemployment and Mental Health Outcomes," http://www.apa.org/pi/ses/resources/indicator/2012/04/unemployment.aspx (April 2012)



	2008	2009	2010	2011	2012
California	7.2	11.3	12.4	11.8	10.5
Yolo County	7.4	11.3	12.7	12.5	11.5
West Sacramento	11.6	17.3	19.4	19.1	17.6
Woodland	8.7	13.2	14.9	14.7	13.5
Davis	4.7	7.2	8.2	8.1	7.4

EDUCATIONAL ATTAINMENT

Educational attainment influences health and longevity through a myriad of complex influences that are not quite fully understood. Increased educational attainment reduces the risk of chronic diseases compared to a lack of or limited educational attainment. Despite the difference in health behaviors between better educated and less educated individuals, health behaviors alone cannot explain all of the disparities in health outcomes between these two groups[5]. Educational attainment can lead to improved health through increasing health knowledge, higher incomes, social and psychological aspects such as control beliefs, social capital, and social support.

Nineteen percent of Yolo County residents age 25 years or older have an educational attainment of a high school diploma and 38% have a bachelor's degree or higher. The South region has over two-thirds of its residents 25 years and older with a bachelor's degree or higher.

Educational Attainment Level, Age 25 and Older: 2007-2011

Report Area	Less than a High School Diploma	High School Graduate	Bachelor's Degree or Higher
California	19%	21%	30%
Yolo County	16%	19%	38%
Regions			
Central	**21%**	23%	25%
East	**19%**	23%	25%
North East	**36%**	24%	17%
North West	**26%**	30%	18%
South	4%	8%	69%
South East	16%	18%	31%
South West	**26%**	26%	23%

[5] David Cutler and Adriana Lleras-Muney, "Education and Health, Policy Brief" http://www.npc.umich.edu/publications/policy_briefs/brief9/policy_brief9.pdf (March 2007)

GRADUATION RATES

Within Yolo County for the class of 2011-2012, 86% of public school students received their high school diploma within four years. This is above the state rate of 79%. The dropout rate[6] for Yolo County was 10% compared to 13% statewide.

The Washington Unified School District was slightly below the county graduation rate with 85% of its student population graduating on time. There were several disparities between racial and ethnic groups with American Indian or Alaskan Natives, Black/African Americans, and Hispanic/Latinos being below the county rate. The graduation and dropout rates for the school districts and by race and ethnicity are listed below.

Graduation and Dropout Rates: 2011-2012

Report Area	Graduation Rate (%)	Dropout Rate (%)
Yolo County	86	10
School Districts		
Davis Joint Unified	95	2
Esparto Unified	88	**12**
Washington Unified	**85**	**11**
Winters Joint Unified	89	6
Woodland Joint Unified	88	8

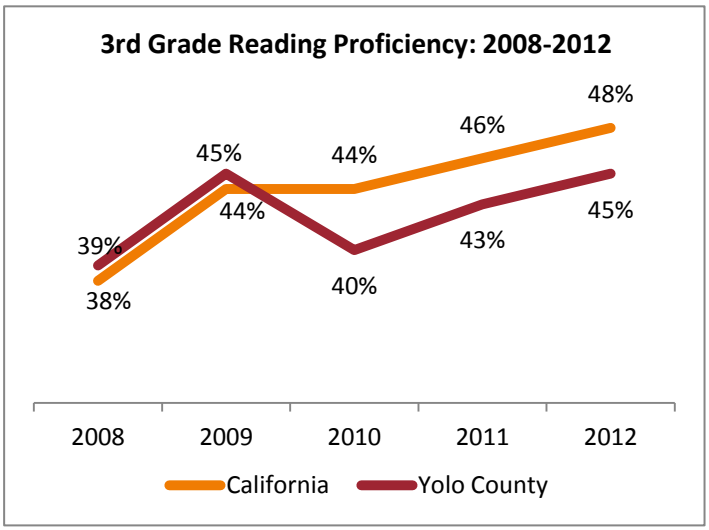
Graduation and Dropout Rates by Race/Ethnicity: 2011-2012

Race/Ethnicity	Graduation Rate (%)	Dropout Rate (%)
Hispanic or Latino of Any Race	**81**	**15**
American Indian or Alaska Native	**67**	**17**
Asian	92	6
Pacific Islander	93	7
Filipino	90	5
African American	**76**	**22**
White	90	6
Two or More Races	89	4

THIRD GRADE READING PROFICIENCY

Third grade reading scores are highly correlated with later academic success; generally, third grade marks the transition from "learning to read" to "reading to learn"[7]. Students with limited reading abilities have a harder time keeping up across multiple subjects and are at risk of falling behind academically.

The percentage of third graders scoring proficient or higher in English Language Arts (reading) on the California Standards Test increased between 2008 and 2012 countywide. In 2012, 45% of Yolo County third graders were proficient or advanced in English Language Arts, up from 39% in 2008. In recent years, the 3rd grade reading



[6] Dropout rate is the rate of students that leave the 9-12 instructional system without a high school diploma, GED, or special education certificate of completion and do not remain enrolled after the end of the 4th year.

[7] Musen, L., Early reading proficiency. http://www.annenberginstitute.org/pdf/LeadingIndicator_Reading.pdf (2010)

proficiency lags slightly behind the state totals.

All of the school districts in Yolo County scored below the countywide percentage with the exception of the Davis Joint Unified School District.

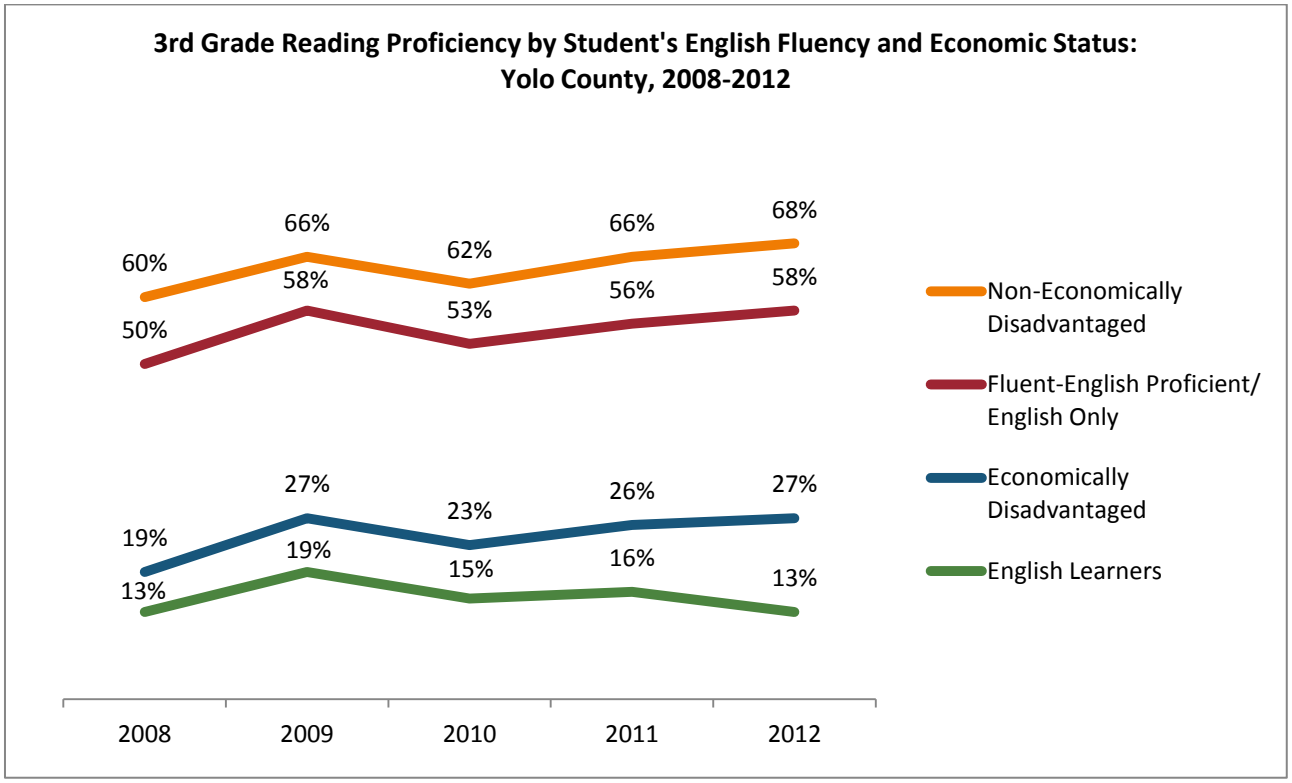
There are also discrepancies among different races, ethnicities, and school districts.

3rd Grade Reading Proficiency by School District					
School District	**2008**	**2009**	**2010**	**2011**	**2012**
Davis Joint Unified	64%	68%	64%	67%	66%
Esparto Unified	**29%**	**31%**	LNE	LNE	LNE
Washington Unified	**29%**	**35%**	**32%**	**39%**	**40%**
Winters Joint Unified	**31%**	**35%**	**27%**	**34%**	**31%**
Woodland Joint Unified	**28%**	**38%**	**31%**	**31%**	**36%**
Delta Elementary Charter District	N/A	**31%**	43%	**21%**	**32%**

LNE (Low Number Event) refers to data that have been suppressed because there were fewer than 20 estimated students.

Asian, Filipino, and White students score above the countywide percentage, whereas Black/African American and Hispanic/Latino students score below the countywide percentage.

Reading proficiency in 3rd grade varies widely by socioeconomic status[8], English language fluency. In graph below, the data show large discrepancies between non-economically disadvantaged students and fluent-English and English only students compared to economically disadvantaged and English language learners. For example, in 2012,only 13% of Yolo County English Language learners were proficient in reading, compared to 58% Fluent-English and English only students. While the countywide 3rd grade reading proficiency has gradually risen over the past five years, it remains relatively stagnant among English language learners students.



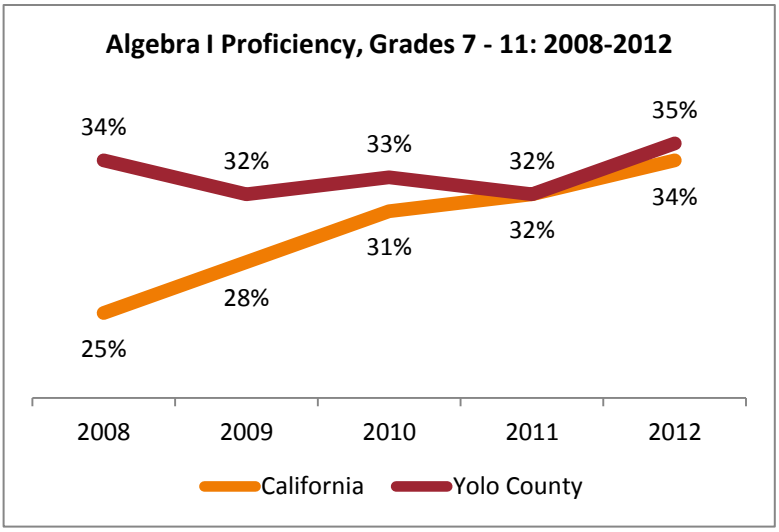
[8] Students are considered "economically disadvantaged" if they are eligible for the free/reduced price lunch program or if neither of whose parents have received a high school diploma.

ALGEBRA I PROFICIENCY

Basic math skills are essential to navigate through life. Basic arithmetic skills are required for everyday computations as well as success in our technology-based society. Mastering algebra is critical as it is a high school graduation requirement for all California students, and algebra is considered "a foundation and language system on which higher order mathematics, science, technology, and engineering courses are built."[9] Competence in mathematics is associated with readiness for college and the workplace.

The following data are the percentage of public school students tested in grades 7 through 11 who scored proficient or advanced on the Algebra I California Standards Test (CST). Years presented are the final year of a school year.

Over the past five years, the county has outperformed the state, but the gap is narrowing. Statewide the percentage of students in grades 7 through 11 who scored proficient or higher on the Algebra I CST increased from 25% to 34% between 2008 and 2012; however, the countywide percentage was stagnant. The Davis Joint Unified School District scored well above the countywide percentage whereas the rest of the school districts in the county appeared to struggle.



Algebra I Proficiency by School District					
School District	**2008**	**2009**	**2010**	**2011**	**2012**
Davis Joint Unified	70%	68%	73%	69%	64%
Esparto Unified	**21%**	**23%**	34%	**28%**	LNE
Washington Unified	**28%**	**21%**	**22%**	**25%**	**28%**
Winters Joint Unified	**30%**	33%	**23%**	**29%**	**23%**
Woodland Joint Unified	**22%**	**18%**	**18%**	**19%**	**26%**
LNE (Low Number Event) refers to data that have been suppressed because there were fewer than 20 estimated students.					

Algebra I proficiency varies dramatically by race/ethnicity and socioeconomic status. Asians and Whites have a higher percentage of public school students scoring proficient or advanced compared to Black/African American and Hispanic/Latino students. Students who are considered economically disadvantaged also had a fewer percentage of students score proficient or advanced in Algebra I.

[9] Musen, L. Pre-algebra and algebra enrollment and achievement. Providence, RI: Annenberg Institute for School Reform, Brown University. Retrieved from: http://www.annenberginstitute.org/pdf/LeadingIndicator_Math.pdf (2010)

Algebra I Proficiency by Race/Ethnicity and Socioeconomic Status					
Report Population	**2008**	**2009**	**2010**	**2011**	**2012**
Race/Ethnicity					
African American/Black	**25%**	**27%**	**28%**	LNE	**25%**
Asian	59%	57%	61%	49%	65%
Hispanic/Latino	**18%**	**16%**	**18%**	**18%**	**20%**
White	46%	44%	46%	48%	47%
Socioeconomic Status					
Economically Disadvantaged	**21%**	**17%**	**19%**	**19%**	**21%**
Non-Economically Disadvantaged	45%	48%	47%	48%	51%

LNE (Low Number Event) refers to data that have been suppressed because there were fewer than 20 estimated students.

SOCIAL AND MENTAL HEALTH

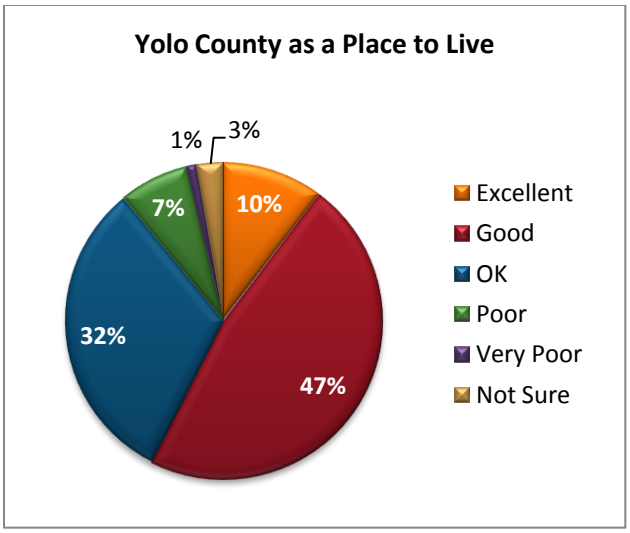
Mental health refers to the successful performance of mental function, resulting in productive activities, the ability to form and maintain fulfilling relationships with other people, and the ability to adapt to change and cope with adversity. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior. Mental health affects our physical and social health.

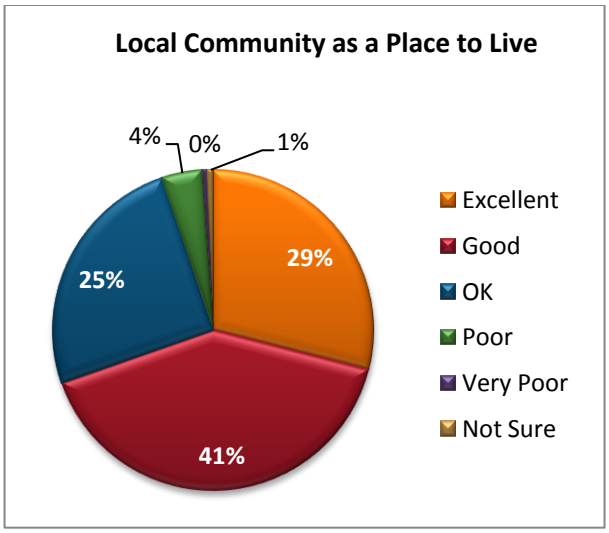
PERCEPTIONS OF QUALITY OF LIFE

The Community Themes and Strengths Assessment (CTSA) survey respondents were asked to rate their perception of the quality of life in their community and that of Yolo County as a whole. Survey respondents were also asked to rate certain components of quality of life: place to live, community involvement, and healthy community. The responses are grouped by Yolo County and the local community. The responses for local community are stratified by sex, ethnicity, race, household income, and age. Due to the low number of responses from Native American/Indigenous Persons and Native Hawaiian or other Pacific Islander, these two race categories were combined (NA/IP & NH/PI).

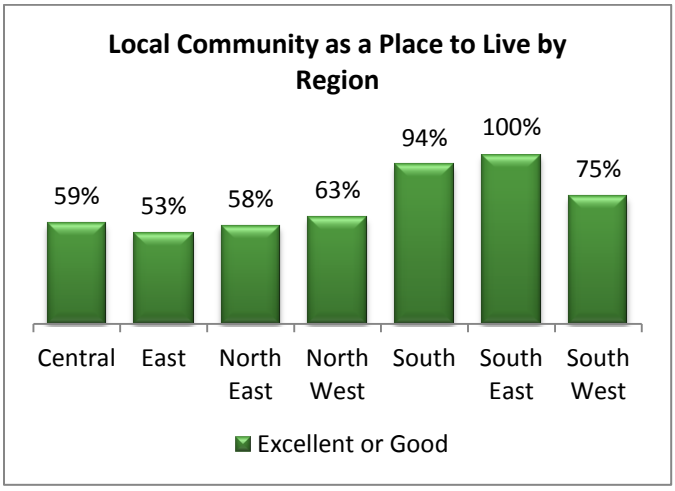
PLACE TO LIVE

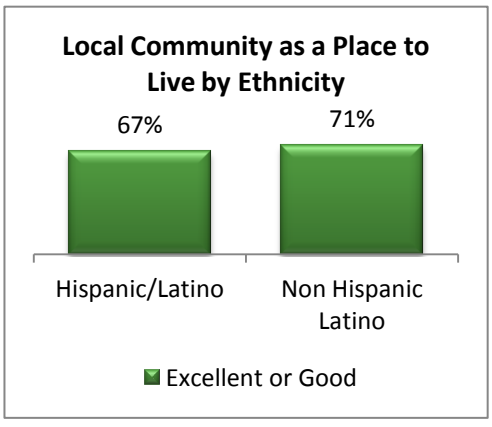
Overall, 57% of respondents view Yolo County as either a “good” or an “excellent” place to live compared to 70% for their local community. Slightly more respondents (811) answered regarding their local community compared to those who answered regarding Yolo County (771).

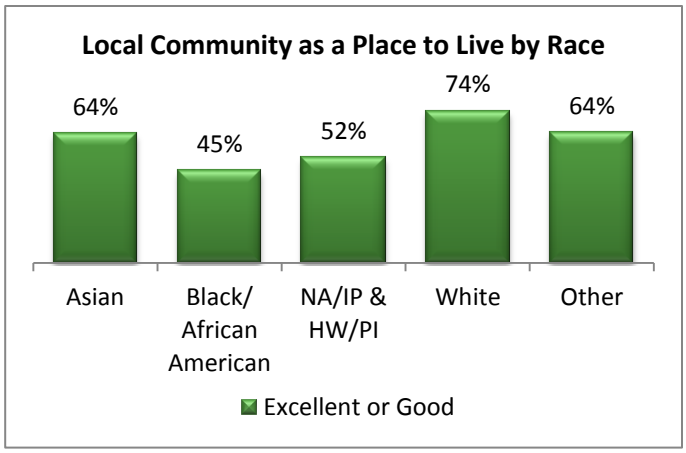


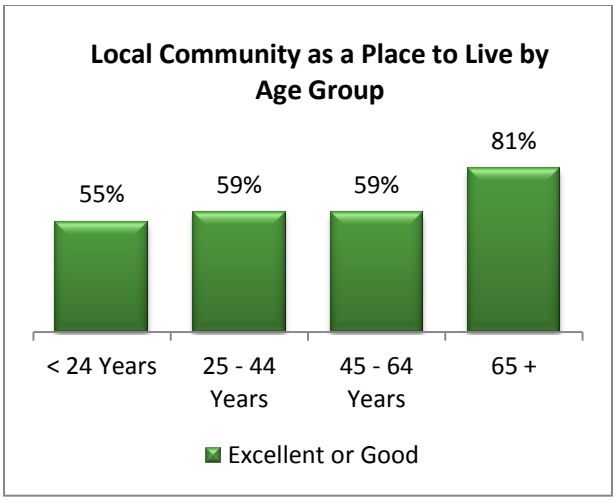


The perception of the respondents' local community as either "good" or "excellent" as a place to live ranged from a low of 53% in the East region to 100% for the South East region. It should be noted that the South East region consisted of a low number of responses (9). There were no large disparities between ethnicities regarding perception of their community as a place to live. Males and individuals above the age of 65 tended to rate their local communities more favorably. As household income increased, so did the positive perception of their local community as a place to live. Whites, Asians, and those who identified themselves as another race, showed more favorable perceptions of their local community as well.



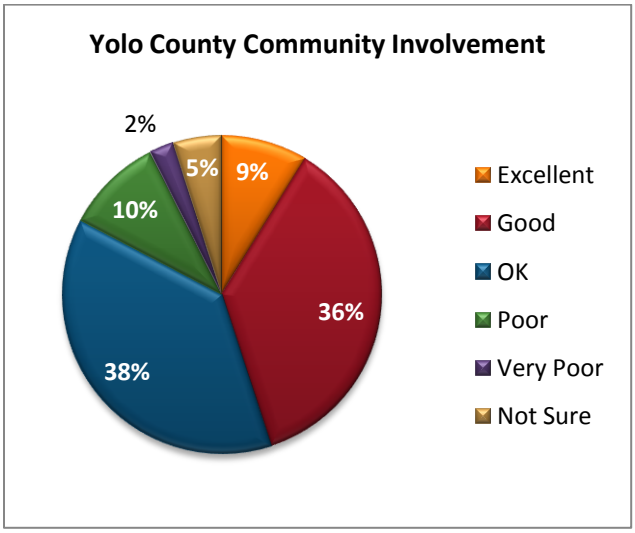


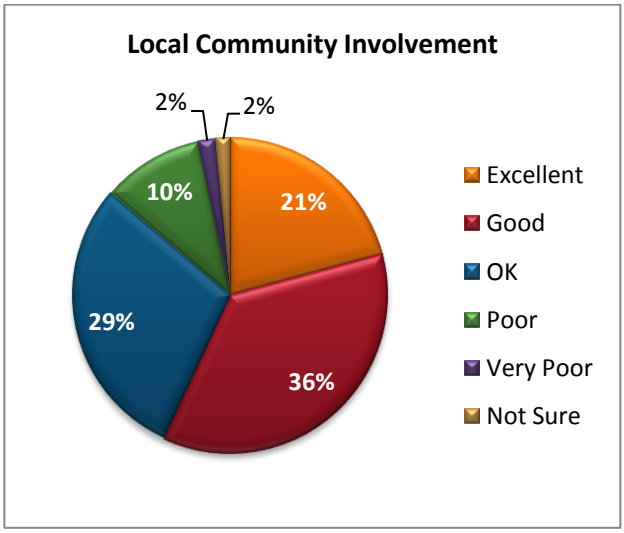




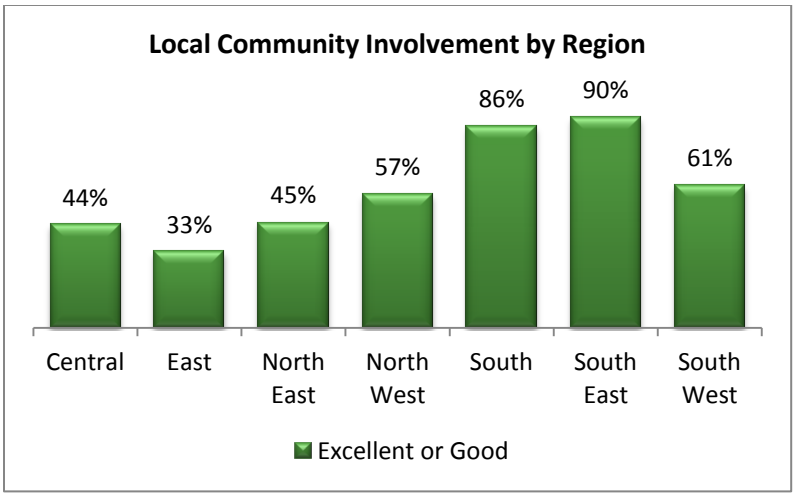
COMMUNITY INVOLVEMENT

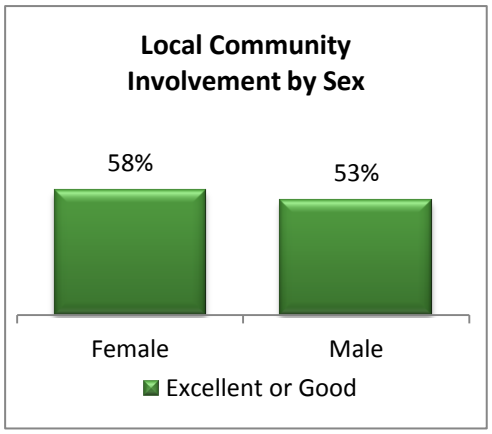
Community involvement in Yolo County as a whole was perceived as “good” or “excellent” by 45% of respondents; 57% viewed their local community as having “good” or “excellent” community involvement.

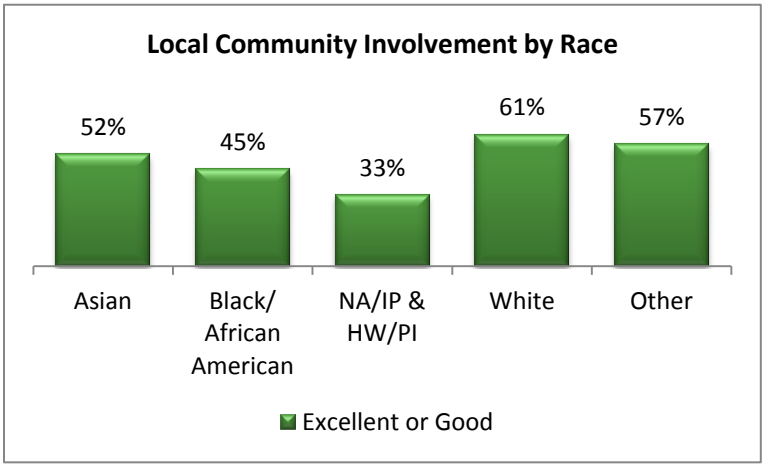


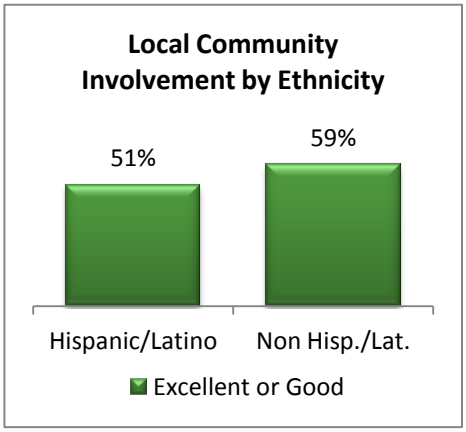


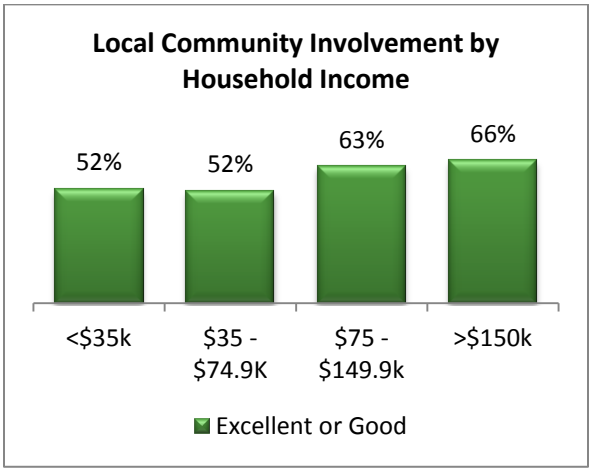
Respondents from the South (86%) and South East (90%) regions rated local community involvement most favorably, compared to 33% from the East region. The highest proportion of respondents rating local community involvement as "poor" came from the Central (26%) and East (19%) regions. Favorable levels of local community involvement were perceived differently between sexes and ethnicities, 58% of females versus 53% of males, and 59% of non-Hispanic/Latino respondents versus 51% of Hispanic/Latino respondents. Less than 50% of respondents of Black/African American, Native American/Indigenous Persons, Native Hawaiian or other Pacific Islander descent rated their local community involvement as "good" or "excellent". Favorable perceptions tended to increase with household income and age.

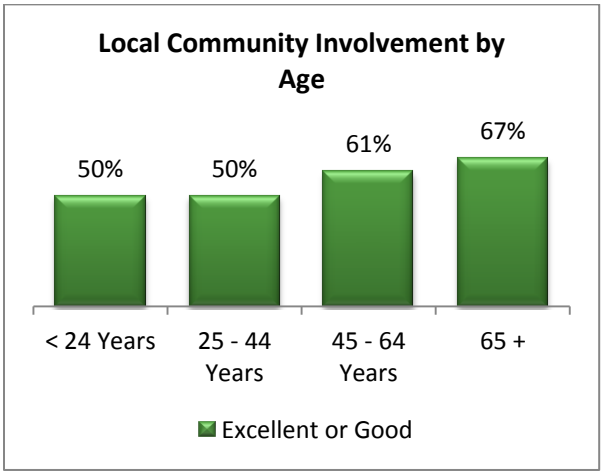

Local Community Involvement by Region
44%
33%
45%
57%
86%
90%
61%
Central
East
North East
North West
South
South East
South West
Excellent or Good


Local Community Involvement by Sex
58%
53%
Female
Male
Excellent or Good


Local Community Involvement by Race
52%
45%
33%
61%
57%
Asian
Black/ African American
NA/IP & HW/PI
White
Other
Excellent or Good

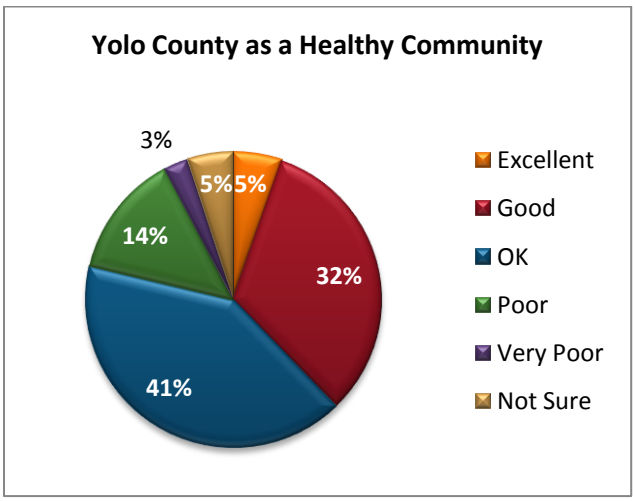

Local Community Involvement by Ethnicity
51%
59%
Hispanic/Latino
Non Hisp./Lat.
Excellent or Good

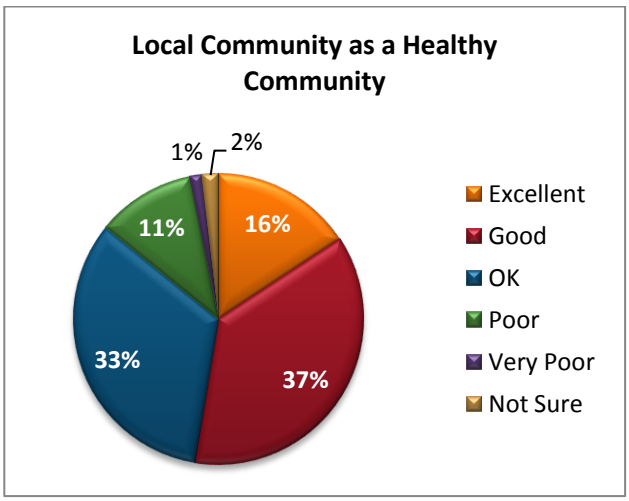

Local Community Involvement by Household Income
52%
52%
63%
66%
<$35k
$35 - $74.9K
$75 - $149.9k
>$150k
Excellent or Good


Local Community Involvement by Age
50%
50%
61%
67%
< 24 Years
25 - 44 Years
45 - 64 Years
65 +
Excellent or Good

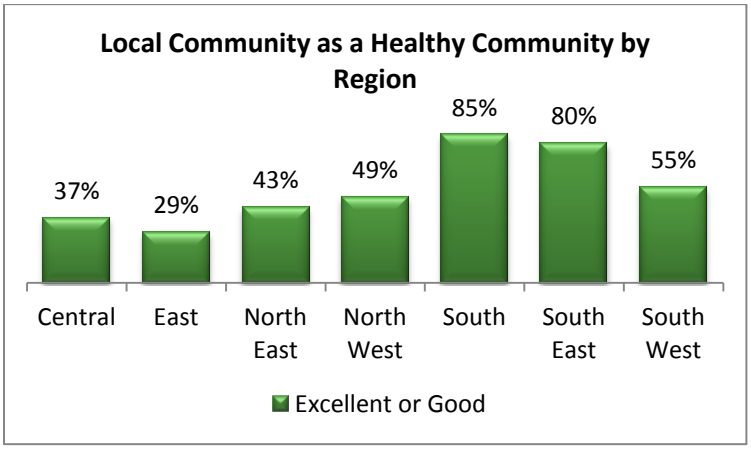
HEALTHY COMMUNITY

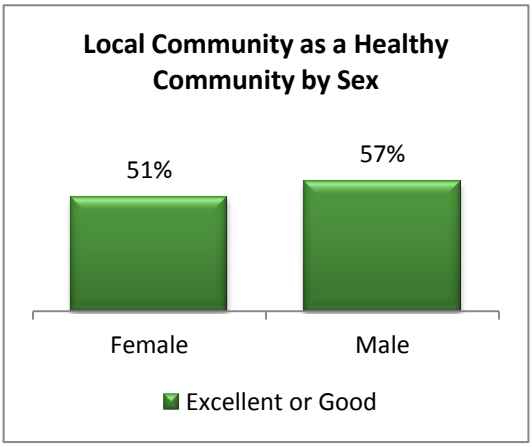
Respondents were asked to rate their local community and all of Yolo County as a "healthy community". Only 37% of respondents rated Yolo County as "good" or "excellent", where as 53% rated their local community as being "good" or "excellent".

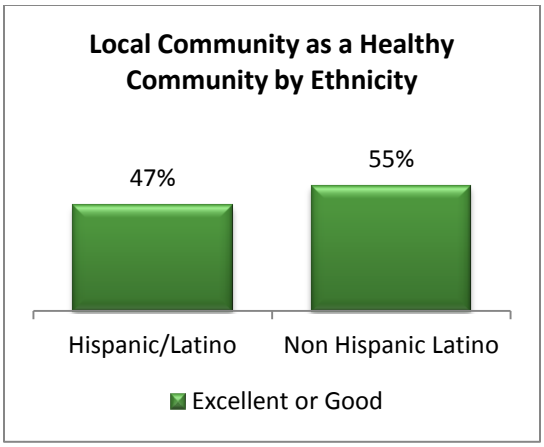


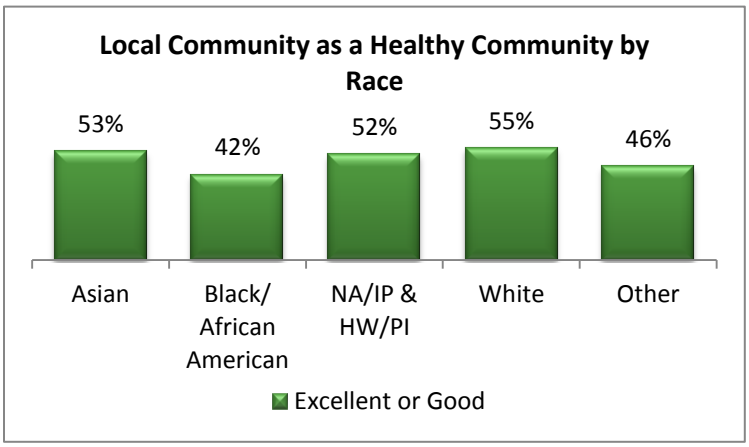


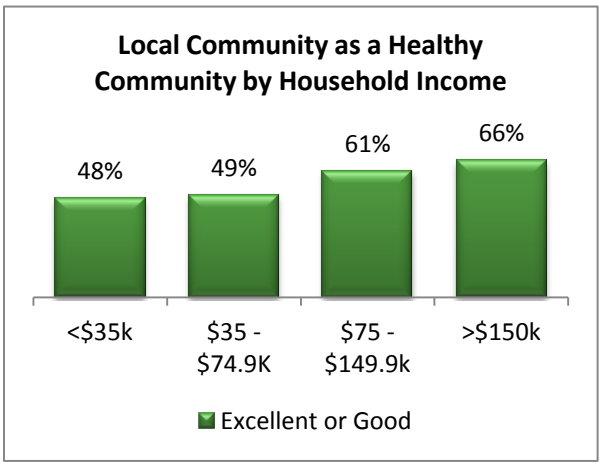
The South and South East regions had the highest percentage of respondents viewing their local community as either "good" or "excellent" as a healthy community. The Central and East regions had the lowest percentage of respondents view their local community as a healthy community. However, 46% and 47% of the respondents from the Central and East regions, respectively, stated their local community was "OK" as a healthy community. There were slight differences between the sexes and ethnicities, with perceptions of community health as "good" or "excellent" higher among males and non-Hispanic/Latino respondents. There was a fairly even distribution among the races ranging from 42% to 55% viewing their local community as being "good" or "excellent" as a healthy community. Perception also tended to be more favorable in respondents as age and household income increased.

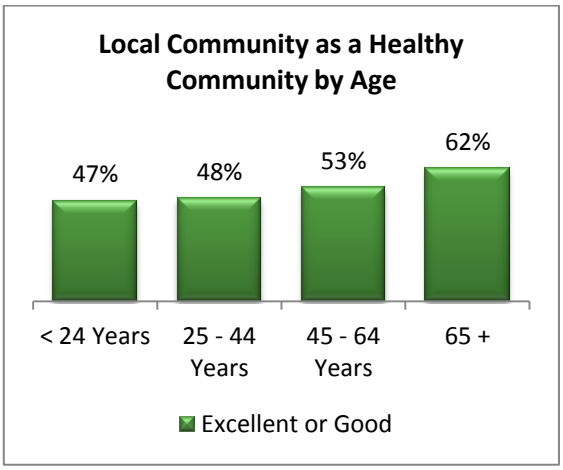






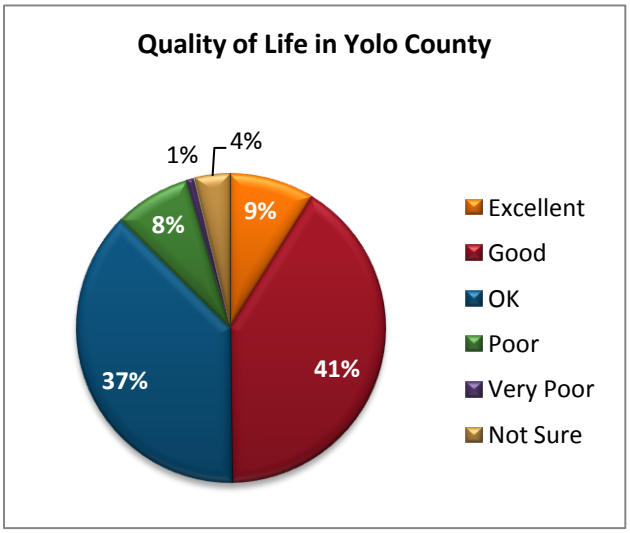


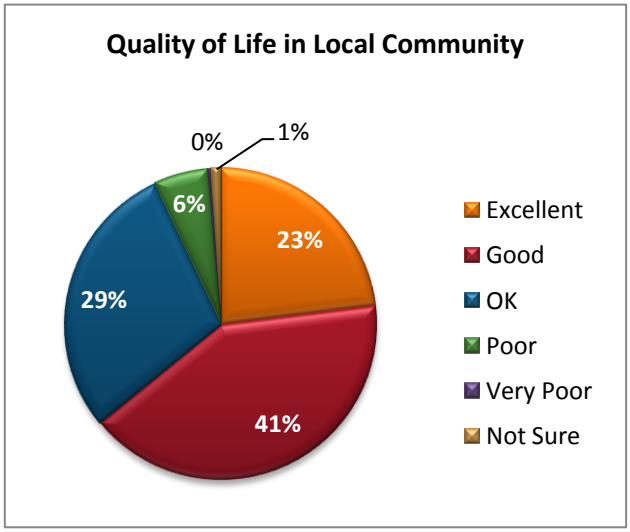




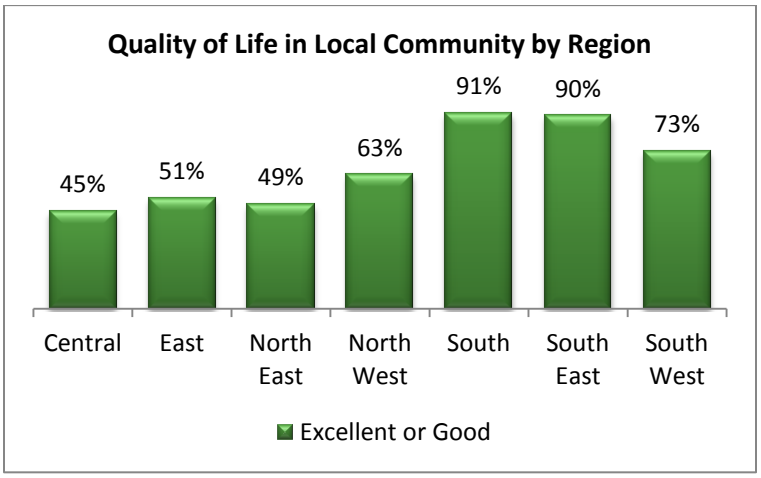
QUALITY OF LIFE

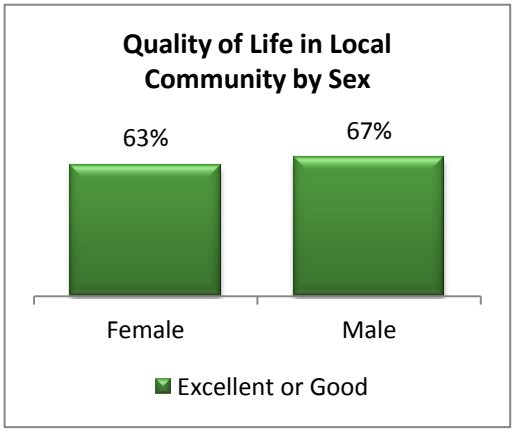
Quality of life in Yolo County as a whole was rated as “excellent” by only 9% of respondents though 41% rated countywide quality of life as "good". In the local community, quality of life was rated as “excellent” by 23% of respondents and 41% rated the quality of life in the local community as “good”. Overall, perception of local quality of life among respondents was generally more favorable, with 64% rating quality of life favorably as either "good" or excellent".

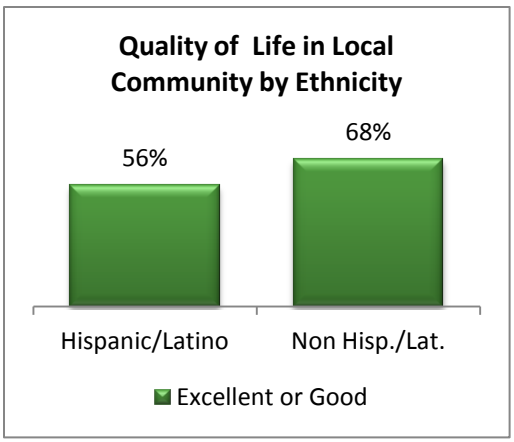


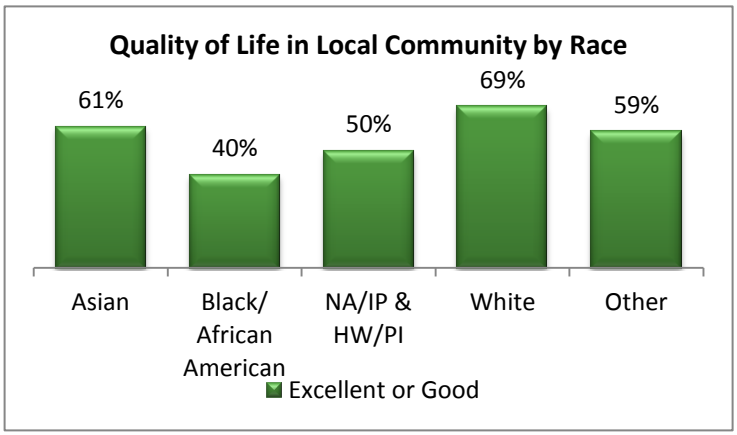


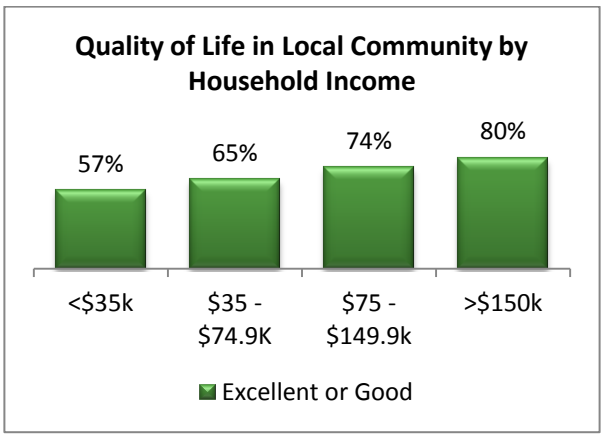
Local community quality of life was generally perceived most favorably in the South, South West, and South East regions. Perceptions of "poor" or "very poor" local quality of life were most common among respondents from the Central (9%), East (12%), and North East (8%) regions. Male respondents and respondents of non-Hispanic/Latino descent also tended to view local quality of life more favorably. Perceptions were also generally favorable among respondents identifying as Asian, White, or Other; respondents identifying as Black/African American, Native American/Indigenous Persons, and Native Hawaiian or other Pacific Islander generally perceived local quality of life as "OK". Additionally, as has been the case in other categories, perceptions of quality of life were generally more favorable with increased age and higher household income.

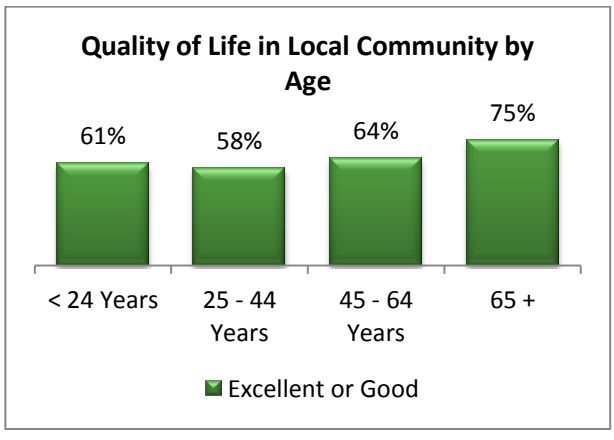












DISCUSSION

Across all measures of quality of life included in the survey (place to live, community involvement, healthy community, and quality of life), CTSA survey respondents from the South and South East regions generally viewed their communities most favorably with 89% (South) and 88% (South East)of the responses being either "excellent" or "good". Conversely, respondents from the East and South West regions least frequently gave favorable ratings on their communities with 40% and 39% of the responses being either "excellent" or "good", respectively.

Other common patterns in the survey results were that favorable perceptions of respondents were most strongly associated with White and Asian descent, higher household income, and older age. Respondents were more likely to view their own overall health favorably and less likely to view their local community favorably as a "healthy community". Because the same disparities are seen across different measures of quality of life, it is critical to note how resources and information reach groups who view their quality of life unfavorably.

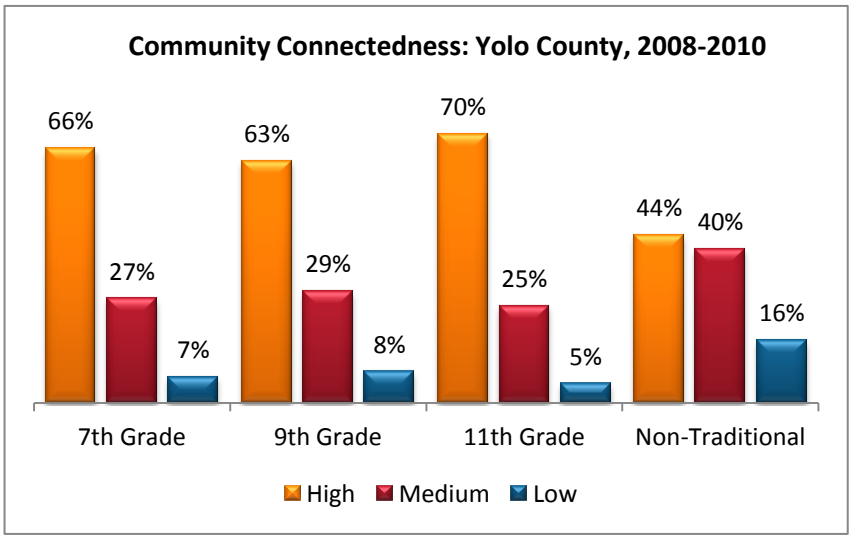
YOUTH QUALITY OF LIFE

Another important dimension of social and mental health is youth quality of life in their communities and educational settings. Quality of life includes the individual's perceptions of well-being and access to the necessities of life, which include such factors as positive expectations from caring adults, meaningful participation within the community, and connectedness at school. Sound emotional health is critical to equipping young people for the challenges of growing up and living as healthy adults. For data provided in tables, all figures in red indicate a percentage or rate that exceeds that of the county's rate.

COMMUNITY CONNECTEDNESS

Community connectedness is a summary measure that includes student reports of caring adults, high expectations from adults, and meaningful participation in the community. Communities can play a critical role in fostering resilience among children and youth, which is associated with healthy development and the avoidance of risky behavior.

Female students perceived high levels of agreement of community connectedness more frequently than their male counterparts did, though females in non-traditional schools agreed with this less so than female students countywide.



High Level of Community Connectedness by School District: 2008-2010					
Grade Level	Davis JUSD	Esparto USD	Washington USD	Winters JUSD	Woodland JUSD
7th Grade	75%	52%	64%	66%	62%
9th Grade	67%	58%	58%	61%	64%
11th Grade	74%	64%	69%	62%	68%

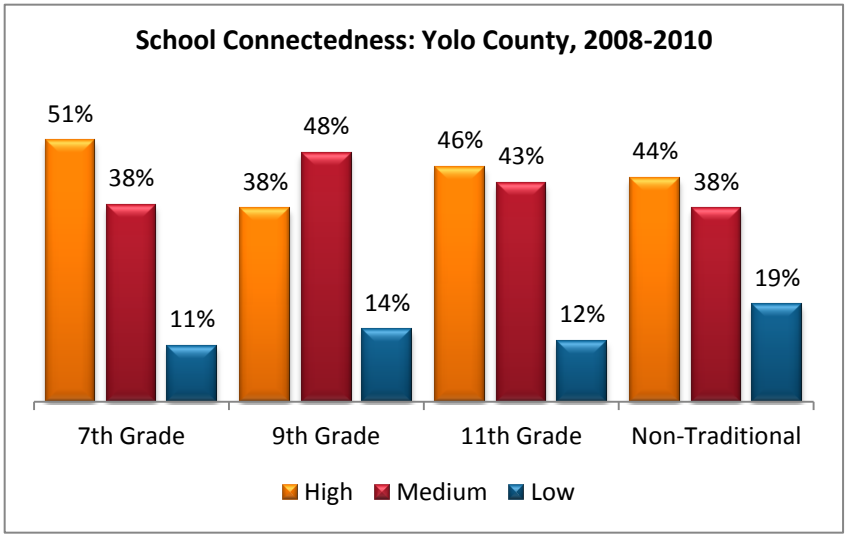
When categorized by race and ethnicity, youth perception of community connectedness differed for certain populations: only 58% of Asian and 59% of Hispanic/Latino youth had a high level of community connectedness, compared to White students at 76%.

SCHOOL CONNECTEDNESS

School connectedness is a summary measure based on student reports of being treated fairly, feeling close to people, feeling happy, and feeling part of and safe at school. When students feel connected to their schools, they are more likely to succeed academically and engage in healthy behaviors. School connectedness is a crucial indicator of youth social and mental health in a community, as low levels of school connectedness are associated with increased likelihood of substance abuse, crime, social isolation, and other mental health issues.

Both countywide and statewide, the general pattern of school connectedness was that in 7th grade, roughly half of the students reported a high level of school connectedness, but a lower percentage reported the same by 11th grade.

In Yolo County, school connectedness is consistently higher in Davis JUSD. In Woodland JUSD, "high" levels of school connectedness in 7th grade is the second highest countywide at 56%. However, by 9th grade, the percentage of students in this school district who reported high connectedness fell by over 20%.



High Level of School Connectedness by School District: 2008-2010

Grade Level	Davis JUSD	Esparto USD	Washington USD	Winters JUSD	Woodland JUSD
7th Grade	61%	**37%**	**35%**	**42%**	56%
9th Grade	**48%**	43%	**28%**	**35%**	**36%**
11th Grade	63%	50%	**28%**	**44%**	**39%**

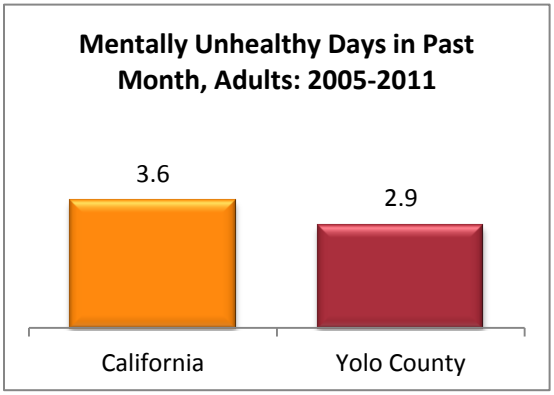
DEPRESSION AND MENTAL HEALTH

Depression is one of the most common mental health issues and encompasses several forms of depressive disorders.

"MENTALLY UNHEALTHY" DAYS

In regards to mental health, which includes stress, depression, and problems with emotions, respondents were asked how many days their mental health was not good during the past month.

Yolo County adults reported fewer "mentally unhealthy" days in the past month than adults statewide did - countywide, 2.9 days where they considered their mental health "not good", compared to statewide, 3.6.



DEPRESSION-RELATED FEELINGS

In 2011, almost 30% of high school students nationwide reported persistent feelings of sadness or hopelessness. Depression-related feelings are when a student felt so sad or hopeless almost every day for two weeks or more that they stopped doing some of their usual activities.

Depression-Related Feelings in Past Year: 2008-2010

Grade Level	California		Yolo County	
	Female	Male	Female	Male
7th Grade	31%	25%	33%	25%
9th Grade	36%	24%	38%	26%
11th Grade	37%	27%	32%	27%
Non-Traditional	47%	29%	39%	41%

Among youth, countywide and statewide, enrolled in grades 7 to 11 as well as those enrolled in non-traditional schools, more females than males reported experiencing depression-related feelings within the past year. Countywide, the gender disparity in depression-related feelings is widest in the Esparto Unified School District, and smallest in the Davis Joint Unified School District.

Depression-Related Feelings in Past Year, Davis JUSD: 2008-2010

Grade Level	Female	Male
7th Grade	24%	23%
9th Grade	30%	28%
11th Grade	29%	23%

Depression-Related Feelings in Past Year, Washington USD: 2008-2010

Grade Level	Female	Male
7th Grade	40%	26%
9th Grade	46%	28%
11th Grade	39%	37%

Depression-Related Feelings in Past Year, Winters JUSD: 2008-2010

Grade Level	Female	Male
7th Grade	25%	32%
9th Grade	50%	18%
11th Grade	42%	18%

Depression-Related Feelings in Past Year, Esparto USD: 2008-2010

Grade Level	Female	Male
7th Grade	LNE	12%
9th Grade	54%	15%
11th Grade	37%	27%

LNE indicates the fewer than 20 respondents

Depression-Related Feelings in Past Year, Woodland JUSD: 2008-2010

Grade Level	Female	Male
7th Grade	36%	27%
9th Grade	34%	25%
11th Grade	30%	29%

Depression-Related Feelings by Race/Ethnicity: Yolo County, 2008-2010

Race/Ethnicity	Percent
African American/Black	37%
American Indian/Alaska Native	39%
Asian	27%
Hispanic/Latino	31%
Native Hawaiian/Pacific Islander	37%
White	27%
Multiracial	36%
Other	36%

Additionally, rates are generally highest among American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Black/African American youth, and lowest among Asian and White youth. Davis and Washington Unified School Districts show higher rates of Black/African American and Hispanic/Latino students reporting depression.

MENTAL HEALTH-RELATED TREATMENT

Almost the same percentage of Yolo County adults felt they did not receive sufficient social and emotional support in Yolo County (24%) as statewide (25%).

Did Not Receive Adequate Social/ Emotional Support, Adults: 2005-2011	
Report Area	**Percent**
California	25%
Yolo County	24%

REASON FOR SEEKING SERVICES

According to the California Health Interview Survey (CHIS) of 2011-2012, an estimated 12% (95% CI 8.1-15.4%) of Yolo County residents felt that they might need to see a professional because of problems with their mental health or alcohol/drug use within the past year. This is slightly lower than but not significantly different from the statewide estimate of 16% (95% CI 15.2%-16.3%).

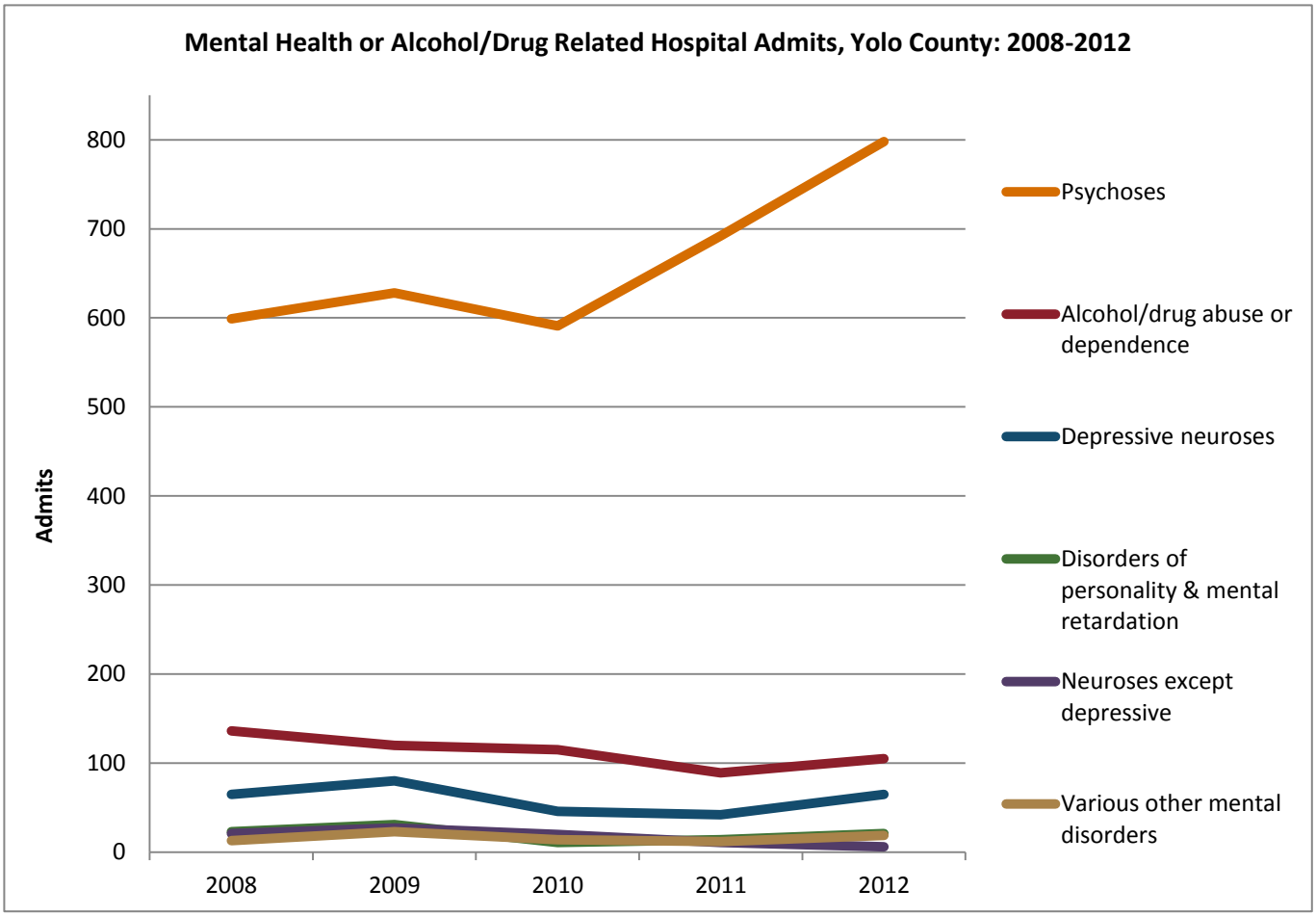
Reason for Seeking Treatment, Adults: 2011/2012		
Reason for Seeking Treatment	**California**	**Yolo County**
Mental-emotional Problem	91%	92%
Alcohol-drug Problem	4%	5%
Both	5%	3%

The CHIS respondents who stated that they needed professional help were then asked whether they received treatment or not for their mental health issue. Fifty-eight percent stated that they received treatment. For those respondents who did not seek treatment, the reasons for not seeking treatment were not clarified in the survey.

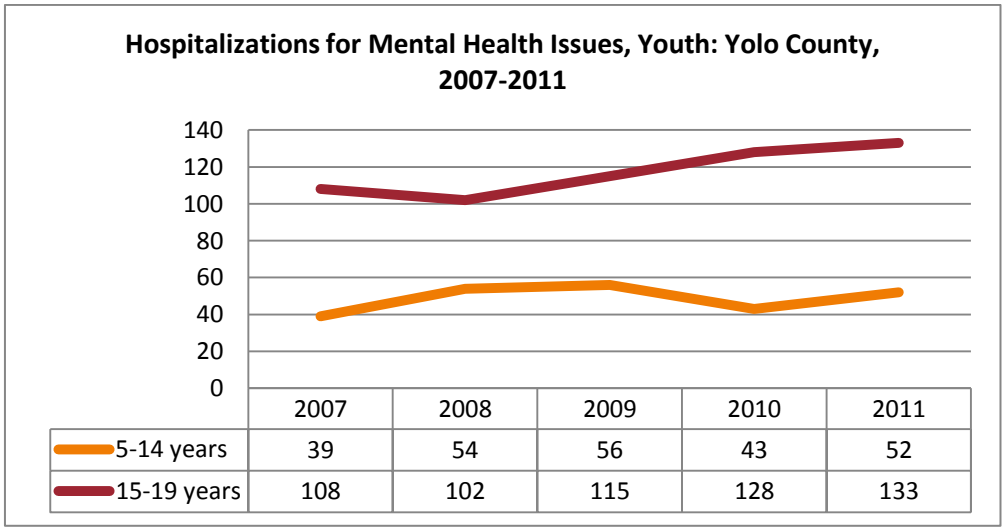
Of those seeking treatment, 92% sought treatment for mental-emotional problems, 5% for alcohol-drug problems, and 3% for both; all of these estimates coincide with the statewide estimates.

HOSPITALIZATIONS

Overall, the rate of hospitalizations for mental health diagnoses has been trending upward since 2008. Most significantly, among the diagnostic groups for mental health or substance abuse-related hospital admissions, hospitalizations related to alcohol abuse or dependence have decreased, while hospitalization for psychoses have considerably increased. In 2012, there was roughly an 8 to 1 ratio of psychoses to alcohol/drug abuse hospitalizations for mental health issues.



In 2011, there were 11,687 hospitalizations for mental health issues among children ages 5 to 14 in California (a rate of 1.2 per 1,000), and 23,514 among youth ages 15 to 19 (4.2 per 1,000). For Yolo County, the rate of children aged 5 to 14 hospitalized for mental health issues is slightly higher at 2.9; the rate among youth aged 15 to 19 is higher at 8.8 than that of the state. From 2007 to 2011, Yolo County has seen an increase in hospitalizations for mental health issues among children and youth.

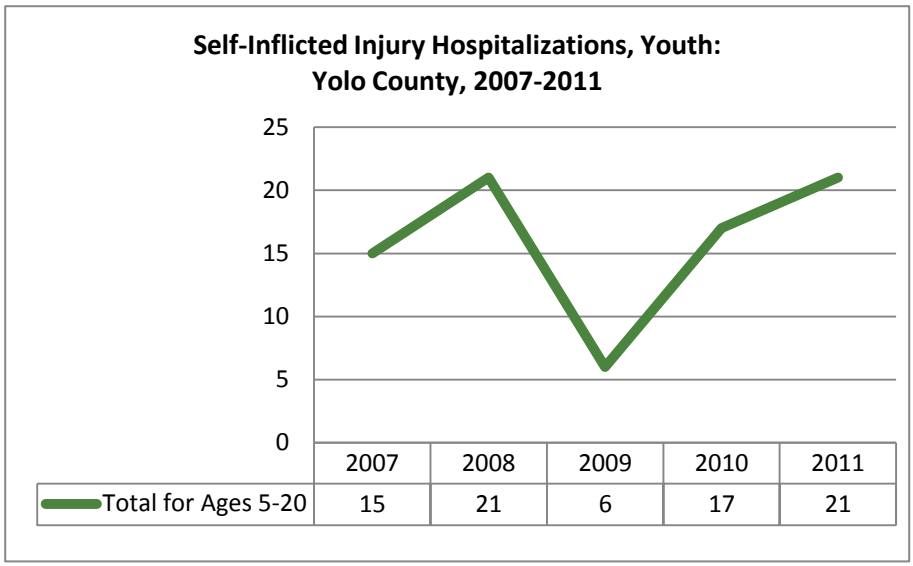


	2007	2008	2009	2010	2011
5-14 years	39	54	56	43	52
15-19 years	108	102	115	128	133

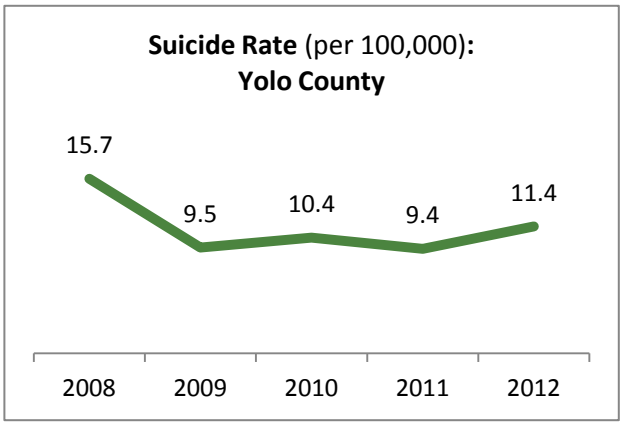
SUICIDE AND SELF-INFLICTED INJURY

Suicide is considered a major preventable mental health problem in the U.S. and is the third leading cause of death for youth ages 10 to 24 nationwide.

In Yolo County, an estimated 18% of high school freshmen and 11% of high school juniors stated they had seriously considered attempting suicide in the past month.



In Yolo County, there has been a net increase in hospitalizations of youth aged 5 to 20 for self-inflicted injuries. Compared to adults, adolescents are at heightened risk for self-injurious behavior (e.g., cutting, scratching, etc.), but these behaviors typically are not suicide attempts. The reasons for adolescent self-injurious behavior are not fully understood, though it may occur for a variety of reasons, such as coping with intense psychological distress[10]. Tracking of suicidal ideation is important because it serves as an early warning sign of poor coping skills, and the need for immediate intervention to help prevent subsequent and more serious suicidal attempts.



Overall, the suicide rate in Yolo County including adults has decreased, with the highest number of suicides apparently among Black/African Americans and Whites.

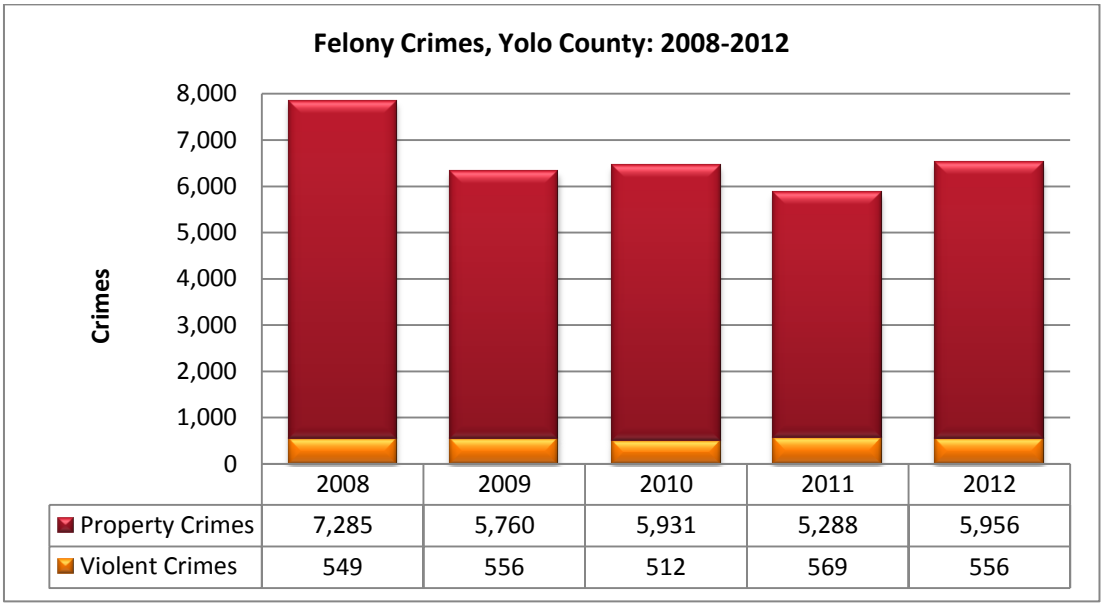
Statewide youth suicides, aged 5 to 24, have seen an increase in recent years; Yolo County has seen a small number of youth suicides from 2007 to 2011.

CRIME

A crime is an act specifically prohibited by law, or failure to perform an act specifically required by law, for which punishment is prescribed. Crime in a neighborhood causes fear, stress, feeling unsafe, and poor mental health. Fear of crime can limit mobility or physical activity in a neighborhood and inhibit social interactions.

The total number of felony crimes has dropped in Yolo County from 7,834 to 6,512 for the years 2008 to 2012.

[10] Nock, M. K., & Prinstein, M. J. (2005). Contextual features and behavioral functions of self-mutilation among adolescents. Journal of Abnormal Psychology. Retrieved from: http://www.wjh.harvard.edu/~nock/nocklab/Nock_Prinstein_JAbP2005.pdf

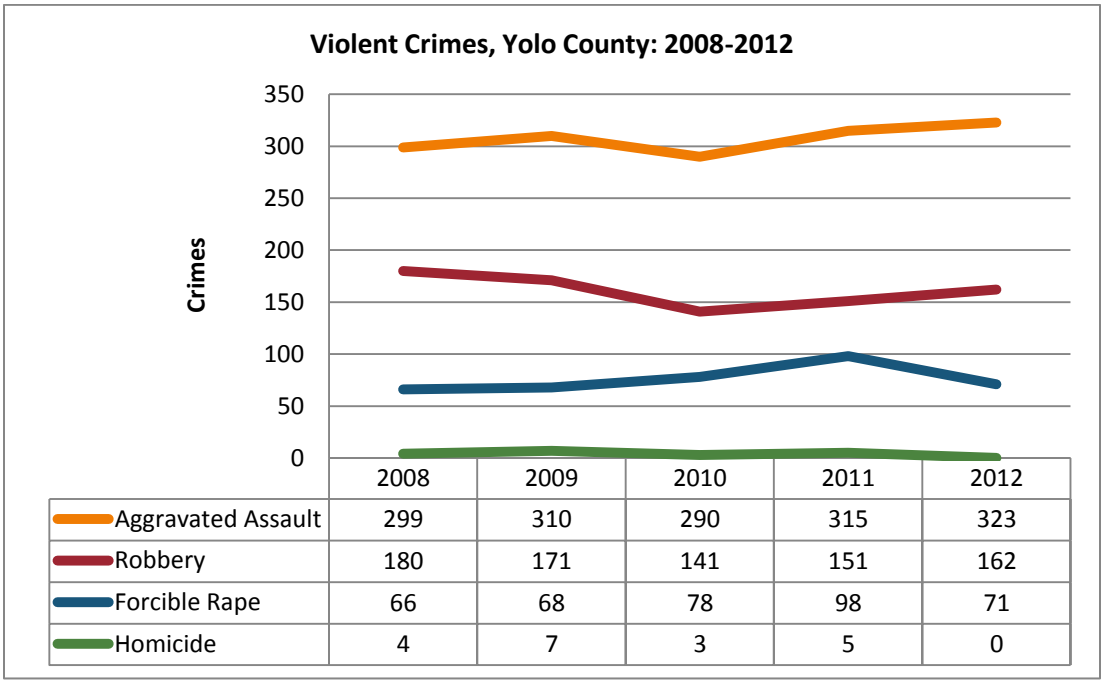


	2008	2009	2010	2011	2012
Property Crimes	7,285	5,760	5,931	5,288	5,956
Violent Crimes	549	556	512	569	556

FELONY: VIOLENT CRIMES

Violent crimes are those offenses that involve force or threat of force. Violent crimes are composed of four offenses: murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault. Between 2008 and 2012, the number of violent crimes remained about the same countywide.

The occurrence of forcible rape increased by 48% in 2011 compared to 2008, but dropped back down to 2008 levels in 2012. Aggravated assault particularly involving the use of knives or other cutting instruments, increased slightly by 8% from 2008 to 2012. The overall occurrence of robbery has decreased, specifically for robberies involving use of firearms or cutting instruments, and those taking place in convenience stores; however, there has been an increase in strong-arm robberies.

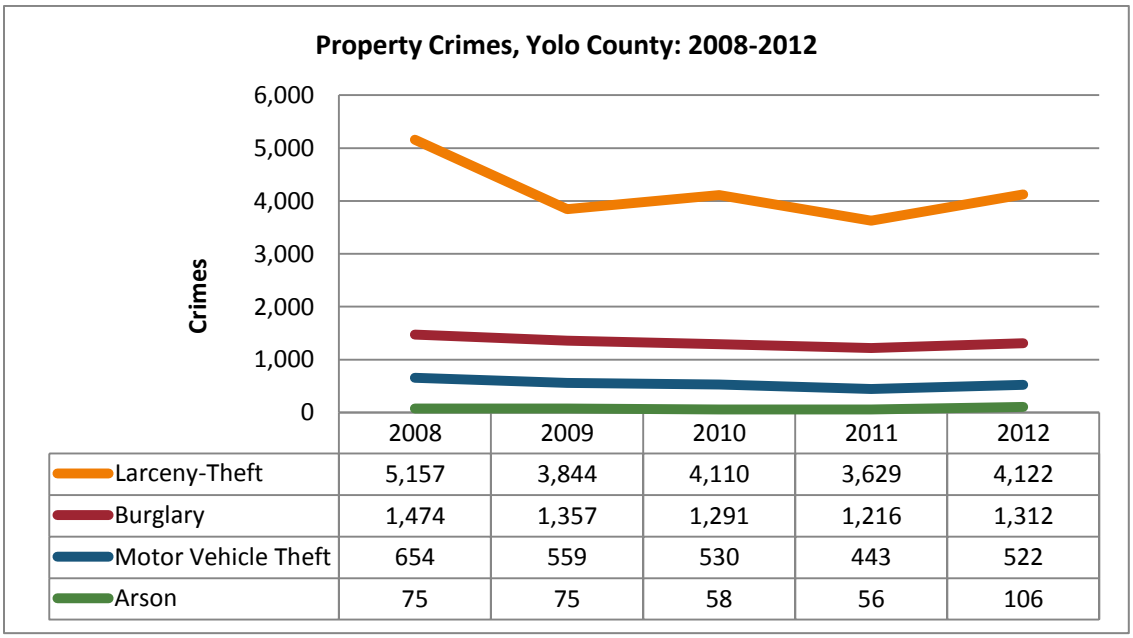


	2008	2009	2010	2011	2012
Aggravated Assault	299	310	290	315	323
Robbery	180	171	141	151	162
Forcible Rape	66	68	78	98	71
Homicide	4	7	3	5	0

FELONY: PROPERTY CRIMES

Property crimes are considered theft-type offenses with the object of taking money or property, but there is no force or threat of force against the victims. Property crimes include the offenses of burglary, larceny-theft, motor vehicle theft, and arson.

Between 2008 and 2012, there has been a 17% decline in the number of countywide property crimes, with decreases in the occurrence of all types of crimes except for arson, which saw a net increase of 41% in 2012 compared to 2008. The most common property crime countywide is larceny-theft, mostly theft of bicycles or property from automobiles. Motor vehicle theft has decreased considerably. Theft of property valued at over $400 is the most prevalent.



	2008	2009	2010	2011	2012
Larceny-Theft	5,157	3,844	4,110	3,629	4,122
Burglary	1,474	1,357	1,291	1,216	1,312
Motor Vehicle Theft	654	559	530	443	522
Arson	75	75	58	56	106

FELONY ARREST

An arrest occurs when a person is taken into custody because an officer has reason to believe the person violated the law. Not all arrests result in persons being jailed.

Total felony arrests countywide have decreased in number from 2,778 to 2,290 (-18%) for the period of 2008 to 2012, though the decrease has been least substantial in arrests for drug offenses.

Felony Arrests, Yolo County: 2008-2012

Type of Offense	2008	2009	2010	2011	2012
Other Offenses	775	662	624	523	637
Drug Offenses	632	614	704	572	630
Violent Offenses	587	585	630	524	489
Property Offenses	732	634	695	567	485
Sex Offenses	52	39	39	43	49

JUVENILE FELONY ARRESTS

Youth who are involved in the juvenile justice system tend to have higher rates of substance use, dropping out of school, injury, and early pregnancy[11].

[11] Juvenile justice. (2008). The Future of Children, 18(2), 3-14. Retrieved from: http://www.futureofchildren.org/futureofchildren/publications/journals/journal_details/index.xml?journalid=31

In Yolo County, the highest numbers of juvenile felony arrests occur in the cities of West Sacramento and Woodland. Over 80% of theses arrests are of male youth; arrests are also most common among Hispanic/Latino youth.

Juvenile Felony Arrests: 2008-2012					
Report Area	2008	2009	2010	2011	2012
Yolo County	359	371	324	285	218
Incorporated City					
Davis	62	55	33	24	39
West Sacramento	110	98	97	66	68
Winters	13	17	17	7	8
Woodland	164	167	169	175	99

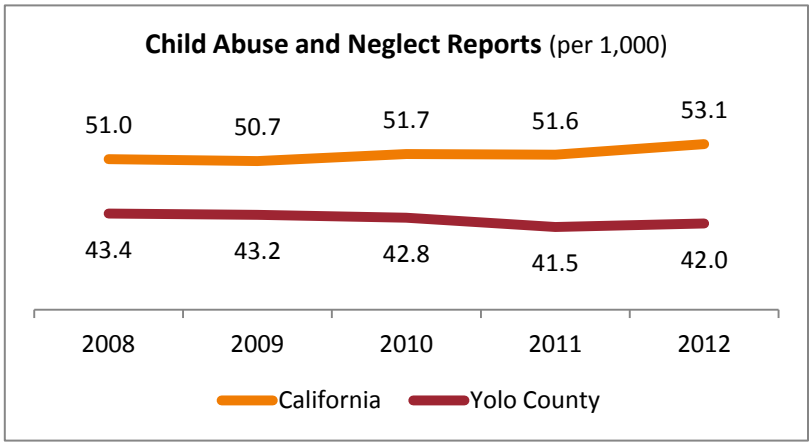
Since 2008, the percentage of juvenile arrests for felony drug and alcohol offenses has nearly doubled, while the percentage of property offenses has fallen by over 20%. There have also been increases in violent offenses and sex offenses. Overall, juvenile felony arrests have decreased considerably both statewide and countywide (by 65%), which is an encouraging trend.

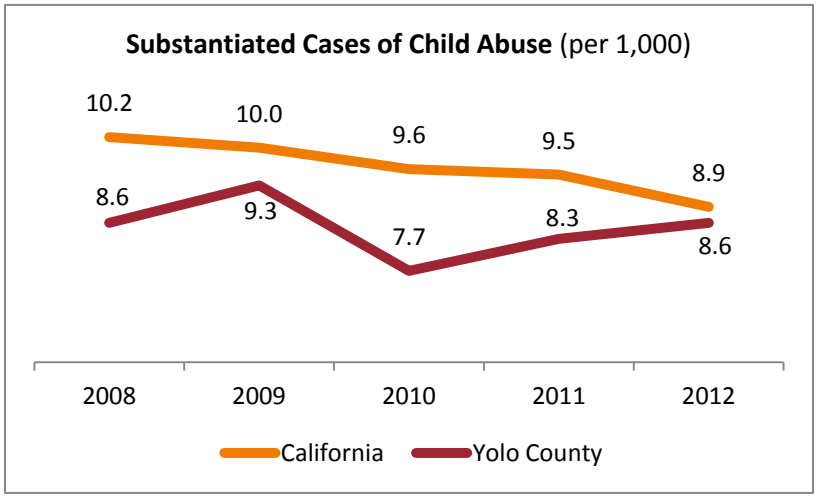
CHILD ABUSE AND DOMESTIC VIOLENCE

CHILD ABUSE

Children who are abused or neglected, including those who witness domestic violence, often exhibit emotional, cognitive, and behavioral problems.

Yolo County has consistently seen lower-than-statewide rates of child abuse and neglect reports as well as substantiated cases.





Seventy-three percent of the substantiated cases of child abuse in Yolo County were for general neglect, 8% for at risk/sibling abused, and 7% physical abuse.

Substantiated cases were most prevalent in children in the age groups of 6 to 10 and 11 to 15, and in children of White or Hispanic/Latino ethnicity.

Type of Abuse of Substantiated Cases of Child Abuse and Neglect: Yolo County					
Type of Abuse	**2008**	**2009**	**2010**	**2011**	**2012**
General Neglect	69%	68%	71%	73%	73%
At Risk/Sibling Abused	2%	2%	4%	6%	8%
Physical Abuse	9%	8%	9%	6%	7%
Caretaker Absence/Incapacity	4%	10%	7%	6%	4%
Sexual Abuse	6%	4%	6%	4%	3%

DOMESTIC VIOLENCE

While the statewide trend of adult domestic violence has significantly decreased from 6.8 to 6.2 per 1,000 persons (ρ^2=0.96), the countywide rate has increased from 5.9 to 6.9 per 1,000 persons. In particular, calls from Woodland, Winters and, by the largest amount, West Sacramento have increased, while calls from Davis have decreased.

PHYSICAL ENVIRONMENT

The physical environment of a community refers to two dimensions: the natural environment, which includes the quality of natural resources such as air and water, and the built environment, which includes roads, buildings, and other manufactured resources. The surrounding physical environment affects a community's health. These factors are crucial in assessing the overall health of a community, as these parts of the environment represent the resources to which the community has access, and the risks to which they are exposed.

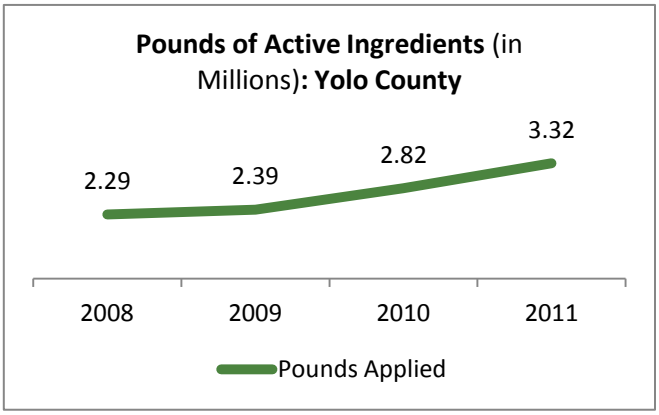
NATURAL ENVIRONMENT

AIR QUALITY

Long-term exposure to high levels of ozone and high concentrations of fine particulate matter in the air is associated with a variety of breathing and heart problems.

Annual Average Concentration of Fine Particulate Matter In the Air: 2007-2011					
Report Area	**2007**	**2008**	**2009**	**2010**	**2011**
California	11.0	11.4	9.5	8.9	9.9
Yolo County	8.3	9.7	7.5	5.7	7.6

From 2007 to 2011, Yolo County has generally followed the statewide trend of improvements in air quality, reducing the number of days with an ozone concentration above the national standard from 3 to 1.



The countywide average particulate matter concentration – a measure of the presence of particles such as smoke, dust, and other pollutants in the air over time – has decreased from 8.3 to 7.6 micrograms of particles per cubic meter of air. The current annual fine particle standard is 15 micrograms per cubic meter, which refers to the density of particles in the air.

However, since 2008, Yolo County has increased its usage of pesticides. Among counties in California in 2008, Yolo County ranked 19th highest in consumption of pesticides; by 2011, Yolo County was ranked 14th highest, applying 3,324,649 pounds of active pesticide ingredient. The agricultural

application of pesticides has also increased from 2008 to 2011 from 24,708 to 32,101. For comparison, the highest-ranking county, Fresno, applied 36,784,255 pounds, while the lowest ranked county, Alpine, applied 621 pounds.

WATER QUALITY

Safe water for the purposes of drinking and hygiene is a basic measure of environmental safety within a community. Unfortunately, the county has followed the statewide trend of increasing the number of water violations – specifically, maximum contaminant level (MCL) violations since 2007. Levels of contamination that exceed the maximum allowed for drinking water, and documented failure to monitor drinking water contamination, indicate a higher risk of exposure to toxic levels of bacteria, metals, and chemical residue.

The California Reportable Disease Information Exchange (CalREDIE) contained 13 cases of reportable waterborne disease in 2012. Waterborne disease is especially a concern among children, who more often suffer serious complications from unsafe water such as dehydration due to severe diarrhea.

BUILT ENVIRONMENT

FOOD ACCESS

Food access refers to the availability and variety of food options to members of the community. While the consumption of fast food is explored in more depth as a health behavior, diet is also influenced by the physical environment as availability and access play a key role in determining dietary choices.

Fast food restaurant access in Yolo County is slightly lower than statewide: 68.7 establishments per 100,000 population, compared to 69.9 per 100,000 statewide. Liquor store access in Yolo County is considerably lower: five establishments per 100,000 compared to 10 per 100,000 statewide.

Fast Food and Liquor Stores per 100,000 Persons: 2011

Stores	California	Yolo County
Fast Food Restaurants (per 100,000)	**69.9**	**68.7**
(Total Establishments)	*(26,048)*	*(138)*
Liquor Stores (per 100,000)	**10**	**5**
(Total Establishments)	*(3,706)*	*(10)*

An estimated 18% of Yolo County residents qualify as having low food access: living over a mile from a large supermarket or grocery store in urban areas, or 10 miles in rural areas. This is greater than the statewide figure of 14%.

"WALKABILITY" AND PEDESTRIAN SAFETY

"Land use patterns and urban design can considerably reduce the number and length of vehicle trips a household makes per day…The extent and quality of pedestrian, bicycle, transit, and rideshare infrastructure and programs have a strong influence over whether people choose to drive or use alternative transportation modes."[12]

[12] Yolo County Climate Action Plan: A Strategy for Smart Growth Implementation, Greenhouse Gas Reduction, and Adaptation to Global Climate Change, 2011. http://www.yolocounty.org/community-development/planning-public-works/planning-division/climate-action-plan

"Walkability" refers to the proximity of and ability to travel safely on foot to services and amenities such as schools, grocery store, and pharmacies. Most of Yolo County, with the exception of the city of Winters, is car-dependent, requiring access to a vehicle in order to complete most everyday errands. However, in Yolo County, 79% of the population lives within half a mile of a park, compared to only 58% statewide. Proximity to parks and other recreational amenities typically encourages a more active, healthy lifestyle.

In 2011, Yolo County reported 39 motor vehicle accidents involving pedestrians and 105 accidents involving bicyclists. Of the 144 accidents, four were fatal. The most common primary collision factors for motor vehicle accidents involving a pedestrian varied by city, but in Davis, Woodland, and unincorporated areas of Yolo County, the most common factor was pedestrian violation. This suggests a possible need for outreach to community members regarding pedestrian safety. The most common primary collision factor for bicycle accidents was automobile right of way violation.

HEALTH CARE AND PREVENTIVE SERVICES

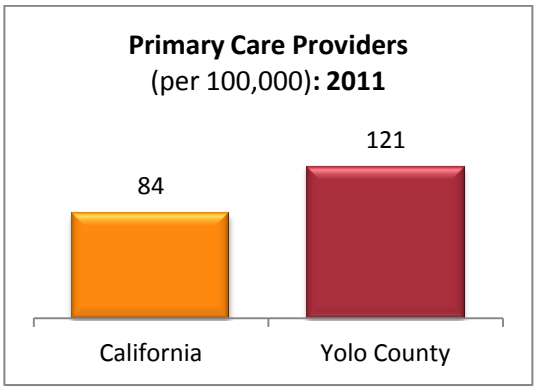
An important aspect of the health status of any community is the availability of healthcare services to its population, especially primary and preventive care. Effective preventive care, including access to resources such as tests, screenings, and vaccinations, is protective against the future development of health issues.

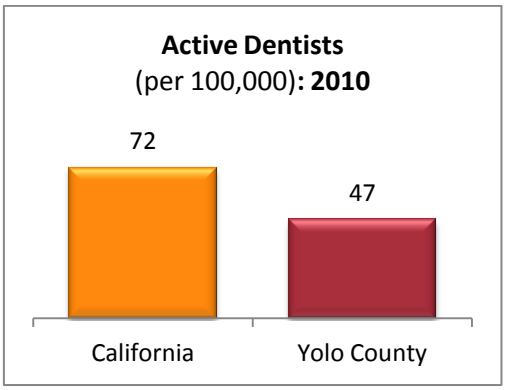
SERVICES AND FACILITIES

With a rate of 121 licensed primary care physicians per 100,000 population, Yolo County has fewer physicians available per person than the statewide rate of 84 per 100,000.

Yolo County has 76 licensed hospital beds per 100,000, less than one-third of the statewide figure. However, with an occupancy rate of 43% compared to the statewide rate of 56%, it is plausible that the lower proportion of hospital beds is appropriate for the community's needs. Additionally, Yolo County surpasses the statewide figures in terms of beds in long-term care facilities per 100,000 population: 371 countywide compared to 305 statewide.

The number of dentists per 100,000 population statewide is 72.3, but only 47.3 in Yolo County. Dental issues and poor dental health are causes of discomfort that can interrupt everyday functioning, as well as poor nutrition and disease. Currently, 11 dentists in Yolo County are listed by the Department of Health Care Services as providers for recipients of Denti-Cal, a dental coverage branch of the Medi-Cal program. Of these providers, four are located in Woodland, four in Davis, two in Winters, and one in West Sacramento. This may potentially indicate an issue of access for low-income individuals, especially in unincorporated and rural areas. Untreated dental disease can lead to serious health effects including pain, infection, and tooth loss. Although lack of sufficient providers is only one barrier to accessing oral health care, much of the country suffers from dentist shortages.



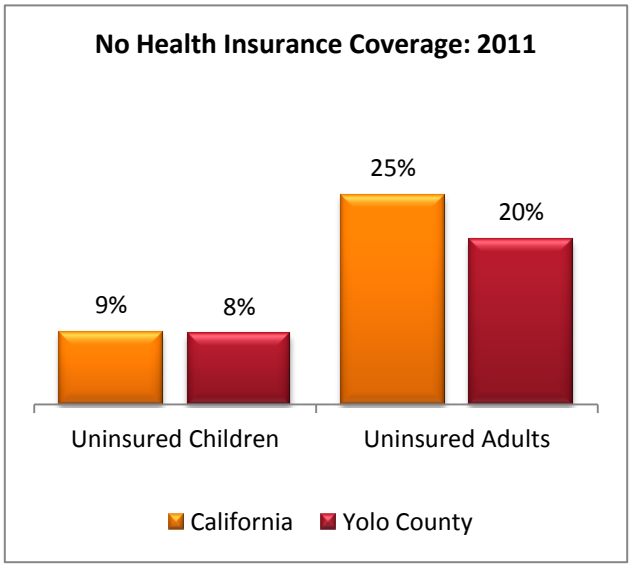


COVERAGE AND ACCESS

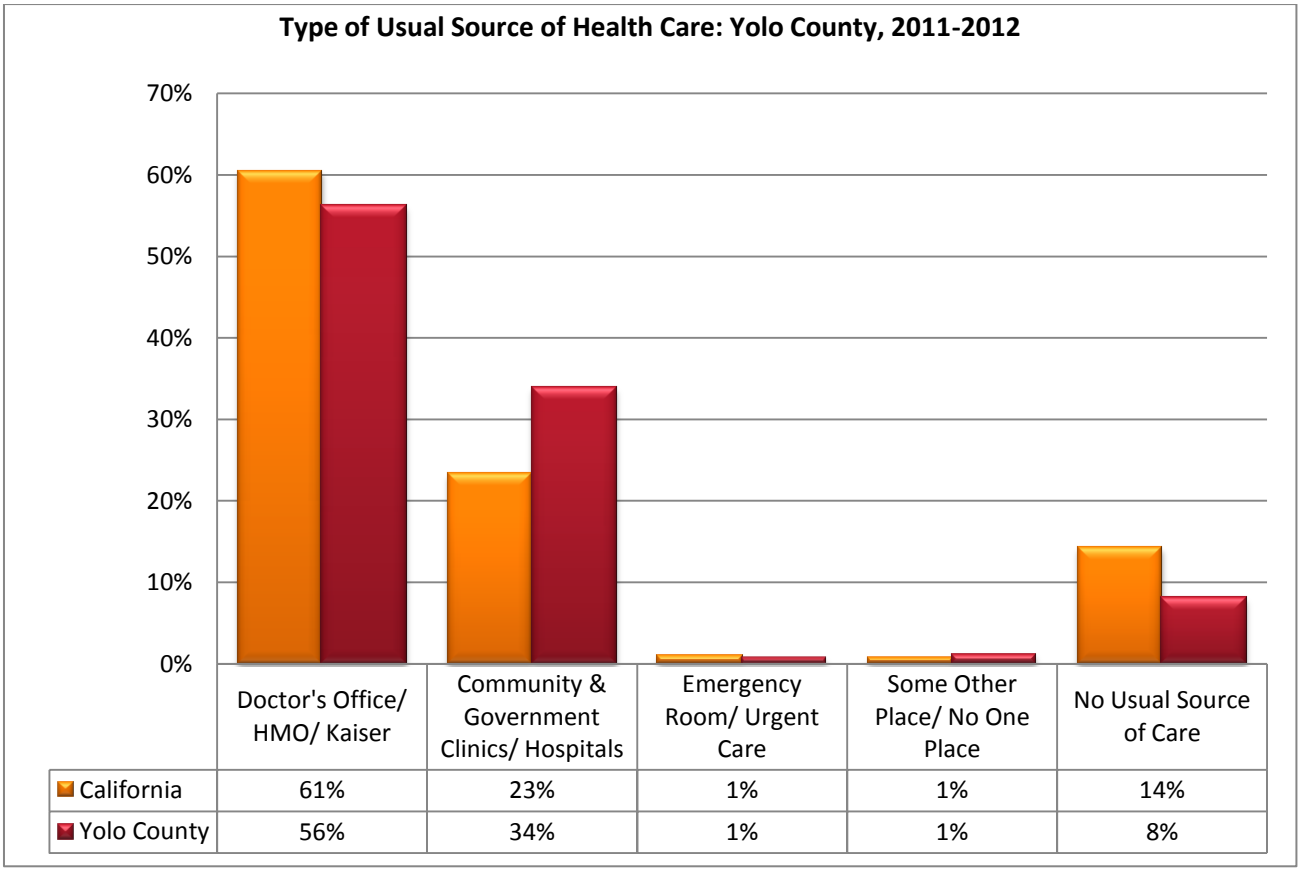
In 2011, nearly 20% of Yolo County adults, aged 18 to 64 were without health insurance, compared to approximately 25% statewide. However, in the same period while the statewide percentage of uninsured children fell by 1%, the percentage in Yolo County rose by approximately the same amount.

Within the county, 92% of residents report having a usual source of healthcare, with 34% of services rendered in the clinic or community hospital setting, over 10% greater than the proportion of services rendered in these settings statewide. A higher percentage of Yolo County residents also utilized migrant health centers as a source of primary care.

As recently as 2012, Yolo County met the Healthy People 2020 goal of 9% or fewer residents reporting having delayed or missed seeking medical services, reporting 8% compared to the statewide estimate of 12%.



Having a usual source of health care to go to when sick varies by household income, with the percentage of persons having a usual source of health care increasing as household income increases.

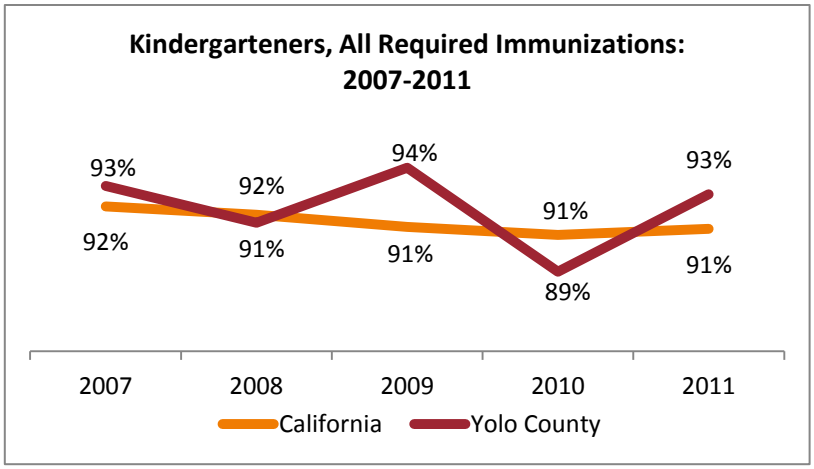


	Doctor's Office/ HMO/ Kaiser	Community & Government Clinics/ Hospitals	Emergency Room/ Urgent Care	Some Other Place/ No One Place	No Usual Source of Care
California	61%	23%	1%	1%	14%
Yolo County	56%	34%	1%	1%	8%

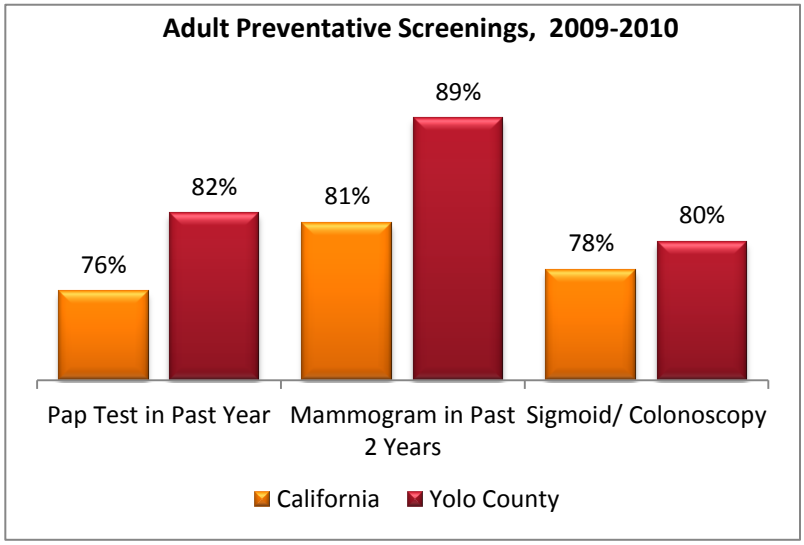
PRIMARY PREVENTION

Primary prevention is used to prevent the development of a disease in a person who is well and does not have the disease.

Between 2007 and 2011, the percentage of kindergarteners in Yolo County with all required immunizations was virtually unchanged at 93.1% in 2011 versus 92.7% in 2007. This is still higher than the statewide figures, which fell from 92% to 91% in the same period. Both statewide and countywide figures still fall short of the Healthy People 2020 goal of 95% adherence to timely administration of each of the appropriate vaccines for children entering kindergarten: DTaP, MMR, polio, and hepatitis B.



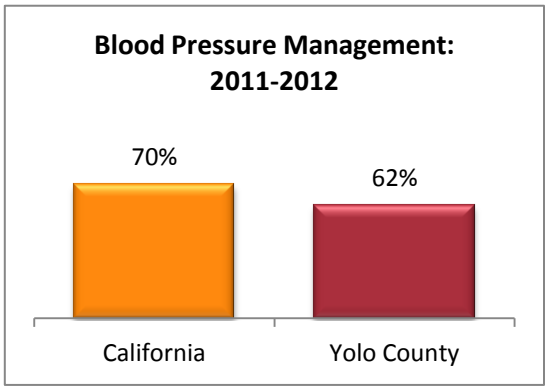
Yolo County surpasses the state in terms of performing preventive screenings for adults such as Pap smears, mammograms, colonoscopies, and sigmoidoscopies, all of which are diagnostic early screening tools for cervical, breast, and colon cancers, respectively.



SECONDARY AND TERTIARY PREVENTION

Secondary prevention is used among patients who have developed a disease, but show no symptoms. The goal of secondary prevention is to halt or slow the progress of the disease. Tertiary prevention targets people who have a disease with the goal of preventing further physical deterioration and maximizing quality of life.

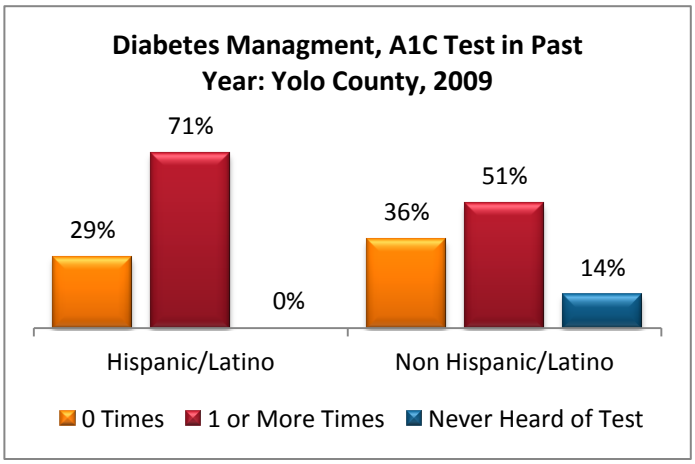
Hypertension (high blood pressure) and diabetes mellitus are two chronic health conditions that are linked to poor health outcomes such as heart disease and stroke. Because of this, the quality of disease management among individuals diagnosed with these conditions and the prevention of complications are a significant indicator of health in a



community.

Among surveyed individuals diagnosed with high blood pressure, 62% of Yolo County respondents reported managing their condition with medication, compared to 70% of respondents statewide.

Among surveyed individuals with a diagnosis of diabetes, 60% reported a hemoglobin A1C test, which measures how effectively blood sugars are controlled over long periods, being performed by their doctor at least once in the past 12 months. A considerably higher proportion of Hispanic/Latino versus non-Hispanic/Latino respondents, 71% and 51% respectively, reported having their hemoglobin A1C levels checked. Diligent management and surveillance of individuals with diabetes by way of regular blood sugar testing is a key step in reducing the occurrence of hyperglycemia (high blood sugar), and preventing many diabetes-related complications.



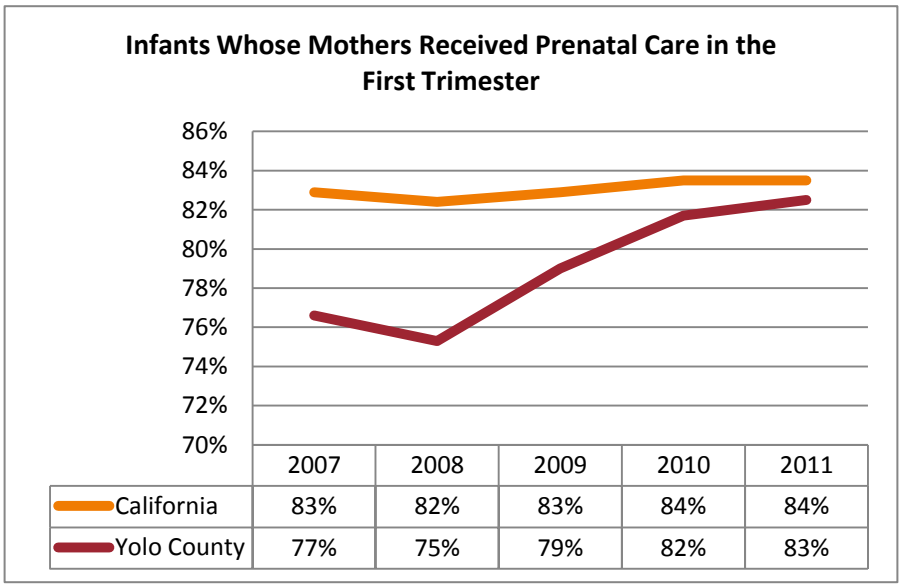
MATERNAL AND CHILD HEALTH

Maternal and child health focuses on pregnancy and prenatal care, birth data, and infant mortality. The state of health among mother-baby couplets within the community is suggestive of the quality and accessibility of healthcare services, as well as particular health problems that pose a concern to this population. For data provided in tables, all figures in red indicate a percentage or rate that exceeds that of the county's rate.

MATERNAL AND PRENATAL HEALTH

ACCESS TO PRENATAL CARE

Timely prenatal care (i.e., in the first trimester) is important as it lowers the risk of other adverse birth outcomes, such as low birth weight, developmental delays, and premature birth[13]. Prenatal care is also important to the health of the mother. Delays in accessing prenatal care are largely linked with poor birth outcomes such as low birth weight, developmental delays, and preterm birth. Associated risk factors for delayed access to care are unintended pregnancy, poverty, completion of less than a high school diploma by either parent, and a maternal age of 18-24 years.



	2007	2008	2009	2010	2011
California	83%	82%	83%	84%	84%
Yolo County	77%	75%	79%	82%	83%

[13] Centers for Disease Control and Prevention. Pediatric and Pregnancy Nutrition Surveillance System. Retrieved from: http://www.cdc.gov/pednss/what_is/pnss_health_indicators.htm (2011)

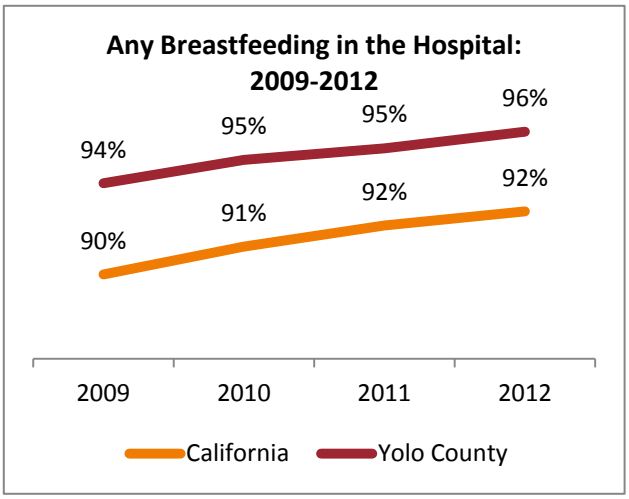
Between 2007 and 2011, the percentage of mothers statewide entering prenatal care within the first trimester of pregnancy showed little fluctuation, remaining close to 83%. Countywide, the percentage rose from 77% to 83% within the same period.

Prenatal Care in the First Trimester, by Race/Ethnicity: Yolo County					
Race/Ethnicity	**2006**	**2007**	**2008**	**2009**	**2010**
Black/African American	**75%**	**69%**	**68%**	**77%**	**62%**
Asian/Pacific Islander	79%	78%	77%	82%	**82%**
Hispanic/Latino	**71%**	**71%**	**69%**	**76%**	**79%**
White	82%	83%	82%	83%	85%
Multiracial	81%	83%	78%	**74%**	83%

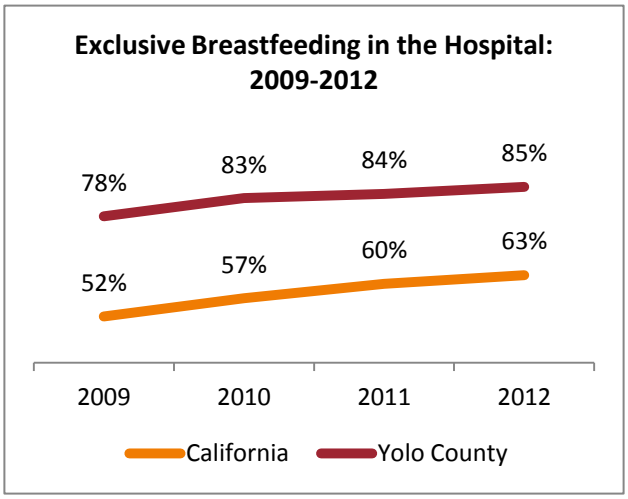
The percentage of Black/African American mothers receiving first trimester prenatal care, however, has fallen by over 12% while rates among all other racial/ethnic groups have increased. In particular, an almost 9% increase in access to first-trimester prenatal care has been observed among Hispanic/Latino mothers. Black/African American and Hispanic/Latino mothers have consistently been below the countywide rate of mothers receiving first trimester prenatal care.

BREASTFEEDING

The proportion of mothers who breastfeed their newborns is significant, as breast milk is regarded as the most beneficial source of nutrition for infants and provides health benefits to mothers as well. Breastfeeding reduces the risk of childhood obesity and assists in building a functioning immune system, and reduces the mother's risk for multiple cancers. In Yolo County, a greater than statewide percentage of mothers breastfed their infant in the hospital. In particular, during postpartum hospitalization, 22 percentage points more mothers in Yolo County breastfed exclusively than statewide. Roughly 22% of Black/African American newborns were not breastfed at all, compared to only 4 to 6% of newborns in other racial/ethnic groups in Yolo County.



Breastfeeding in the Hospital by Race/Ethnicity: Yolo County, 2011		
Race/Ethnicity	**Exclusive**	**Any**
African American/Black	**65%**	**78%**
Asian American	**77%**	96%
Hispanic/Latino	**80%**	95%
White	87%	96%
Multiracial	86%	**94%**
Other	**66%**	96%



DELIVERY AND BIRTH OUTCOMES

The number of live births in Yolo County has been declining slightly since 2007 from 2,522 live births to 2,340 in 2011.

TEEN BIRTHS

The teen birth rate indicates the number of live births per 1,000 females 15 to 19 years old. Teen mothers are more likely to have babies born prematurely or with low birth weight. They are more likely to have babies who die in infancy, compared to mothers in their 20s and early 30s. Giving birth as a teenager can also create disadvantages for the mother and the father. Teen mothers are more likely to become welfare dependent than other teens; and teen parenthood is associated with lower educational attainment and lower income levels[14].

Teen Birth Rate per 1,000 Females: Yolo County

Age of Mother	2007	2008	2009	2010	2011
15 - 17	15.5	15.9	12.2	15.8	12.9
18 - 19	26.7	26.5	22.2	18.5	18.9

For the period from 2007 to 2011, the teen birth rate in California and Yolo County has decreased. The state teen birth rate dropped from 40 to 28 per 1,000 females aged 15 to 19, whereas Yolo County the rate dropped from 17 to 16 per 1,000 females. The decrease is observed particularly among mothers 18 to 19 years of age, and remains significantly lower than the statewide rate. However, the teen birth rate among mothers aged 15 to 19 within the county is significantly higher among Hispanic/Latino and American Indian women.

Teen Birth Rate by Race/Ethnicity: Yolo County, 2011

Race/Ethnicity	Age of Mother	
	15 - 17	18-19
Asian	3.6	2.2
Black	11.6	0
Hispanic/Latino	**20.9**	**59.3**
White	6.4	9.3
American Indian	**35.7**	**50**
Pacific Islander	0	0
Two or More Races	**19.9**	16.5

Teen Birth Rate by Maternal City of Residence: 2012

City of Residence	Rate
Davis	3.9
West Sacramento	26.2
Woodland	34.6

Teen births appear concentrated most heavily within West Sacramento and Woodland. The repeat birth rate to teen mothers was 2.3 instances per 1,000 females aged 15 to 19 countywide.

BIRTH WEIGHT

Low birth weight (LBW) is a term that applies to newborns weighing less than 2500 grams, but more than 1500 grams at birth. Newborns born below 1500 grams are classified as very low birth weight (VLBW). Birth weight is a significant aspect of birth outcomes, as babies classified as LBW or VLBW are at an increased risk for long-term effects such as disability, developmental delays, hearing and vision impairments, and respiratory problems. The table below shows the percentage of newborns born at very low birth weights and low birth weights by race/ethnicity in Yolo County and California.

[14] U.S. Department of Health and Human Services. Healthy People 2020. Retrieved from: http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=13 (2011)

Birth Weight by Race/Ethnicity: 2010				
Race/Ethnicity	Very Low Birth Weight		Low Birth Weight	
	Yolo County Percent	California Percent	Yolo County Percent	California Percent
Hispanic	0.9	1.1	4.7	6.2
White	1.0	1.0	4.4	6.1
Black	2.1	2.6	12.5	12.2
Asian/Pacific Islander	2.2	1.0	8.4	7.8
Other Race	0.0	1.5	5.3	8.6
Overall	**1.1**	**1.1**	**5.2**	**6.8**

In general, both Yolo County and the state of California met the Healthy People 2020 objectives regarding birth weight: less than 7.8% of newborns classified as LBW, and less than 1.7% classified as VLBW. However, a higher percentage of Black/African-American newborns fall into these categories both countywide and statewide.

INFANT MORTALITY

Infant mortality is the death of a baby before his or her first birthday. Infant mortality is one of the most important indicators of the health of a nation, as it is associated with a variety of factors, including maternal health, quality of and access to medical care, socioeconomic conditions, and public health practices.

The 2009 infant mortality rate in Yolo County, 2.4 per 1,000 live births overall, is lower than the statewide rate of 5.0 per 1,000 and meets the Healthy People 2020 objective of 6 or lower. However, among Hispanic/Latino mothers in Yolo County, the infant mortality rate is 5.7 per 1,000, higher than the statewide rate of 4.7 per 1,000 for the same ethnic subgroup.

Between 2007 and 2009, infant mortality rates were highest in the South West region of Yolo County, which includes the city of Winters.

HEALTH BEHAVIORS

Health behavior refers to the actions of individuals or groups concerning particular behaviors or behavior patterns and habits that affect health. This also includes personal beliefs, values, perceptions, and personality characteristics such as emotional states.

The individual health behaviors and lifestyle choices common among members of a community are indispensable sources of information about the community as a whole. Behaviors such as diet, exercise, and substance use provide meaningful insight into the community's specific strengths, needs, and risk factors. For data provided in tables, all figures in red indicate a percentage or rate that exceeds that of the county's rate.

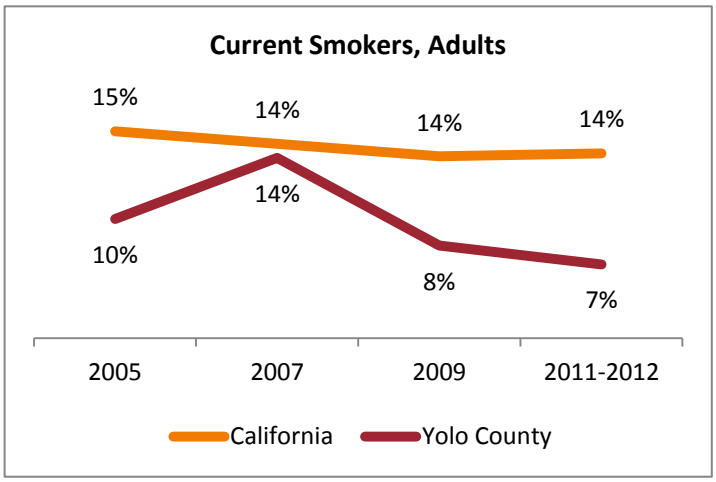
SUBSTANCE USE

In Yolo County, substance use is a significant concern, especially among youth. In particular, students who attend non-traditional schools and various ethnic groups, depending on school district, are using substances such as tobacco, alcohol, and marijuana in higher percentages. Potential consequences of substance use, particularly among youth, include risky behaviors, motor vehicle accidents, and poor academic performance.

SMOKING AND TOBACCO USE

Each year approximately 443,000 premature deaths can be attributed to smoking nationwide. Cigarette smoking is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as birth weight and other adverse health conditions.

Among Yolo County adults, the prevalence of smoking and tobacco usage is consistently lower than the statewide rate and has decreased by almost 3% between 2005 and 2012.



Among youth, slightly higher than statewide percentages of students in grades 7 through 11, as well as in non-traditional schools, report being non-smokers. Among 9th and 11th graders, approximately 90% of students report zero days of smoking, meeting the Healthy People 2020 goals of 16% or fewer of students in grades 9 through 12 reporting having used cigarettes in the past 30 days. However, as early as 7th grade, there is an observable gender disparity in most school districts, with 1-2 percentage points more males than females reporting having smoked at least one day in the past 30 days. In Woodland Joint Unified School District, the gender disparity is wider, with 4 percentage points more males than females in both 7th and 11th grade reporting at least one day of smoking.

Cigarette Use in the Past Month, Youth: 2008-2010

Grade Level	California			Yolo County		
	0 days	1-19 Days	20+ Days	0 Days	1-19 Days	20+ Days
7th Grade	95%	4%	1%	96%	4%	1%
9th Grade	90%	8%	2%	90%	8%	2%
11th Grade	87%	10%	3%	90%	8%	3%
Non-Traditional	61%	24%	15%	65%	**25%**	10%

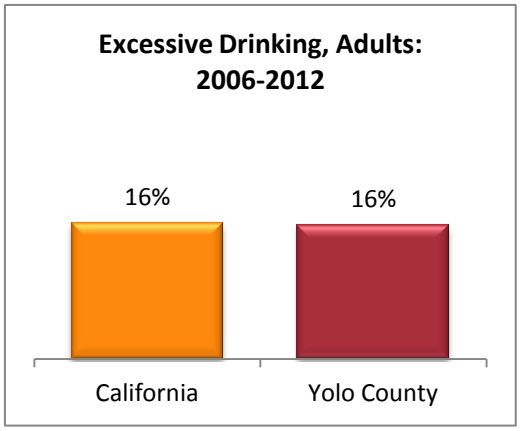
Cigarette Use in the Past Month by Race/Ethnicity, Youth: 2008-2010

Race/Ethnicity	0 days	1-19 days	20 days or more
African American/Black	90%	9%	1%
American Indian/Alaska Native	86%	12%	2%
Asian	97%	3%	1%
Hispanic/Latino	92%	7%	2%
Native Hawaiian/Pacific Islander	88%	7%	5%
White	93%	5%	2%
Multiracial	90%	7%	3%
Other	90%	8%	3%

When categorized by race and ethnicity, most ethnic groups show lower than statewide proportions of youth reporting the highest level of smoking - 20 or more days in the past 30 days. The most notable exceptions are individuals of Native Hawaiian or Pacific Islander descent. In Yolo County, 5% reported smoking 20 or more days, compared to 3% statewide. Higher percentages of individuals who identify as Black, American Indian, or Other reported smoking between 1 to 19 days in the past 30 days. This is worth noting, as current literature indicates that even light to moderate cigarette and tobacco use place an individual at increased risk for negative health outcomes.

ALCOHOL USE

Excessive alcohol consumption can have long-term consequences including liver disease, cancer, and cardiovascular disease. "Excessive drinking" is defined as having 5 or more drinks (men) or 4 or more drinks (women) on one or more occasions during the previous 30 days.



In Yolo County, 16% of adults aged 18 and older reported excessive drinking between 2006 and 2012, which is equivalent to the statewide percentage.

Youth alcohol use in Yolo County also exhibits higher prevalence compared to the state. Higher percentages of 9th and 11th graders in Yolo County compared to the state reported having consumed alcohol at least once in the past 30 days: 29% of 9th graders compared to 25% statewide, and 38% of 11th graders compared to 34% statewide. Higher percentages of 7th and 9th graders within Yolo County reported having consumed alcohol for at least 20 of the past 30 days.

Alcohol Consumption in the Past Month, Youth: 2008-2010

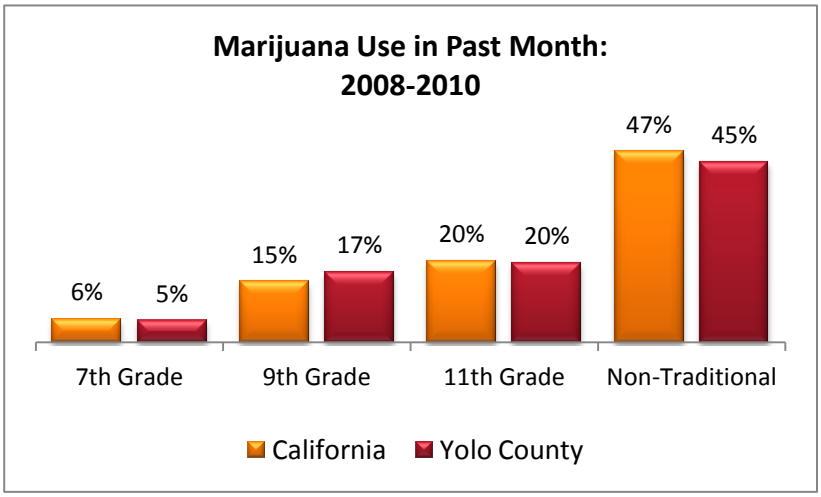
Grade Level	California			Yolo County		
	0 days	1-19 days	20 days or more	0 days	1-19 days	20 days or more
7th Grade	86%	12%	2%	86%	12%	2%
9th Grade	75%	22%	3%	71%	**25%**	**4%**
11th Grade	66%	31%	3%	62%	**36%**	2%
Non-Traditional	46%	47%	7%	50%	46%	4%

Youth alcohol use is also more common in males than in females within Yolo County, with the largest gender disparity occurring in Winters Joint Unified School District: 67% of females reported 0 days of alcohol use, compared to 48% of males in the 11th grade. Conversely, the lowest gender disparity occurred in Woodland Joint Unified School District, which exhibited the lowest percentage of students of both sexes in 11th grade reporting zero days of alcohol consumption: 59% female and 57% male.

Within Yolo County, 30% of Black/African American youth reported having consumed alcohol at least once out of the past 30 days, compared to 21% statewide.

MARIJUANA USE

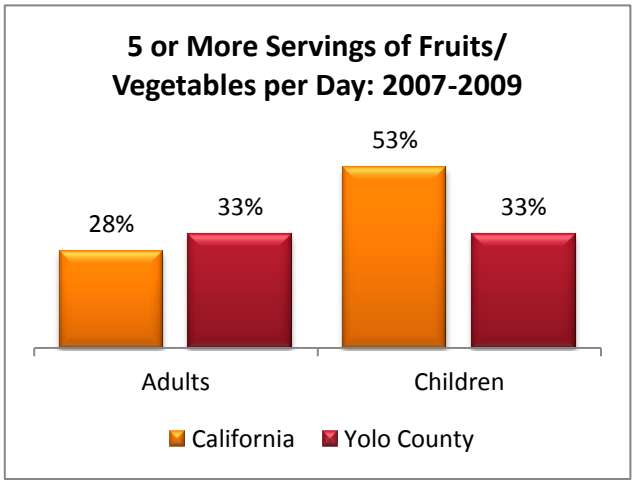
Between 2008 and 2010, the prevalence of youth marijuana usage was slightly lower in Yolo County than statewide, except in the case of 9th grade students, 17% of whom reported marijuana use at least once in the past 30 days, compared to 15% statewide.



Both statewide and countywide, marijuana use is most common among students attending non-traditional schools. There appears to be a correlation between lower levels of school involvement and connectedness and the

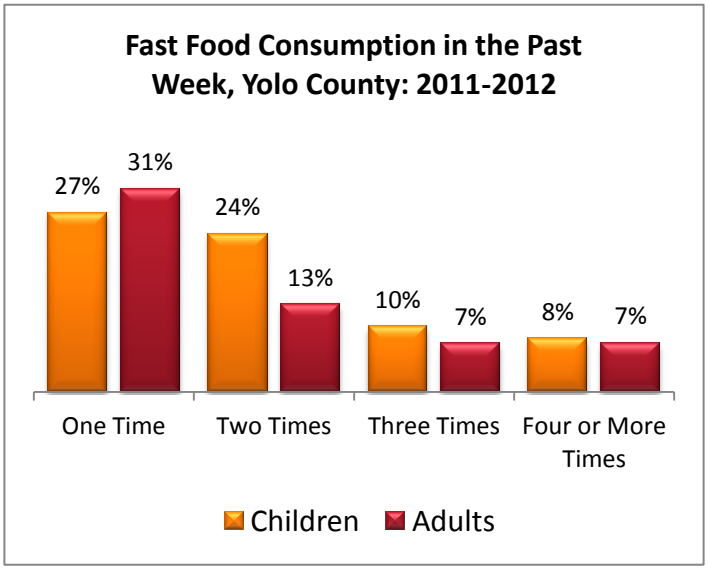
likelihood of reporting at least one instance of marijuana use in the past 30 days.

DIET AND NUTRITION



Proper nutrition over the course of life can help prevent certain diseases and lower risk of developing cancer, stroke cardiovascular disease, obesity, and diabetes. Consuming fast food and sugar-sweetened beverages contributes to poor health. Drinking sugar-sweetened beverages is associated with overweight and obesity, dental decay, and type 2 diabetes.

A slightly higher than statewide percentage of Yolo County adults ate at least five servings of fruits and vegetables daily: 33% countywide compared to 28% statewide. However, the estimated percent of children eating five or more servings in Yolo County was far below the statewide estimate, 33% compared to 53%.



Between 2007 and 2012, fast food consumption among children has neither increased nor decreased. During this period, a slightly lower than statewide percentage of Yolo County youth reported no consumption of fast food within the past 7 days; 29% compared to 32% statewide. In the same time period, the percentage of Yolo County adults who reported no fast food consumption in the past 7 days increased by just over 4 percentage points. In the same period, this percentage has decreased by nearly 2 percentage points statewide. Additionally, the percentage of Yolo County adults who report eating fast food 4 or more time in the past week has decreased, whereas the statewide percentage slightly increased. It is estimated that Yolo County children eat fast food more frequently than adults do.

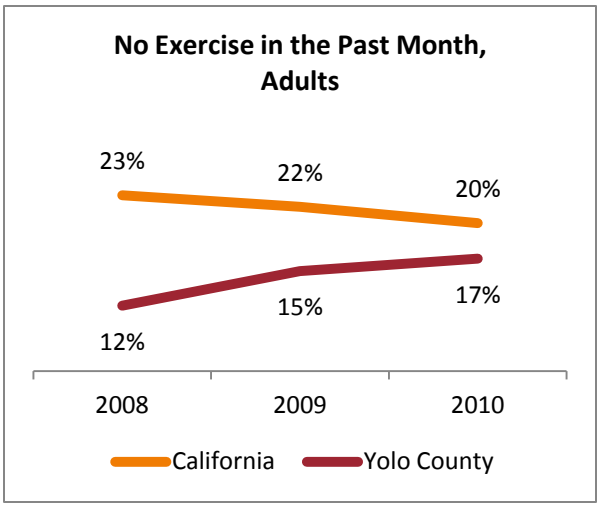
While consumption of sodas and other sugary drinks has shown little change statewide over the past five years, the percentage of Yolo County children and teens consuming 2 or more sugary drinks within a day more than doubled between 2007 and 2012. Among ethnic groups, the percentage of Hispanic/Latinos who consume two or more sugary drinks within a day is slightly higher than non-Hispanic/Latinos, 21% compared to 17%, respectively.

EXERCISE AND PHYSICAL ACTIVITY

Exercise and the incorporation of physical activity into daily living is also an important factor that influences a community's health outcomes. Though there are numerous ways in which exercise and physical activity can be quantified, a common measure is the amount of time spent performing physical activities. Physical activity is linked to weight control and reduced risk of chronic diseases.

The percentage of Yolo County adults who reported no physical activity or exercise within the past month was consistently lower than statewide between 2008 and 2010. However, the percentage of adults reporting no physical activity increased by almost 5% in this time period, while the percentage decreased by almost 3% statewide. This falls far short of the Healthy People 2020 objective for a 10% reduction of the proportion of adults who reported no physical activity in the past month.

A similar trend appeared in Yolo County teens where a decrease of nine percentage points among teens who reported at least an hour a day of physical activity in the past week was seen between 2009 and 2012. Over half of teen males are physically active for at least one hour compared to one-third of female teens.



Yolo County has the benefit of school programs and fitness testing to determine the extent to which children in the community are able to perform physical activities. The California Department of Education monitors physical fitness in terms of aerobic capacity with a fitness test that determines whether a student is within a Healthy Fitness Zone (HFZ). Additionally, the test also determines if a student is below the HFZ and needs improvement or is at an increased health risk based on their performance on the fitness test. Aerobic capacity assesses the capacity of the cardiorespiratory system by measuring endurance.

Aerobic Capacity, Youth: Yolo County

School Year	5th Grade			7th Grade			9th Grade		
	% HFZ	% Needs Improvement	% Health Risk	% HFZ	% Needs Improvement	% Health Risk	% HFZ	% Needs Improvement	% Health Risk
2010-11	57%	37%	7%	67%	23%	10%	58%	31%	11%
2011-12	60%	35%	5%	61%	30%	9%	57%	32%	11%
2012-13	53%	40%	8%	61%	29%	10%	63%	24%	13%

Percent of Youth in Health Risk for Aerobic Capacity by School District: 2012-2013

Grade Level	Davis JUSD	Esparto USD	Washington USD	Winters JUSD	Woodland JUSD
5th Grade	N/A	**10%**	4%	8%	**10%**
7th Grade	6%	**16%**	8%	**12%**	**15%**
9th Grade	7%	**22%**	**15%**	**17%**	**15%**

Percent of Youth in Health Risk for Aerobic Capacity by Population Group: 2012-2013			
Report Population	**5th Grade**	**7th Grade**	**9th Grade**
All Students	**8%**	**10%**	**13%**
Sex			
Male	6%	8%	**13%**
Female	**10%**	**13%**	**13%**
Race/Ethnicity			
African American/ Black	3%	7%	**16%**
American Indian/Alaska Native	LNE	**11%**	**19%**
Asian	5%	5%	10%
Filipino	0%	0%	7%
Hispanic/ Latino	**11%**	**15%**	**18%**
White	4%	7%	7%
Multiracial	0%	9%	**27%**
Economic Advantage			
Economically Disadvantaged	**8%**	**39%**	**18%**
Not Economically Disadvantaged	**8%**	8%	10%
LNE (Low Number Event) refers to data that have been suppressed because there were fewer than 20 estimated students.			

In general, higher percentages of Yolo County youth fall below the HFZ in 5th, 7th, and 9th grades than statewide. However, slightly fewer are categorized as being at a health risk based on their capacity for aerobic exercise. Youth from Esparto USD and Woodland JUSD exhibit higher percentages of students that fall in the health risk category.

Considerably higher percentages of Yolo County 5th and 7th grade females are in the health risk category compared to their male classmates.

Economically disadvantaged youth, and Hispanic/Latino and multiracial students also exhibit higher percentages in the health risk category.

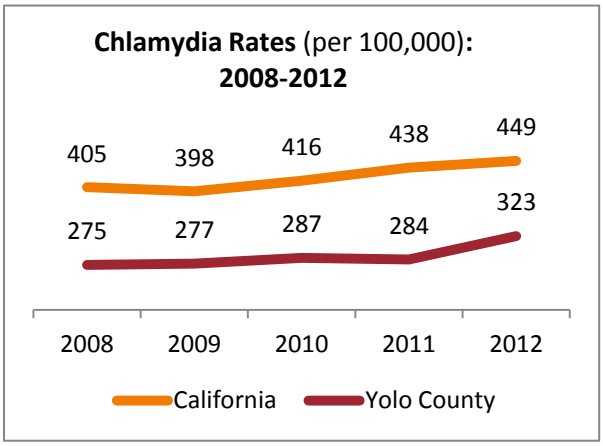
COMMUNICABLE DISEASE

Measuring rates of illness and disease (morbidity) for reportable communicable diseases enables assessment of linkages with social determinants of health.

SEXUALLY TRANSMITTED DISEASES

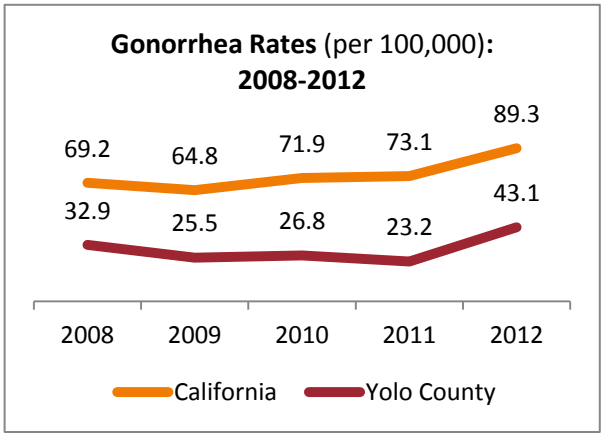
The extent to which a community suffers from sexually transmitted diseases (STDs) such as chlamydia, gonorrhea, and syphilis is an indicator of unsafe sexual practices and increased risk for unplanned pregnancy, especially among youth.

Chlamydia, in particular, is the most commonly diagnosed STD in California counties. Women are more frequently diagnosed than men are, as they are more likely to experience symptoms because of infection.



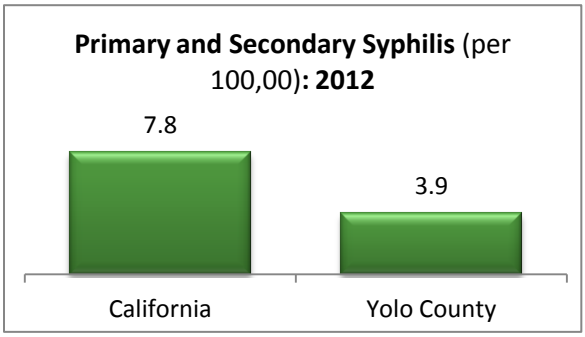
Chlamydia Rates per 100,000 Persons, Youth: Yolo County, 2008-2012				
Age Group	2008	2009	2010	2010
Ages 10-14	50	49	24	16
Ages 15-19	626	869	758	690

Between 2007 and 2013, there has been a steady and significant increase in the chlamydia rate in Yolo County from 261 to 309 cases per 100,000 persons. Chlamydia rates are highest among young adults, aged 20 to 29 years, and decline steadily thereafter. In Yolo County, rates were significantly lower in Asians and Whites persons and significantly higher in Blacks and Other/Multiracial persons. Rates were higher in some areas of the cities of West Sacramento and Woodland, and one area southwest of Davis.



Conversely, gonorrhea is more commonly diagnosed in men. Between 2007 and 2013, the Yolo County rate almost doubled from 35 to 61 cases per 100,000 persons. Like chlamydia, gonorrhea was most commonly diagnosed in young adults between the ages of 20 and 29. Gonorrhea rates were highest in American Indians, Blacks, and persons of multiracial background. Over 75 percent of cases were geographically concentrated in the cities of West Sacramento and Woodland, contrary to expectation that diagnoses would be concentrated in Davis, as the University of California, Davis has a sizable young adult student population.

Gonorrhea Rates per 100,000 Persons, Youth: Yolo County, 2008-2012				
Age Group	2008	2009	2010	2011
Ages 10-14	0.0	0.0	15.7	0.0
Ages 15-19	62.6	48.3	53.0	68.5



The prevalence of another serious STD, syphilis, is considerably lower than statewide in Yolo County.

OTHER COMMUNICABLE DISEASES

TUBERCULOSIS

Outbreaks of tuberculosis, or TB, most often occur among poor people living in crowded conditions and homeless shelters, but TB can afflict all levels in society since it is transmitted by the airborne route. TB is endemic in Southeast Asia and South America, and occurs more frequently in immigrants to the U.S. It may remain dormant for many years in the human body and develop as active infection later in life.

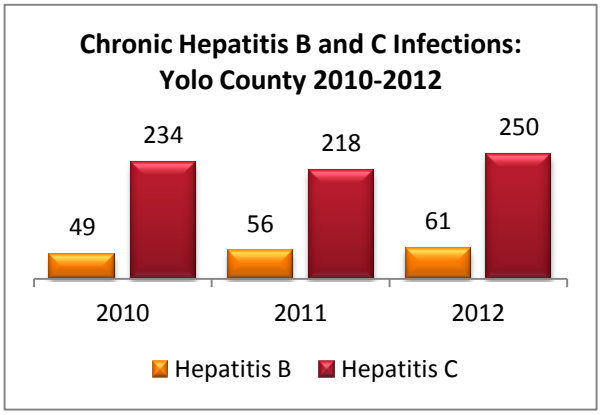
Tuberculosis Cases: Yolo County, 2012	
Tuberculosis	**Cases**
Latent Infection	24
Active Cases	3
Total	**27**

Tuberculosis is at low levels in Yolo County compared to many other urbanized counties in California. From 2008 to 2012, foreign-born persons had a higher rate of infection (7.5 per 100,000) than U.S. born persons (2.2) and as did seniors (12.1) compared to adults aged 25 to 64 (3.3). No deaths due to tuberculosis were recorded between 2007 and 2012.

HEPATITIS

Hepatitis is a disease of the liver most commonly caused by viral infection. While there are five different types (A through E), the most common infections are Type B and C, both of which are able to cause long-term, chronic infections associated with outcomes such as liver cirrhosis and cancer. Hepatitis B and C are transmitted most commonly through contact with infected blood; hepatitis B is also transmissible through other bodily fluids and from mother to infant during childbirth.

Prevalence of chronic hepatitis B and C occur at much lower levels in Yolo County than statewide.



High prevalence of these forms of hepatitis is often associated with needle sharing of injectable drugs. While there is no vaccine for hepatitis C, immunization for Hepatitis B is available.

HUMAN IMMUNODEFICIENCY VIRUS

In Yolo County, the number of Human Immunodeficiency Virus (HIV) was highest among adults aged 45-54 years, males, and individuals of Black/African-American descent. As with STDs, it is useful to track the prevalence of HIV infections as they pose a possible correlation with unsafe sexual practices and injection drug use.

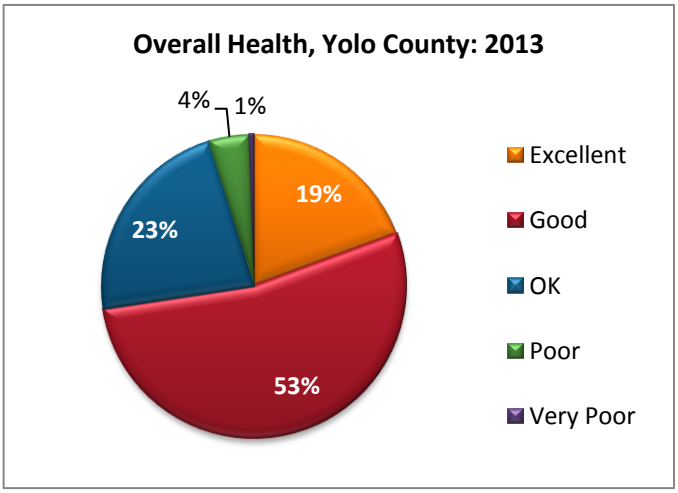
Persons Living with HIV per 100,000 by Population Group: Yolo County			
Population Group	**2008**	**2009**	**2010**
Age			
25-34 Years	N/A	N/A	110.2
35-44 Years	N/A	N/A	133.2
45-54 Years	N/A	N/A	333.5
Sex			
Male	140.5	167.7	183.6
Female	24.9	33.9	38.7
Race/Ethnicity			
Hispanic/Latino	70.7	83.6	92.8
NH-White	83.1	99.1	114.1
NH-Black	320.4	491.2	587.9
TOTAL	**81**	**98.9**	**108.5**

HEALTH OUTCOMES

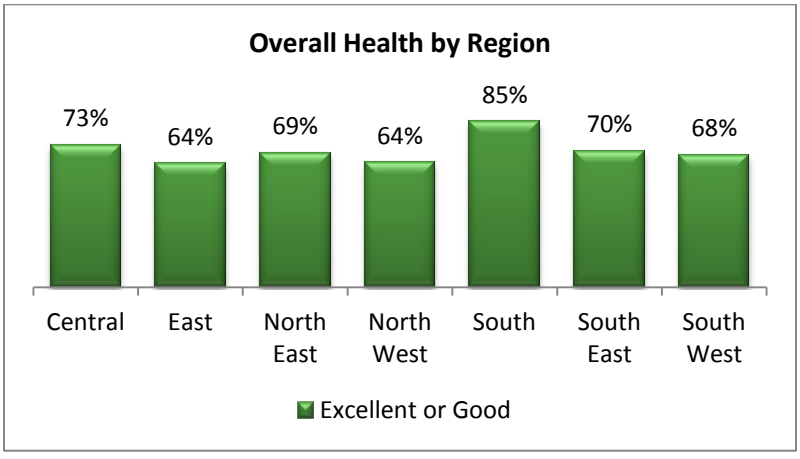
Health outcome refers to medical diagnoses and conditions that directly affect the length or quality of a person's life and its distribution within the community. Health outcomes represent how healthy a community is. Measuring prevalence of certain health outcomes and comparing them to the prevalence of indicators and risk factors is a useful mechanism of assessing a community's overall health, as it creates the opportunity to identify relationships and disparities.

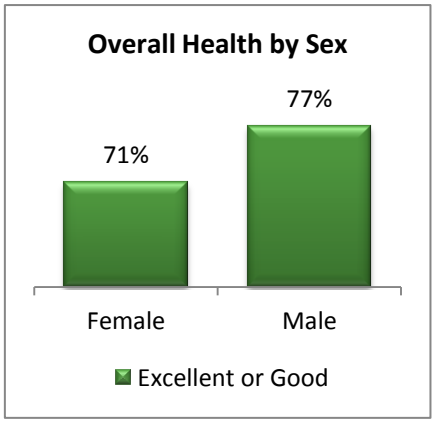
OVERALL HEALTH

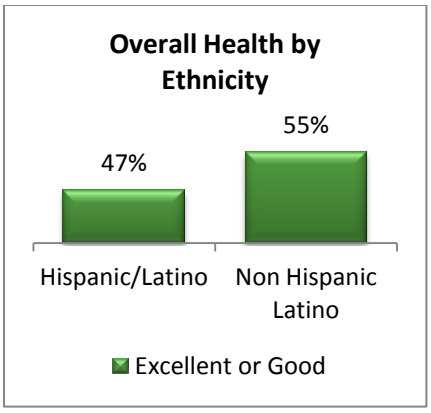
Respondents of the CTSA survey were asked to rate their overall health. A majority of the respondents (53%) rated their overall health as "good". Five percent of the respondents rated their overall health as either "poor" or "very poor". The South region had the highest percentage of respondents (85%) state that their health was either "good" or "excellent". The remaining regions ranged from 64% and 73%.

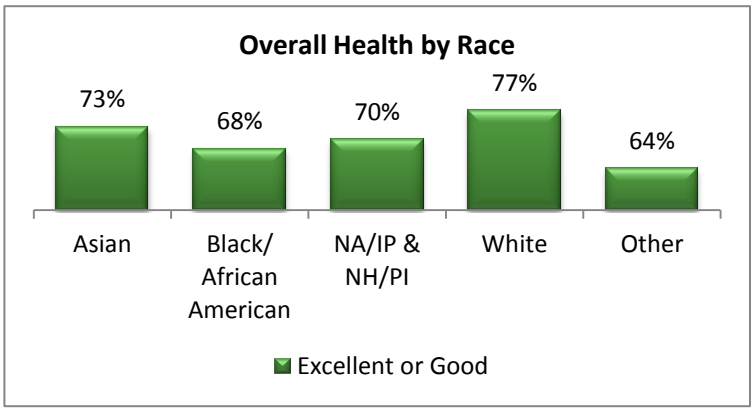


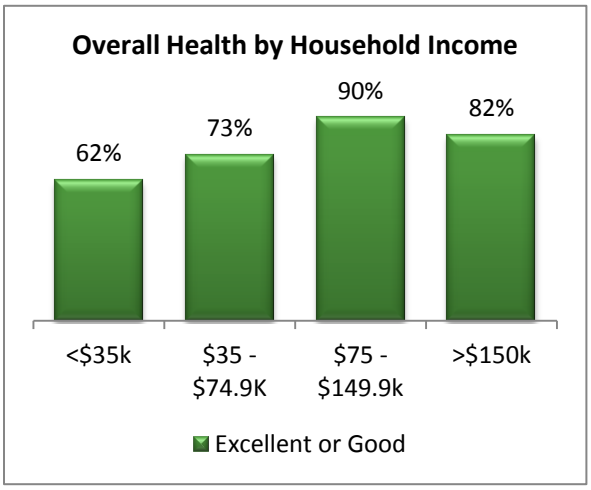
There was a slight difference between the sexes and ethnicities. A higher percentage of males (77%) viewed their health as being "good" or "excellent" compared to 71% of females. More non-Hispanic/Latinos (55%) viewed their health as being "good" or "excellent" compared to 47% of Hispanic/Latinos. White (77%) and Asian (73%) respondents viewed their health slightly better than the other races. The percentage of respondents who identified themselves as either Black/African American or Other who rated their health as "good" or "Excellent" was 68% and 64%, respectively. Ninety percent of the respondents who had a household income of $75,000 to $149,999 rated their health as either "good" or "excellent", compared to 62% of those respondents with a household income of less than $35,000. There were only slight disparities among age groups, generally ranging from 71% to 75% as being in "good" or "excellent" health.

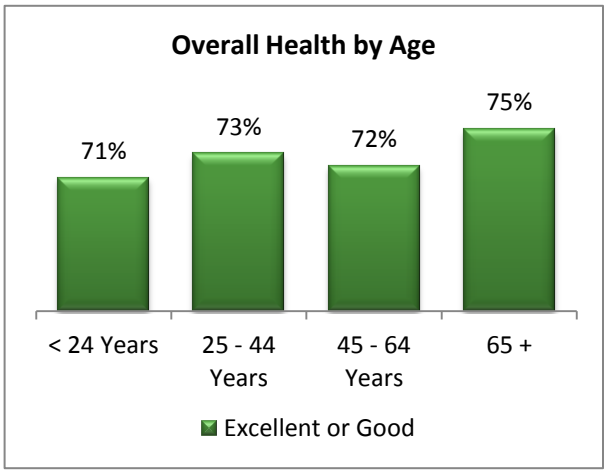










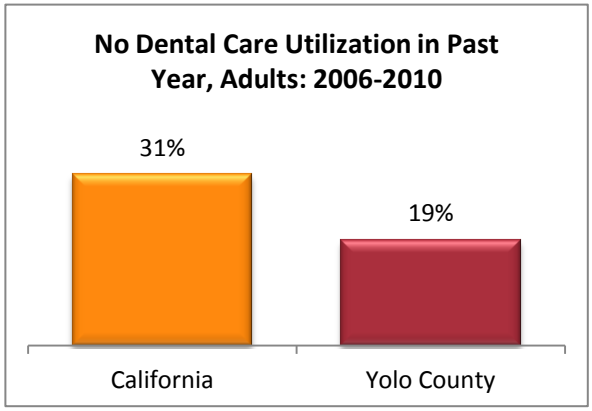


DENTAL HEALTH

The availability of dental care within a community has a marked effect on quality of life, as poor dental health is associated with poor nutrition and increased likelihood of infections and illness.

Almost 19% of Yolo County adults reported receiving no dental care within the past 12 months, much lower than the statewide percentage of 31%.

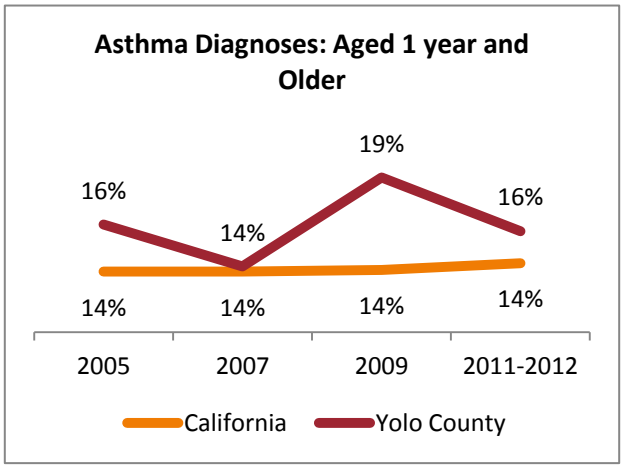
Despite a lower than statewide ratio of dental care providers in Yolo County, a lower percentage of county adults (9%) reported poor dental health (i.e., having six or more permanent teeth removed due to tooth decay, gum disease, or infection) than statewide.

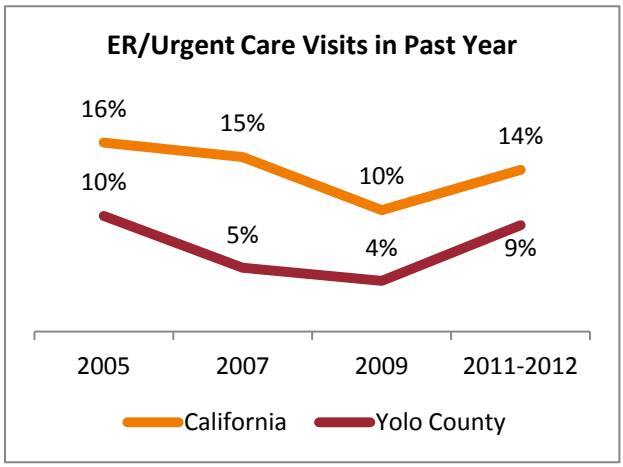


ASTHMA

Asthma prevalence is a significant health indicator, as it can be strongly influenced by environmental factors such as air quality, pollution, smoking, and the presence of other allergens and irritants.

Between 2005 and 2012, Yolo County had a slightly higher percentage as compared to the state of residents aged 1 year and older with a formal diagnosis of asthma from a doctor. Most recent data indicates a countywide rate two percentage points higher than the statewide rate of asthma diagnoses.





Despite the higher diagnosis of asthma in Yolo County, the percentage of visits of asthma patients to an emergency room or urgent care facility for asthma within the past 12 months is less than the state.

The countywide rate of hospitalizations per 10,000 persons due to asthma has declined since 2007. The decrease in hospitalization rates per 10,000 persons was observed predominantly in adults, as hospitalization rates for asthma among youth below 18 years of age increased from 18 to 33 between 2007 and 2010 before decreasing again to 18 in 2011.

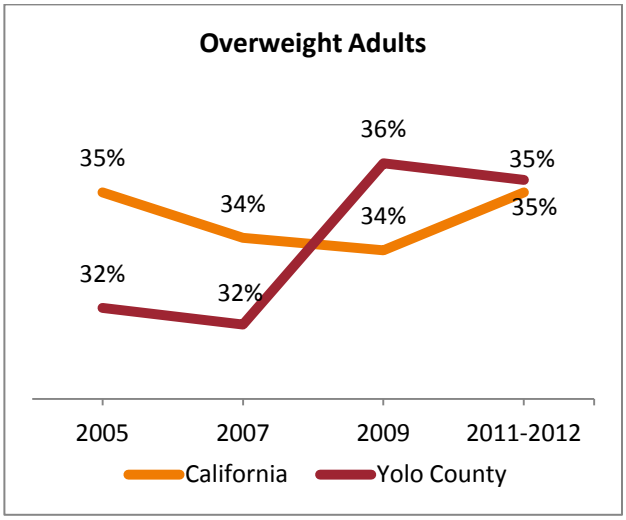
Asthma Hospitalizations Rate per 10,000 Persons: Yolo County

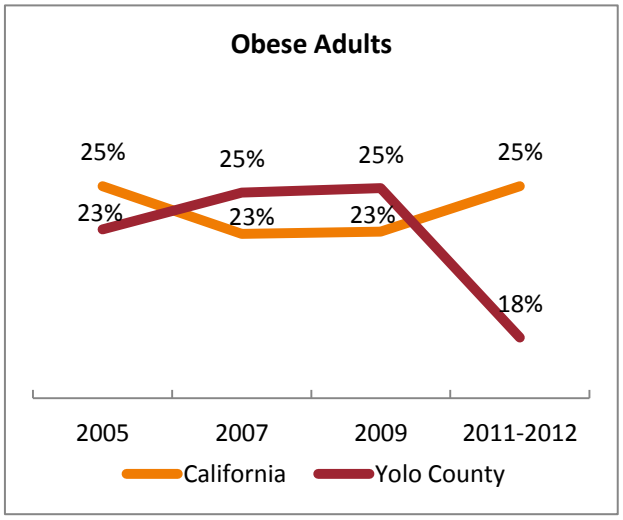
Age Group	2007	2008	2009	2010	2011
Children	18	28	27	33	18
Adults	77	57	55	46	51
Total	**95**	**85**	**82**	**79**	**69**

OBESITY

Excess weight is a nationwide health concern, as it is indicative of unhealthy habits such as poor diet and sedentary lifestyle. It also presents an increased risk for future health issues such as diabetes, stroke, and heart disease.

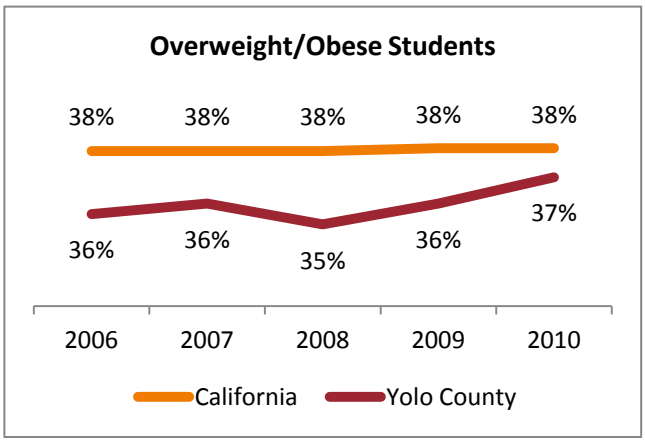
Both statewide and countywide, the percentage of adults who are obese (i.e., having a body mass index of 30 or greater) has consistently met the Healthy People 2020 target of fewer than 30.5% of adults. However, an increasing percentage of Yolo County adults are reported as being overweight (i.e., having a body mass index between 25 and 30).





Weight Status, Adults: Yolo County				
Population Group	2009		2011-2012	
	Overweight	Obese	Overweight	Obese
Sex				
Male	**46%**	**31%**	**36%**	**22%**
Female	26%	19%	34%	14%
Ethnicity				
Hispanic/Latino	31%	**46%**	**46%**	**20%**
Non-Hispanic/Latino	**38%**	16%	32%	17%
Household Income				
Less than $50,000	**39%**	**30%**	**38%**	18%
$50,001 - $100,000	**36%**	21%	29%	**21%**
Greater than $100,001	27%	17%	**36%**	16%

In Yolo County, obesity is more common among males and Hispanic/Latinos. In addition, there is an inverse relationship between household income and obesity levels; as household income increases, obesity levels decrease. Reductions in the percentage of both overweight and obese adults have been observed across the sexes, ethnic groups, and income levels. However, the combined percentage of adults who are either overweight or obese in Yolo County still represents about 53% of the adult population.



Among youth, the percentage of Yolo County public school students in grades 5, 7, and 9 who are overweight or obese increased slightly between 2006 and 2010 whereas statewide, the percentage remained the same. Youth in particular face numerous significant negative effects from excess weight, including poor self-esteem, joint problems, and continued excess weight into adulthood, which in turn creates an increased risk for chronic disease. Obese youth are more likely to become obese adults.

The California Department of Education (CDE) monitors physical fitness in terms of body composition, which provides an estimate of the percent of a student's weight that is fat in contrast to body mass made up of muscles, bones, and organs. The CDE uses age and sex specific growth charts and measures body mass by skinfold

Body Composition, Youth: Yolo County, 2012-2013			
Grade Level	% in HFZ	% in Needs Improvement	% in Health Risk
5th Grade	48%	14%	38%
7th Grade	56%	14%	30%
9th Grade	60%	14%	25%

measurements, bioelectric impedance analyzer, or body mass index.

Percent of Youth at Health Risk for Body Composition by School District: 2012-2013					
Grade Level	Davis JUSD	Esparto USD	Washington USD	Winters JUSD	Woodland JUSD
5th Grade	N/A	35%	34%	36%	41%
7th Grade	19%	38%	35%	6%	39%
9th Grade	15%	22%	29%	26%	32%

Youth from Washington Unified School District and Woodland Joint Unified School District exhibit lower percentages of students in the healthy fitness zone (HFZ) based on their body composition; higher percentages of students in these school districts fall into the "Needs Improvement" and "Health Risk" categories.

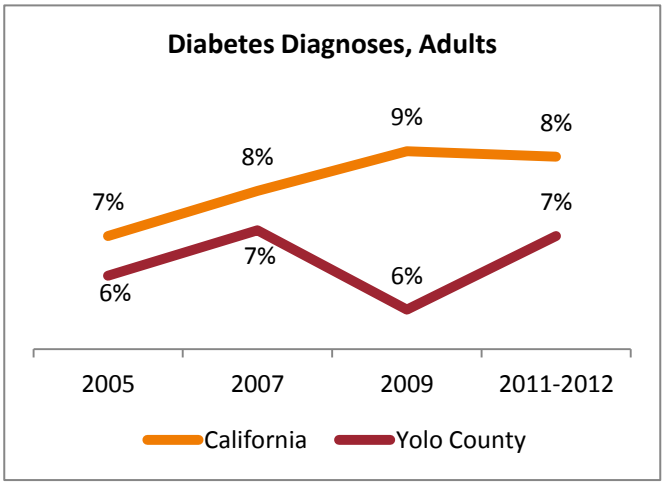
Percent of Youth at Health Risk for Body Composition by Population Group: 2012-2013			
Population Group	5th Grade	7th Grade	9th Grade
All Students	**38%**	**30%**	**25%**
Sex			
Male	39%	29%	24%
Female	37%	31%	27%
Race/Ethnicity			
African American/ Black	37%	21%	23%
American Indian/ Alaska Native	LNE	32%	29%
Asian American	14%	15%	19%
Filipino	26%	14%	10%
Hispanic/ Latino	45%	40%	32%
White	29%	21%	20%
Multiracial	17%	35%	42%
Economic Advantage			
Economically Disadvantaged	42%	37%	31%
Not Economically Disadvantaged	35%	25%	22%

The prevalence of students with a body composition falling into the "Needs Improvement" category is also higher among students who are economically disadvantaged, and students of Hispanic/Latino descent.

DIABETES

Diabetes is among the chronic conditions nationwide with an increase that is attributed to the rise in poor diet, sedentary lifestyle, and obesity.

Between 2005 and 2012, the percentage of adults diagnosed with diabetes has been slightly lower than statewide, but has also been slowly increasing.



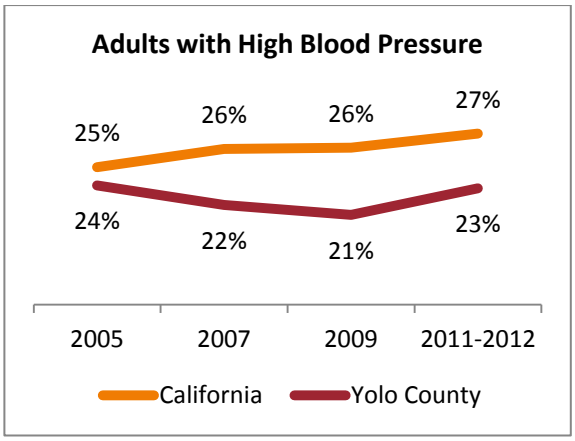
Diabetes Diagnosis by Population Group, Adults: Yolo County				
Population Group	**2005**	**2007**	**2009**	**2011-2012**
Ethnicity				
Hispanic/Latino	6%	**11%**	**10%**	**13%**
Non-Hispanic/Latino	6%	6%	4%	5%
Gender				
Female	**7%**	7%	3%	7%
Male	5%	**8%**	**9%**	**7%**
Household Income				
Less than $50,000	**8%**	**9%**	**9%**	**11%**
$50,001 - $100,000	5%	3%	0%	4%
$100,000 +	5%	**7%**	4%	3%

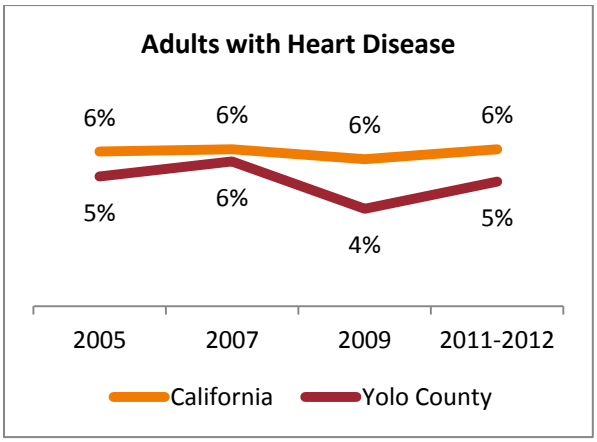
In particular, while the percentage of non-Hispanic/Latino adults with diabetes has fallen, the percentage of Hispanic/Latino adults diagnosed with diabetes has more than doubled. Other groups exhibiting comparatively higher prevalence of diabetes are males and individuals in households with an annual income below $50,000.

HEART DISEASE AND HIGH BLOOD PRESSURE

Poor heart health is a leading cause of death nationwide and has been linked to high cholesterol, high blood pressure, and heart attacks.

A consistently lower-than-statewide percentage of Yolo County adults reported having a diagnosis of heart disease (i.e. coronary heart disease or angina) since 2005.





The prevalence of hypertension, or high blood pressure, has shown minimal change since 2005 within Yolo County, despite moderate increases in its prevalence statewide. The proportion of adults who report having ever suffered from a stroke is similar both statewide and countywide.

CHRONIC LUNG DISEASE

Across all age groups, sexes, and ethnic groups, the number of emergency room visits for chronic lung disease (e.g., COPD, asthma, emphysema, etc.) in Yolo County between 2008 and 2012 has significantly increased, though the number of hospital admissions

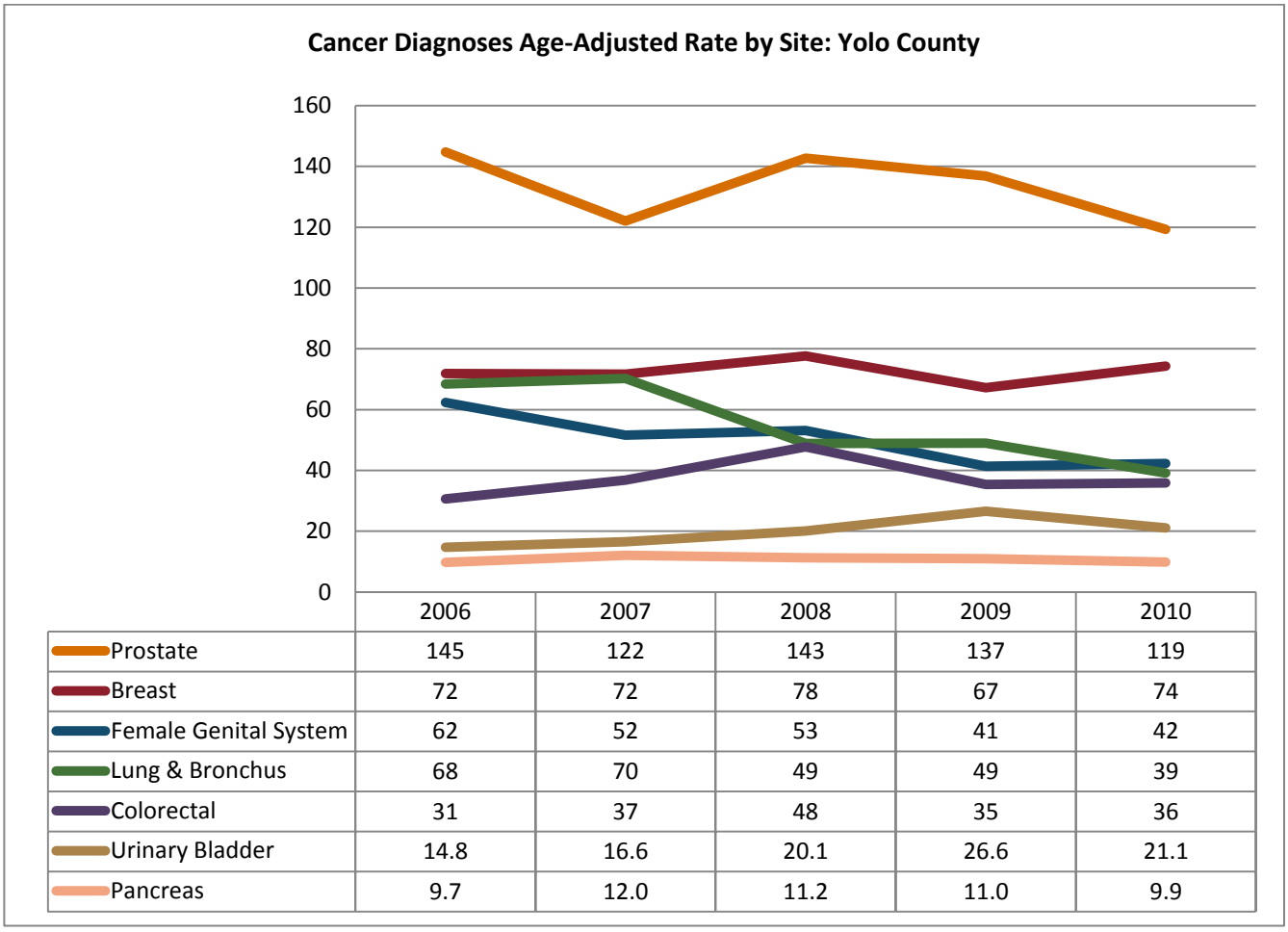
Hospital Admits for Chronic Lung Disease: Yolo County					
	2008	**2009**	**2010**	**2011**	**2012**
Total	248	225	214	195	240
Rate per 100K	125.5	112.7	106.5	97.0	118.7
**ICD-9 Codes 490-496*					

decreased within the same timeframe. These data suggests that while issues related to chronic lung disease are apparently more frequent, they are less severe than in the past.

CANCER

Cancer has come to be among the leading causes of death nationwide. Both countywide and statewide, the age-adjusted rate of cancer in all sites of the body has decreased. Below are the incidence rates, or new cases of cancer that are diagnosed.

The countywide age-adjusted rates of colorectal, lung/bronchus, prostate, and female reproductive cancers have been decreasing in prevalence, the age-adjusted rates of breast and pancreatic cancers have remained relatively stable, and the age-adjusted rate of urinary bladder cancers has increased. The following graph compares these trends:



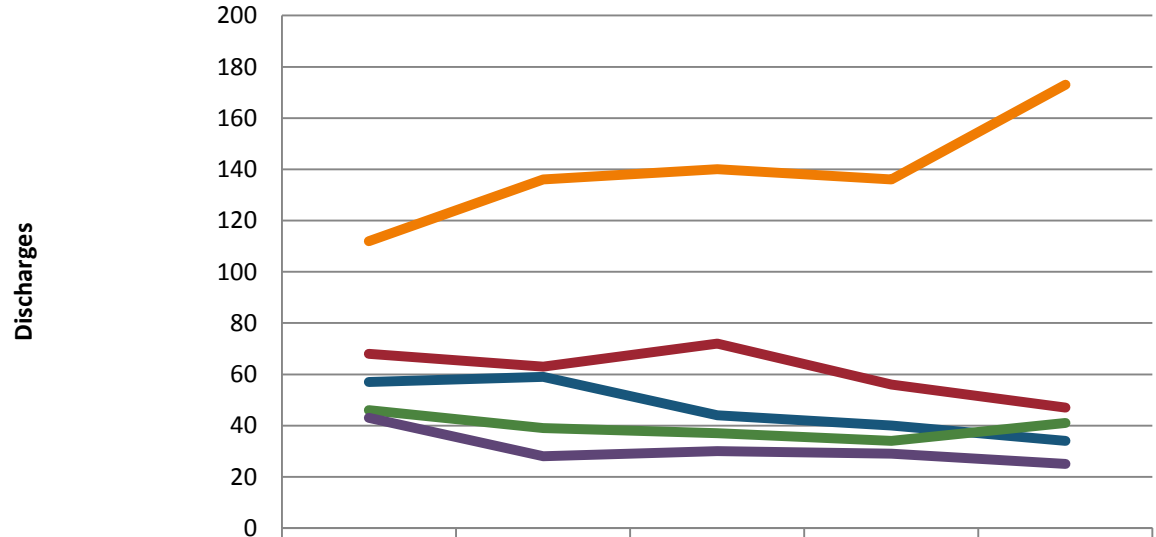
	2006	2007	2008	2009	2010
Prostate	145	122	143	137	119
Breast	72	72	78	67	74
Female Genital System	62	52	53	41	42
Lung & Bronchus	68	70	49	49	39
Colorectal	31	37	48	35	36
Urinary Bladder	14.8	16.6	20.1	26.6	21.1
Pancreas	9.7	12.0	11.2	11.0	9.9

HOSPITALIZATIONS

Both countywide and statewide, the top three leading causes of hospitalization overall based on primary diagnosis listed at time of discharge were mental diseases and disorders, asthma/bronchitis, and pneumonia/pleurisy. Compared to statewide figures, Yolo County exhibits lower rates of hospitalization for asthma, bronchitis, and pneumonia, but considerably higher rates of hospitalization due to mental diseases and disorders. Mental illness constitutes 10.5% of hospitalizations statewide, but 13.2% of hospitalizations within Yolo County.

For children ages 0 to 17, the most common primary diagnosis in 2012 was for mental diseases and disorders, which consisted of nearly 17% of all hospital discharges, much greater than the statewide rate of 12%. Mental diseases and disorders have been trending upwards over the past five years, going from 112 hospitalizations in 2008 to 173 in 2012. Hospitalizations for diagnoses including metabolic/nutritional disorders, diabetes, and traumatic injuries decreased between 2007 and 2011.

Hospital Discharges by Primary Diagnosis, Ages 0-17: Yolo County



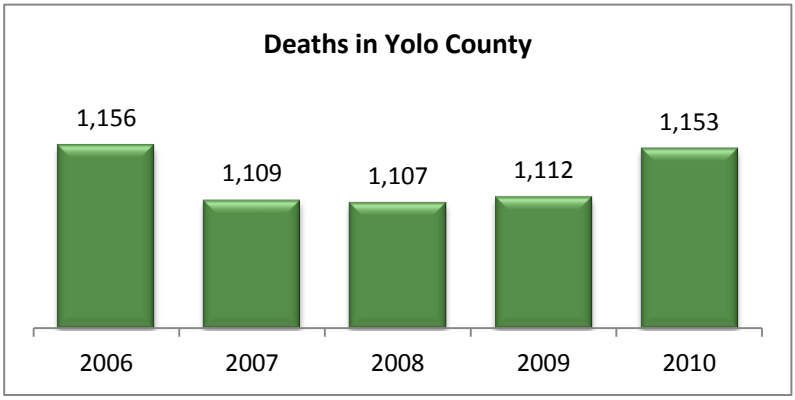
	2008	2009	2010	2011	2012
Mental Diseases and Disorders	112	136	140	136	173
Asthma/Bronchitis	68	63	72	56	47
Pneumonia/Pleurisy	57	59	44	40	34
Fractures	46	39	37	34	41
Seizures/Headaches	43	28	30	29	25

MORTALITY

Mortality is an important indicator of underlying health conditions in the population. Measuring the leading causes of mortality and trends in mortality in our community allows for understanding and/or predicting the connections between social and economic determinants of health and health outcomes, and allowing for a better understanding of how certain community health needs may be addressed.

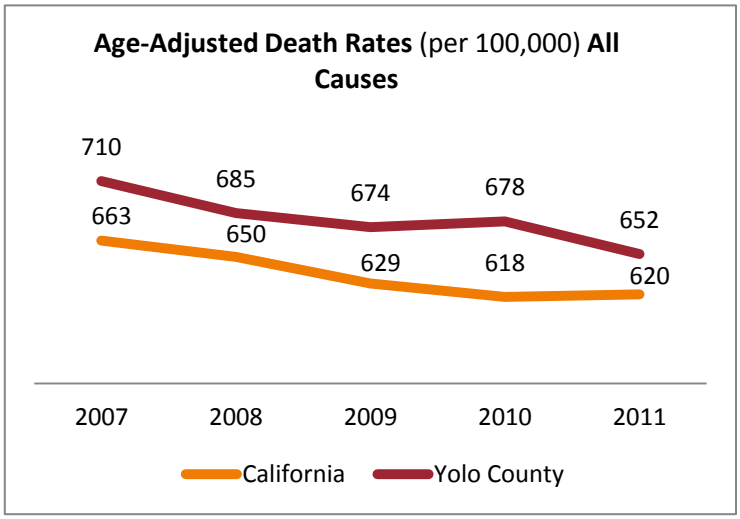
The life expectancy in 2010 for Yolo County residents mirrors that of the state. Males in Yolo County have a life expectancy of 78 years and females have a life expectancy of 82.1 years. The life expectancy is slightly below that of the state with males at 78.2 years and females at 82.5 years.

Deaths in Yolo County



The overall death rate is a measure of the number of deaths per 100,000 persons per year; a higher overall death rate indicates that deaths are more frequent in that population. Different groups are compared by calculating the death rate by age group or race/ethnicity. The age-adjusted mortality rates for all causes of death have been steadily decreasing over the past five years for both the state and Yolo County. Yolo County's death rate has consistently been higher than the state's death rate, but the gap is narrowing.

The overall age-adjusted death rate in Yolo County in 2011 was 652 deaths per 100,000 persons, a risk of dying equivalent to approximately one death for every 153 persons per year. Yolo County's overall death rate is higher than California's at 620, a risk of dying equivalent to approximately one death for every 161 persons.



Age-Adjusted Death Rates, All Causes: 2011		
Population Group	**California**	**Yolo County**
Sex		
Male	732.7	**744.3**
Female	529.2	580.3
Race/Ethnicity		
American Indian	406.4	**802.2**
Asian	401.2	320.5
Black/African American	903.7	**1026.2**
Hispanic/Latino	495.9	592.3
Pacific Islander	587.4	456.7
White	691.1	**699.5**
Two or More Races	346.4	356.2

Males typically have a higher death rate than females; however, the female death rate in Yolo County is 10% higher than the state and only 2% higher for males. The death rate for American Indians in Yolo County is 97% higher than the state rate and the Hispanic/Latinos' death rate is nearly 20% higher. Asians and Pacific Islanders have a death rate roughly 20% lower than the statewide death rate.

LEADING CAUSES OF DEATH

In 2010, the five leading causes of death in Yolo County based on grouped cause of death codes were cancers (22%), diseases of the heart (20%), chronic lower respiratory diseases (8%), cerebrovascular diseases (7%), and Alzheimer's disease (6%).

Forty-two percent of deaths were premature and the four leading causes of premature death were cancer (29%), diseases of the circulatory system (22%), external causes of mortality, which include accidents, suicide, and homicide (15%), and diseases of the respiratory system (9%).

The table on the following page displays the age-adjusted leading causes of death by age group in Yolo County. Accidents, in particular motor vehicle accidents, and suicides are the leading causes of death for Yolo County residents 34 years and younger. For older adults and seniors, cancer and ischemic heart disease were the leading causes of death. Cerebrovascular diseases increased from a rank of fifth for the 55 to 64 age group to third for those 75 and over. Of note, influenza and pneumonia ranked fifth among those 75 and over.

Leading Causes of Death by Age Group, Yolo County: 2000 - 2010

Rank	1 - 14 Years	15 - 24 Years	25 - 34 Years	35 - 44 Years	45 - 54 Years	55 - 64 Years	65 - 74 Years	75 + Years
1	Accidents other than Motor Vehicle	Motor Vehicle Accident	Motor Vehicle Accident	Cancer	Cancer	Cancer	Cancer	Cancer
2	Motor Vehicle Accident	Suicide	Suicide	Accidents other than Motor Vehicle	Ischemic Heart Diseases	Ischemic Heart Diseases	Ischemic Heart Diseases	Ischemic Heart Diseases
3	Cancer	Accidents other than Motor Vehicle	Cancer	Motor Vehicle Accident	Diseases of Liver	Chronic Lower Respiratory Diseases	Chronic Lower Respiratory Diseases	Cerebro-vascular Diseases
4	*Suppressed*	*Suppressed*	Accidents other than Motor Vehicle	Suicide	Accidents other than Motor Vehicle	Diseases of Liver	Cerebro-vascular Diseases	Chronic Lower Respiratory Diseases
5	*Suppressed*	*Suppressed*	*Suppressed*	Ischemic Heart Diseases	Motor Vehicle Accident	Cerebro-vascular Diseases	Other forms of heart disease	Influenza and Pneumonia

Leading causes of death are based on the ICD Sub-Chapter
Rates are "Suppressed" for data representing less than 10 deaths.

Among the leading causes of death for females and males 25 years and older in Yolo County are lung cancer, heart disease, COPD, and heart attack (myocardial infarction). The following tables show that the death rates for Alzheimer's disease among females and males have increased over time. For the period of 2001 to 2005 Alzheimer's disease ranked seventh and eighth, respectively, whereas in the period of 2006 to 2010 Alzheimer's disease has risen to the number one leading cause of death for women and the fifth leading cause for men.

Leading Causes of Death, Females 25 Years and Older: Yolo County, 2006 - 2010

2006-10 Rank	Cause of Death: Females	Age-Adjusted Rate	2001-05 Rank	Change in Rank
1	Alzheimer's disease	59.3	7	↑
2	Cancer - Bronchus or lung, unspecified	55.7	2	↔
3	Chronic obstructive pulmonary disease (COPD)	45.0	4	↓
4	Atherosclerotic heart disease	43.5	1	↓
5	Acute myocardial infarction	42.7	5	↔
6	Stroke, not specified as hemorrhage or infarction	39.2	3	↓
7	Pneumonia	34.8	6	↓
8	Cancer - Breast	33.5	8	↔
9	Unspecified dementia	21.6	10	↑
10	Congestive heart failure	19.4	9	↓

Leading Causes of Death, Males 25 Years and Older: Yolo County, 2006 - 2010

2006-10 Rank	Cause of Death: Males	Age-Adjusted Rate	2001-05 Rank	Change in Rank
1	Atherosclerotic heart disease	86.5	1	↔
2	Cancer - Bronchus or lung, unspecified	74.8	3	↑
3	Acute myocardial infarction	64.8	2	↓
4	Chronic obstructive pulmonary disease (COPD)	57.9	4	↔
5	Alzheimer's disease	43.2	8	↑
6	Stroke, not specified as hemorrhage or infarction	42.4	6	↔
7	Pneumonia, unspecified	40.0	5	↓
8	Cancer of prostate	35.0	7	↓
9	Congestive heart failure	28.4	11	↑
10	Cancer - Colon	21.4	13	↑

Both ethnicities are experiencing high death rates for heart disease and lung cancer. Non-Hispanic/Latinos have a higher death rate for Alzheimer's disease (56.2) compared to Hispanic/Latinos (34.2). Hispanic/Latinos have had an increase in the death rates for cirrhosis of the liver, colon, and pancreatic cancers. In 2001 to 2005, these were not listed in the top ten causes of death for Hispanic/Latinos. Also of note, unspecified diabetes mellitus is listed as the eighth cause of death for Hispanic/Latinos.

Leading Causes of Death, Hispanic/Latinos 25 Years and Older: Yolo County, 2006 - 2010

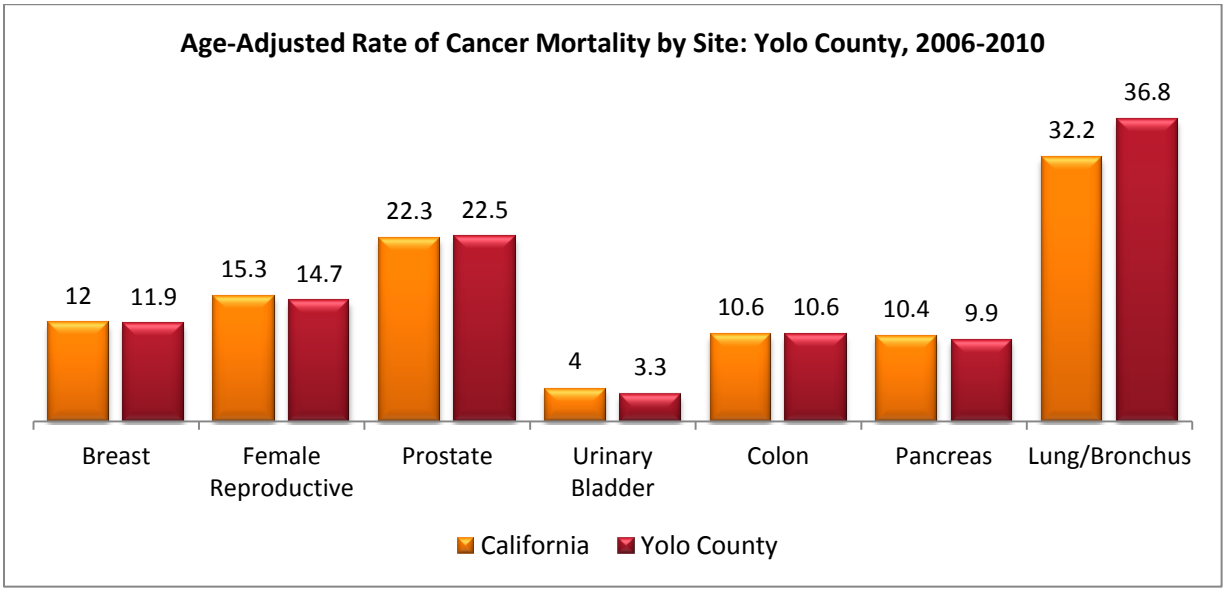
06-10 Rank	Cause of Death: Hispanic/Latino	Age-Adjusted Rate	01-05 Rank	Change in Rank
1	Atherosclerotic heart disease	64.3	2	↑
2	Cancer - Bronchus or lung	42.5	3	↓
3	Acute myocardial infarction	38.0	1	↓
4	Stroke, not specified as hemorrhage or infarction	38.3	4	↔
5	Pneumonia, unspecified	35.0	5	↔
6	Alzheimer's disease	34.2	8	↑
7	Alcoholic cirrhosis of liver	Unreliable	N/R	↑
8	Unspecified diabetes mellitus, without complications	Unreliable	6	↓
9	Cancer - Colon	Unreliable	N/R	↑
10	Cancer - Pancreas	Unreliable	N/R	↑

Leading Causes of Death, Non-Hispanic/Latinos 25 Years and Older: Yolo County, 2006 - 2010

06-10 Rank	Cause of Death: Non-Hispanic/Latino	Age-Adjusted Rate	01-05 Rank	Change in Rank
1	Cancer - Bronchus or lung	68.1	2	↑
2	Atherosclerotic heart disease	62.3	1	↓
3	Chronic obstructive pulmonary disease (COPD)	56.9	3	↔
4	Alzheimer's disease	56.2	7	↑
5	Acute myocardial infarction	55.2	4	↓
6	Stroke, not specified as hemorrhage or infarction	42.1	5	↓
7	Pneumonia	36.8	6	↓
8	Congestive heart failure	25.5	8	↔
9	Unspecified dementia	23.3	9	↔
10	Cancer - Breast	19.5	11	↑

CANCER

Death due to malignant neoplasm or cancer is a major indicator of health as cancer is a leading cause of death nationwide. Countywide, cancers are the leading cause of premature death and the leading cause of death overall. The top six sites for cancer deaths in Yolo County between 2007 and 2012 were lung or bronchus, unspecified sites, pancreas, colon, breast, and prostate.

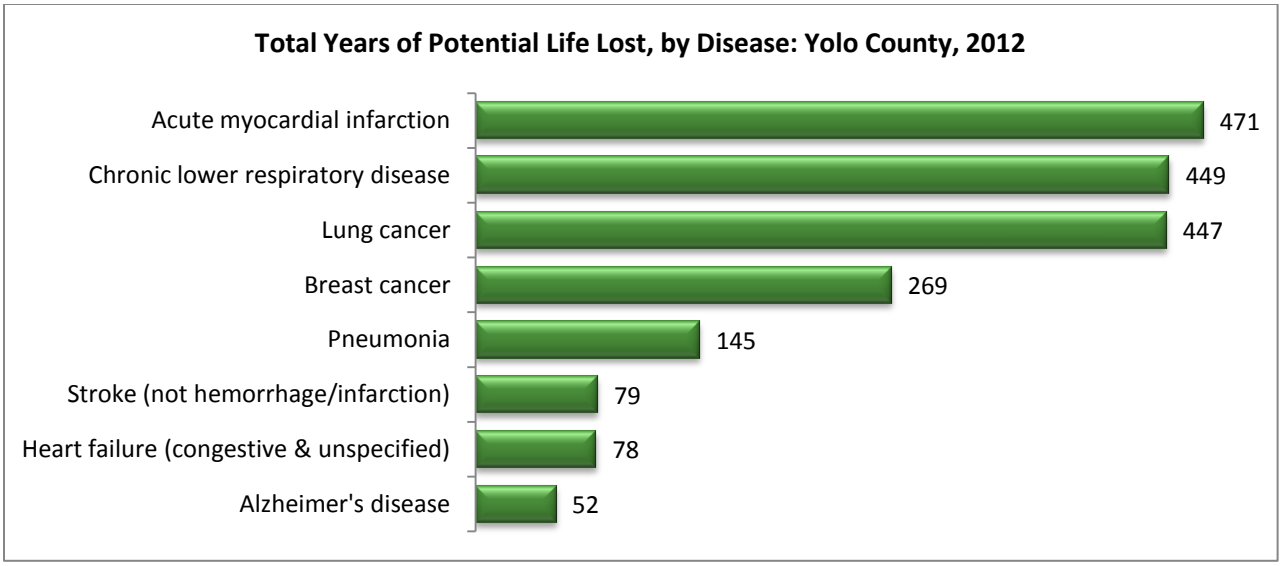


YEARS OF POTENTIAL LIFE LOST

Premature death is represented by the years of potential life lost before the age of 75. Every death occurring before the age of 75 contributes to the total number of years of potential life lost (YPLL). For example, a person dying at age 25 contributes 50 years of life lost, whereas a person who dies at age 65 contributes 10 years of life lost to a county's YPLL.

Measuring premature death, rather than overall mortality, reflects the intent to focus attention on deaths that could have been prevented. Measuring YPLL allows communities to target resources to high-risk areas and further investigate the causes of premature death.

Heart attacks, chronic lower respiratory disease, and cancer, both lung and breast, account for the highest number of years of potential life lost to Yolo County residents in 2012.



COMMUNITY THEMES AND STRENGTHS ASSESSMENT RESULTS

Results of the Community Themes and Strengths Assessment (CTSA) survey are categorized by survey topic and county region. The respondents' demographics compared to the U.S. Census data are presented in the CTSA report located on the Healthy Yolo website.

RESPONDENT DEMOGRAPHICS

The CTSA survey was designed for Yolo County residents 15 years and older. In total, 900 surveys collected; 88 surveys did not state a city of residence. The number of surveys from each county region is listed to the right.

CTSA Survey Responses by Region

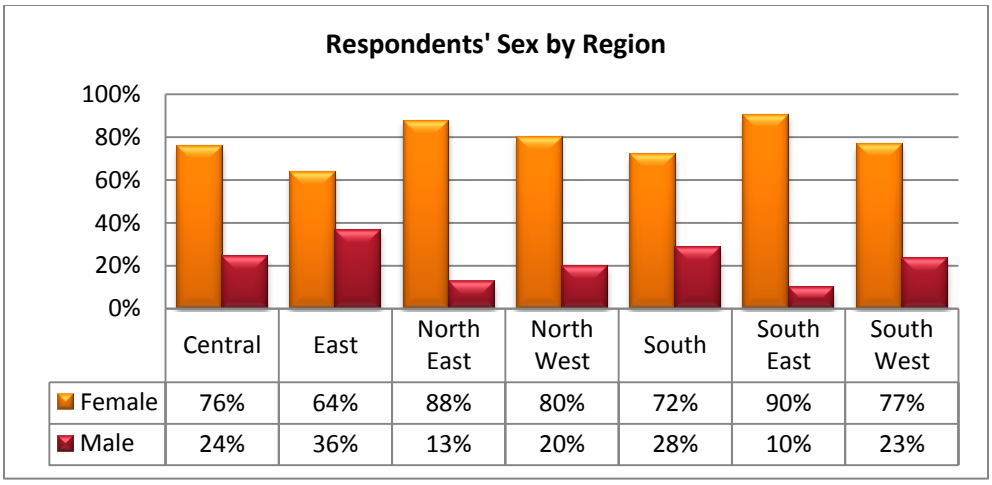
Region	Surveys
Central	163
East	215
North East	42
North West	68
South	245
South East	10
South West	69
Total	**900**

RESPONDENT DEMOGRAPHICS BY REGION

The majority of respondents were long-time (10 years or more) Yolo County residents, English-speaking, non-Hispanic/Latinos, white females, 44% of whom were between the ages of 35 and 64; most respondents reported a household income of $35,000 or more.

SEX

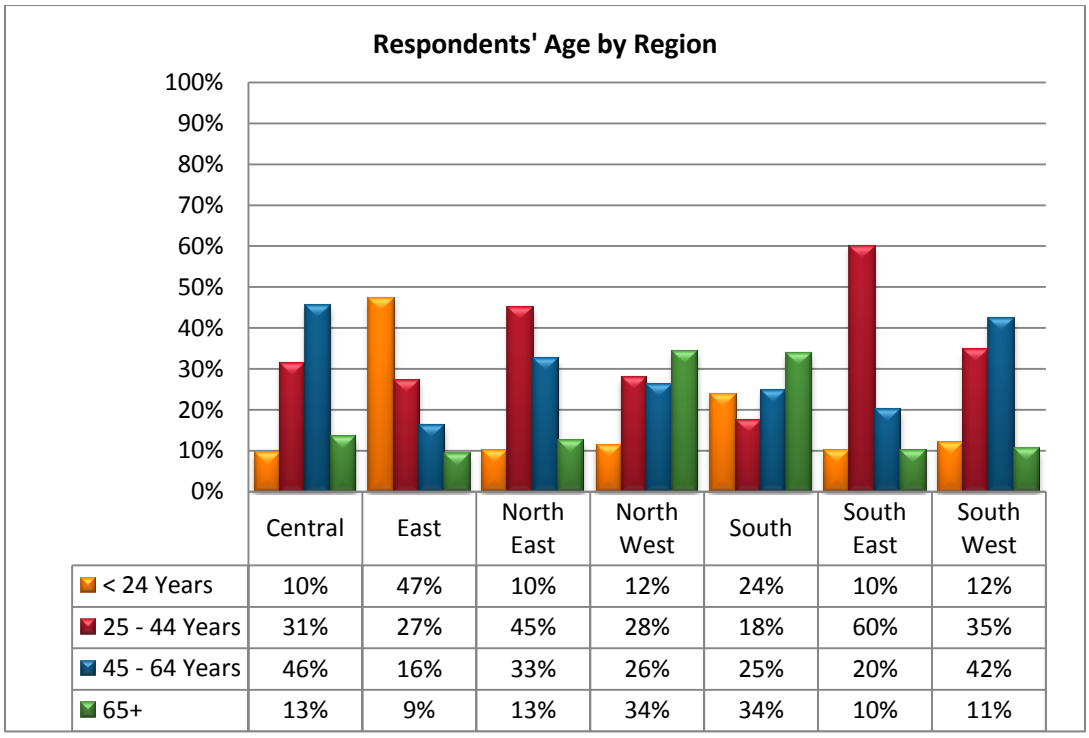
Survey respondents included nearly 600 females, 228 males, and 74 declining to state.



	Central	East	North East	North West	South	South East	South West
Female	76%	64%	88%	80%	72%	90%	77%
Male	24%	36%	13%	20%	28%	10%	23%

AGE

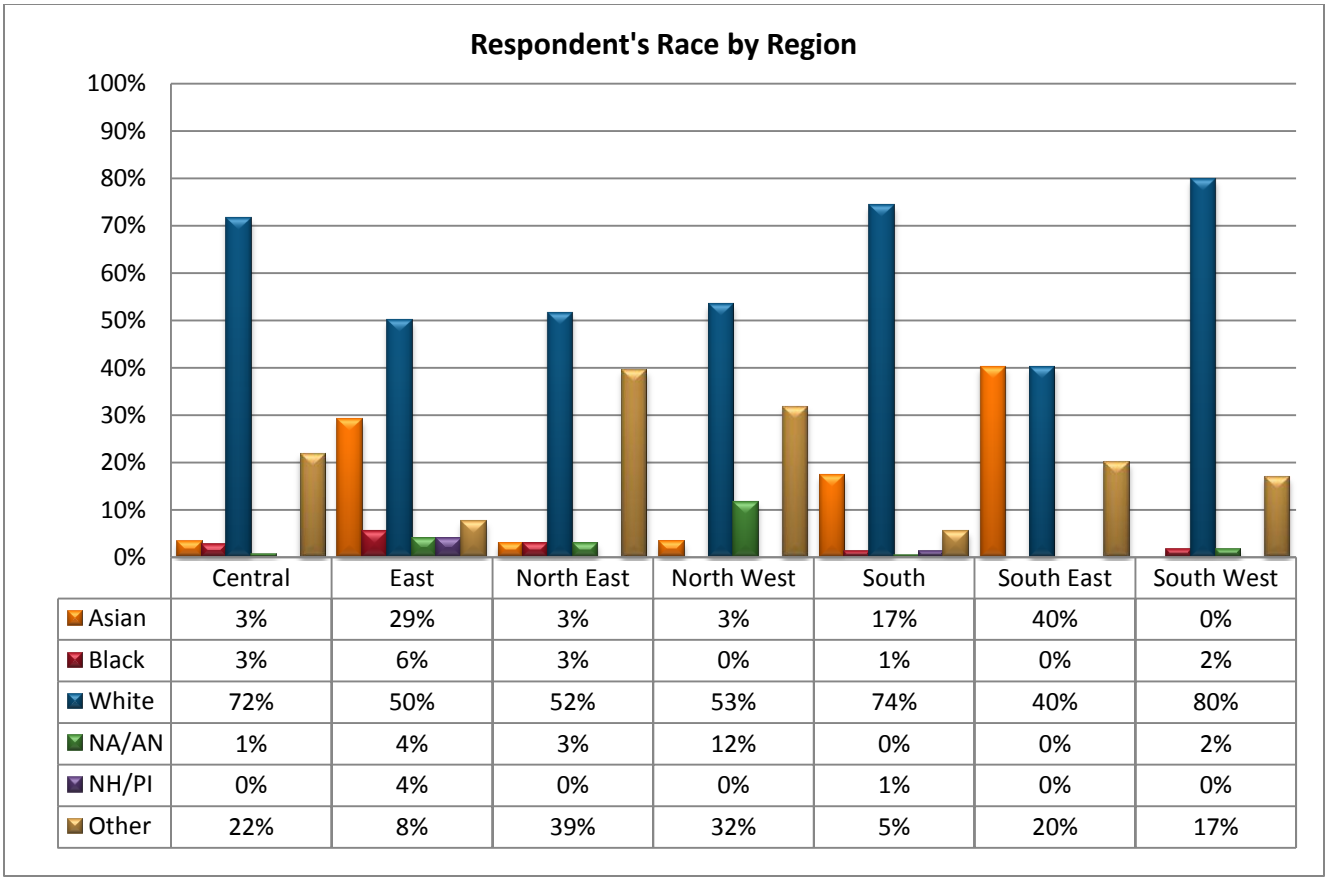
Overall, 56% of the survey respondents were between the ages of 25 to 64 years of age. Seventy-eight respondents chose not to answer this question. The East region had the largest youth and young adult (ages 15 – 24) response rate with 47%. Conversely, the North West and South regions had the largest senior (65 years and older) response rate with 34% each.



	Central	East	North East	North West	South	South East	South West
< 24 Years	10%	47%	10%	12%	24%	10%	12%
25 - 44 Years	31%	27%	45%	28%	18%	60%	35%
45 - 64 Years	46%	16%	33%	26%	25%	20%	42%
65+	13%	9%	13%	34%	34%	10%	11%

RACE AND ETHNICITY

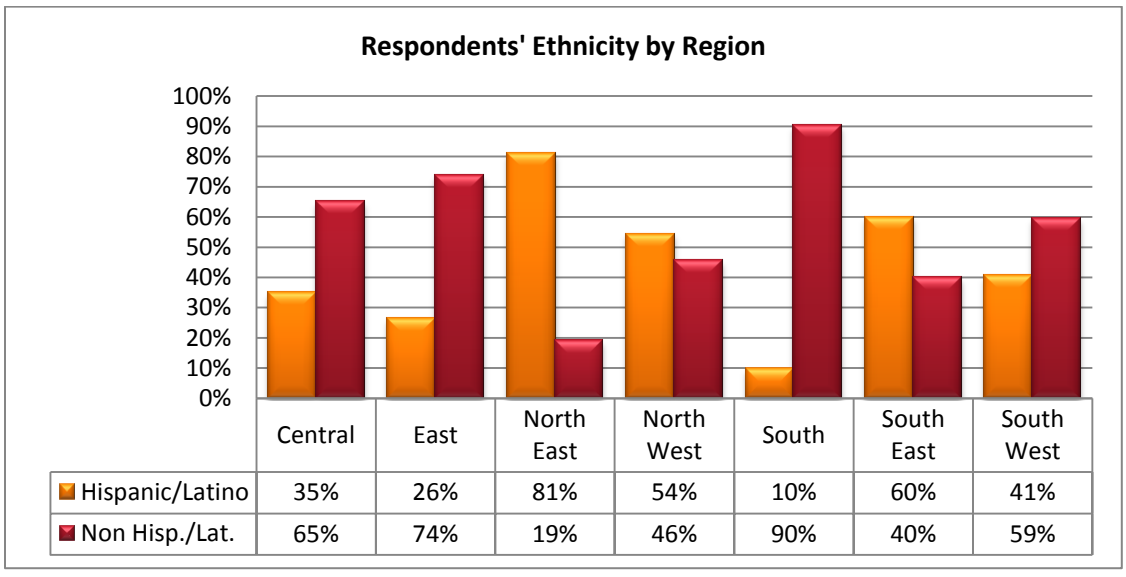
Approximately two-thirds of respondents as a whole were White; 130 respondents declined to state their race. Similar percentages of respondents in the Central, South, and South West regions were White. The East region exhibited the highest level of diversity, including a considerable Asian population (29%).



	Central	East	North East	North West	South	South East	South West
Asian	3%	29%	3%	3%	17%	40%	0%
Black	3%	6%	3%	0%	1%	0%	2%
White	72%	50%	52%	53%	74%	40%	80%
NA/AN	1%	4%	3%	12%	0%	0%	2%
NH/PI	0%	4%	0%	0%	1%	0%	0%
Other	22%	8%	39%	32%	5%	20%	17%

Note: NA/AN (Native American and Indigenous Persons). NH/PI (Native Hawaiian or other Pacific Islander).

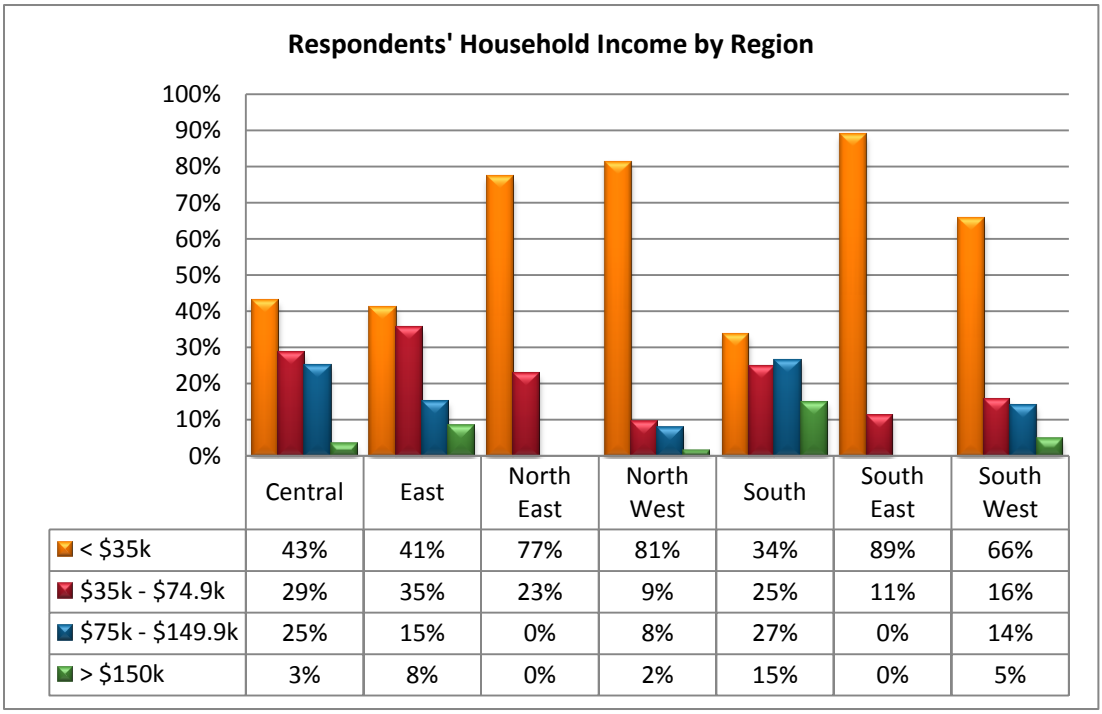
Approximately one-third of respondents were Hispanic/Latino, reflective of the percentage of the population as a whole. The largest proportions of Hispanic/Latino respondents were in the North East (81%), South East (60%), and North West (54%) regions; the smallest proportion was in the South region (10%).



	Central	East	North East	North West	South	South East	South West
Hispanic/Latino	35%	26%	81%	54%	10%	60%	41%
Non Hisp./Lat.	65%	74%	19%	46%	90%	40%	59%

HOUSEHOLD INCOME

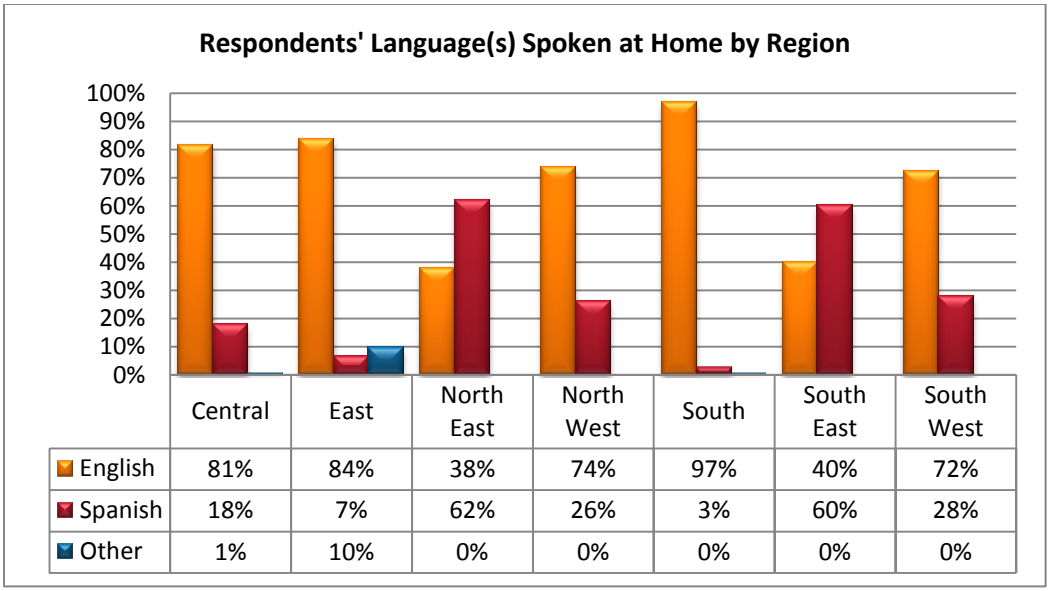
While 17% of respondents declined to state their annual household income, 48% of respondents reported a household income of less than $50,000, with 17% being under $10,000. Respondents from the South exhibited the widest variety of household incomes, as well as the largest proportion of respondents with an annual household income of over $75,000. Households with an annual income of less than $35,000 were most represented in the North East (77%), North West (81%), and South East (89%) regions. One hundred fifty two respondents chose not to state their household income.



	Central	East	North East	North West	South	South East	South West
< $35k	43%	41%	77%	81%	34%	89%	66%
$35k - $74.9k	29%	35%	23%	9%	25%	11%	16%
$75k - $149.9k	25%	15%	0%	8%	27%	0%	14%
> $150k	3%	8%	0%	2%	15%	0%	5%

LANGUAGE SPOKEN AT HOME

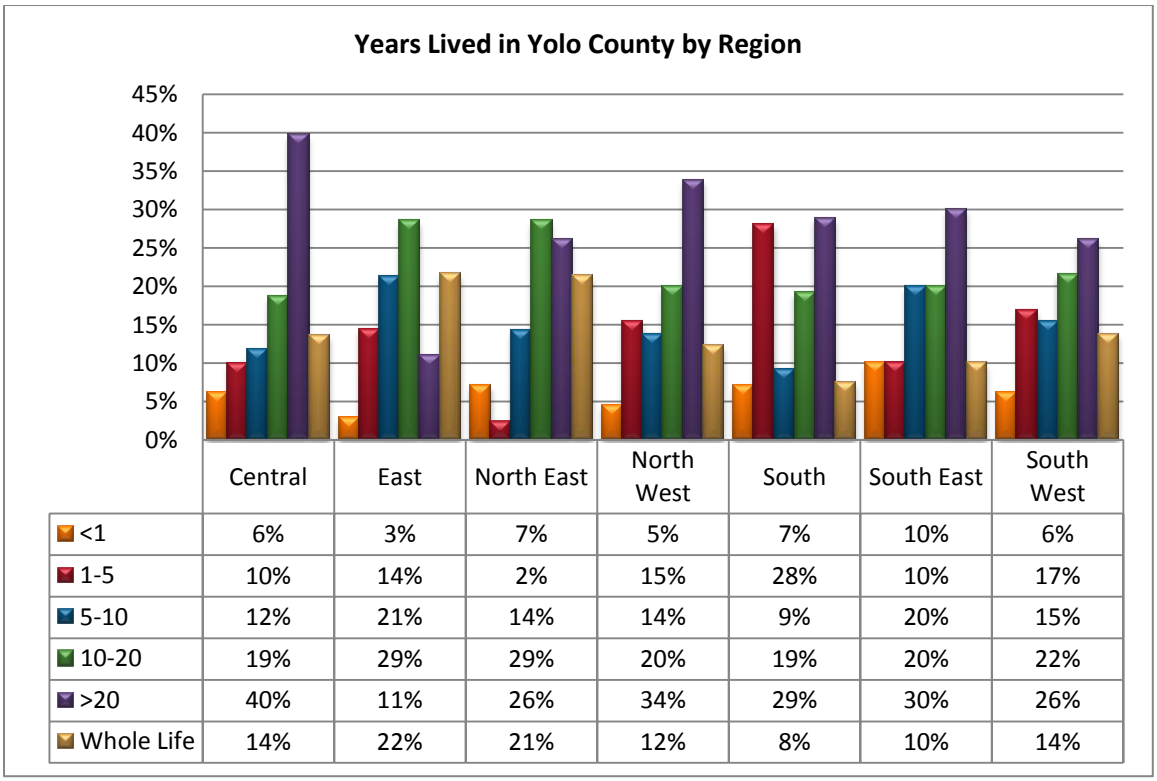
Overall, the language most frequently spoken at home by respondents was English (83%). However, in the North East and South East regions, the language most frequently reported spoken at home was Spanish. The East region also exhibited the highest percentage of respondents (10%) speaking a language other than English or Spanish at home. Sixty-two respondents chose not to state the language spoken at home.



	Central	East	North East	North West	South	South East	South West
English	81%	84%	38%	74%	97%	40%	72%
Spanish	18%	7%	62%	26%	3%	60%	28%
Other	1%	10%	0%	0%	0%	0%	0%

YEARS LIVED IN YOLO COUNTY

A vast majority of respondents have lived in Yolo County for more than five years, with 14% of the respondents having lived in Yolo County their whole life. Specifically, over half of Central region respondents reported living in Yolo County either "more than 20 years" or their whole lives. Sixty-nine respondents chose not to state the years lived in Yolo County.



	Central	East	North East	North West	South	South East	South West
<1	6%	3%	7%	5%	7%	10%	6%
1-5	10%	14%	2%	15%	28%	10%	17%
5-10	12%	21%	14%	14%	9%	20%	15%
10-20	19%	29%	29%	20%	19%	20%	22%
>20	40%	11%	26%	34%	29%	30%	26%
Whole Life	14%	22%	21%	12%	8%	10%	14%

COMMUNITY HEALTH ISSUES AND CONTRIBUTING FACTORS

The CTSA survey respondents were asked to select the top three health issues that most affect their communities from a list of 20 health issues, as well as two write-in options. Respondents were also asked to identify contributing factors most responsible for health issues in our community: three for each contributing factor. The CTSA survey provided 16 individual behaviors, 10 social and economic circumstances, and 14 environmental issues. Each contributing factor had two write-in options available. Respondents selected three contributing factors for each category.

In addition, during the community open house events, Healthy Yolo provided a health issues wall chart where, out of 30 options, community members selected three priority health issues by placing a sticker after that health issue. The additional health issues provided specificity to the health issues on the CTSA survey.

YOLO COUNTY

PRIORITIZED HEALTH ISSUES

Obesity was selected as the health issue that most affects our community with 375 selections followed by mental health issues and diabetes. The write-in responses primarily consisted of drug abuse (22) and other issues that are considered contributing factors. The 20 health issues and two write-in options, in rank order, are listed in the table below.

Health Issues that Most Affect Our Community: Yolo County	Number	Percent	Rank
Obesity	375	42%	1
Mental Health Issues	287	32%	2
Diabetes	272	30%	3
Health Problems assoc. with Aging	254	28%	4
Cancer	244	27%	5
Alcoholism	227	25%	6
Heart Disease	183	20%	7
Dental Problems	134	15%	8
Child Abuse and Neglect	134	15%	8
Teenage Pregnancy	105	12%	10
Respiratory Illnesses/Lung Disease/Asthma	92	10%	11
Motor Vehicle/Bicycle Accidents	85	9%	12
Sexually Transmitted Diseases	55	6%	13
Infectious Diseases	54	6%	14
Other 1	52	6%	15
Sexual Abuse	46	5%	16
Stroke	40	4%	17
Homicide	19	2%	18
Poor Birth Outcomes	18	2%	19
Other 2	3	0.3%	20
Total Participants	**900**		

The top five health issues that most affect our community that respondents identified were stratified by sex, ethnicity, race, age, and household income. Female and non-Hispanic/Latino respondents were more likely to identify mental health issues as priorities in their communities. Hispanic/Latino residents most frequently expressed concern about diabetes. Obesity was generally ranked high among Black/African American respondents as a priority, though they were the only racial subgroup that identified other health issues, namely mental health issues and alcoholism, which outranked obesity as a health concern. The percentage of respondents identifying heart disease as a priority health issue was higher among Asians than in other racial subgroups. Additionally, concern about obesity appears to decrease with age, while concern about mental health issues and age-related health problems increases.

Stratified by household income, obesity is the most commonly identified issue that affects health in our community across all income levels. However, lower-income respondents more frequently expressed concern about mental health issues, while higher-income respondents more frequently expressed concern about diabetes.

Health issues are followed by the percentage of participants and count of responses.

Top 5 Health Issues of Concern, by Sex

Rank	Female (n=597)	Male (n=220)
1	**Obesity** 43% (257)	**Obesity** 42% (96)
2	**Mental Health Issues** 35% (211)	**Health Problems assoc. with Aging** 34% (77)
3	**Diabetes** 30% (178)	**Diabetes** 32% (74)
4	**Alcoholism** 28% (165)	**Cancer** 29% (66)
5	**Health Problems assoc. with Aging** 27% (162)	**Heart Disease** 28% (65)

Top 5 Health Issues of Concern, by Ethnicity

Rank	Hispanic/Latino (n=234)	Non-Hispanic/Latino (n=646)
1	**Diabetes** 47% (120)	**Obesity** 40% (259)
2	**Obesity** 46% (116)	**Mental Health Issues** 37% (239)
3	**Cancer** 35% (88)	**Health Problems assoc. with Aging** 32% (207)
4	**Alcoholism** 23% (59)	**Alcoholism** 26% (168)
5	**Dental Problems** 22% (55)	**Cancer** 24% (156)

Top 5 Health Issues of Concern, by Race

Rank	White (n=498)	Black (n=20)	Asian (n=109)	NA/IP & NH/PI (n=31)	Other (n=112)
1	**Obesity** 43% (212)	**Mental Health Issues** 45% (9)	**Obesity** 52% (57)	**Obesity** 36% (12)	**Obesity** 46% (51)
2	**Mental Health Issues** 38% (187)	**Alcoholism** 45% (9)	**Diabetes** 39% (43)	**Alcoholism** 29% (9)	**Diabetes** 46% (51)
3	**Health Problems assoc. with Aging** 32% (161)	**Obesity** 25% (5)	**Heart Disease** 34% (37)	**Health Problems assoc. with Aging** 29% (9)	**Cancer** 30% (34)
4	**Cancer** 27% (135)	**Cancer** 25% (5)	**Alcoholism** 33% (36)	**Cancer** 26% (8)	**Alcoholism** 27% (30)
5	**Diabetes** 26% (127)	**Dental Problems** 25% (5)	**Health problems assoc. with aging** 25% (27)	**Mental Health Issues** 26% (8)	**Mental Health Issues** 23% (26)

Top 5 Health Issues of Concern, by Age Group

Rank	< 25 Years (n=88)	25 - 44 Years (n=222)	45 - 64 Years (n=238)	65 + Years (n=165)
1	**Obesity** 48% (42)	**Obesity** 45% (101)	**Mental Health issues** 39% (92)	**Health Problems assoc. with Aging** 61% (100)
2	**Heart Disease** 32% (28)	**Diabetes** 37% (83)	**Obesity** 39% (92)	**Mental Health Issues** 38% (62)
3	**Diabetes** 28% (25)	**Mental Health Issues** 35% (77)	**Health Problems assoc. with Aging** 32% (77)	**Obesity** 36% (60)
4	**Mental Health Issues** 27% (24)	**Cancer** 32% (70)	**Diabetes** 29% (68)	**Diabetes** 28% (47)
5	**Alcoholism** 32% (60)	**Alcoholism** 27% (61)	**Alcoholism** 25% (59)	**Cancer** 27% (44)

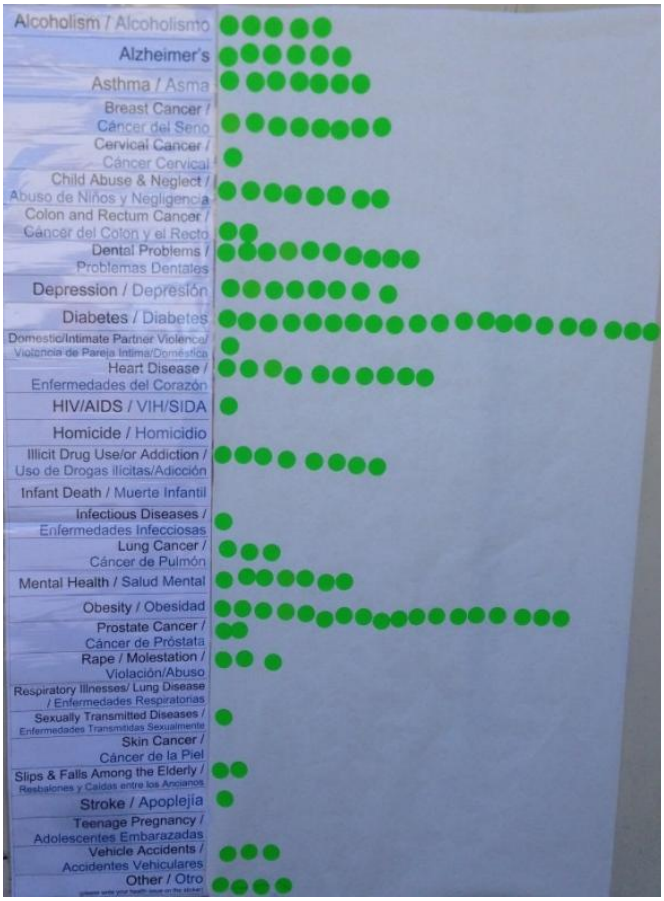
Top 5 Health Issues of Concern, by Household Income

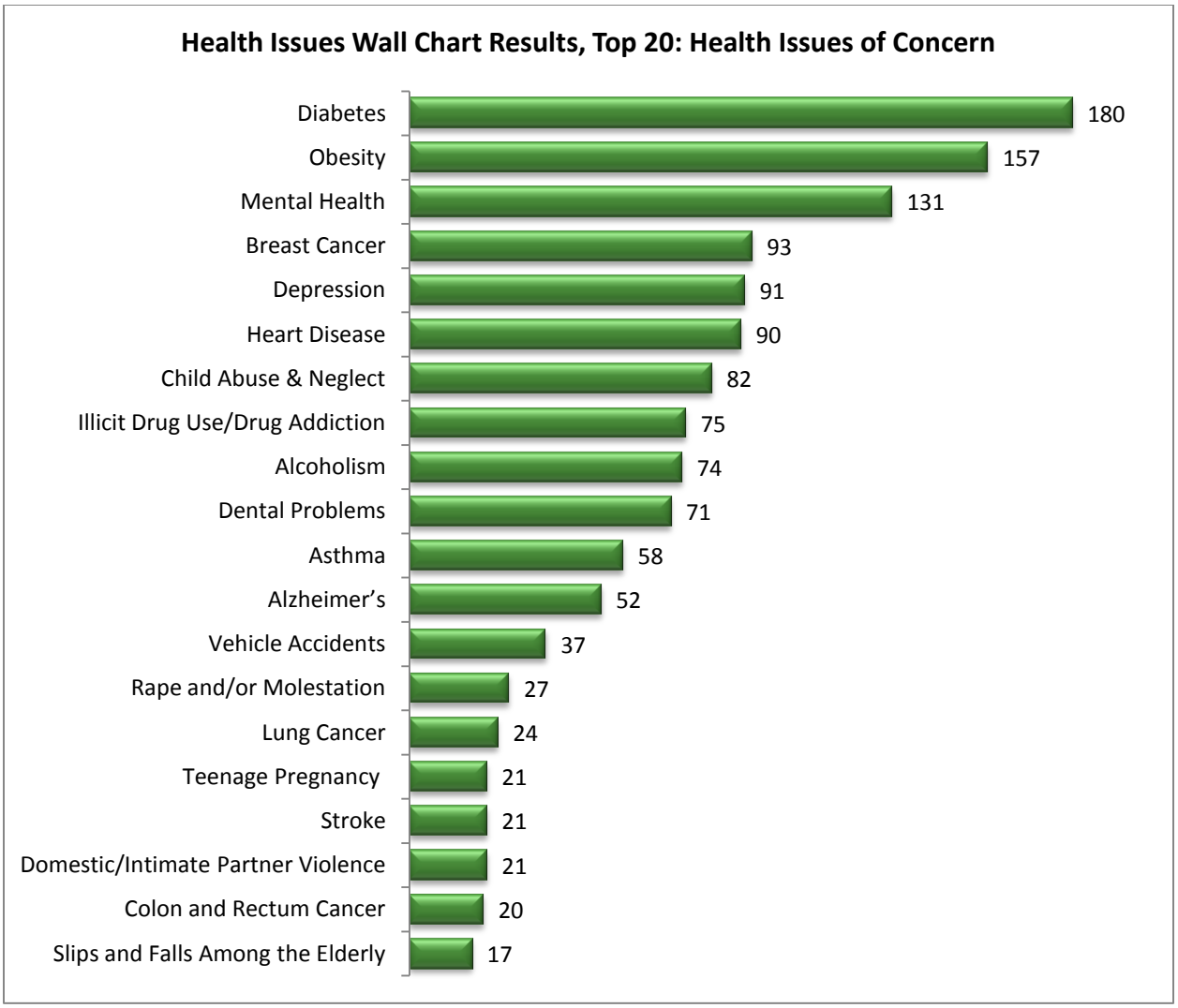
Rank	<$35k (n=362)	$35-74.9k (n=189)	$75-149.9k (n=139)	>$150k (n=58)
1	**Obesity** 36% (132)	**Obesity** 43% (82)	**Obesity** 52% (72)	**Obesity** 60% (35)
2	**Mental Health Issues** 35% (125)	**Alcoholism** 34% (65)	**Alcoholism** 47% (65)	**Alcoholism** 28% (16)
3	**Health Problems assoc. with Aging** 34% (122)	**Mental Health Issues** 32% (60)	**Diabetes** 35% (48)	**Diabetes** 28% (16)
4	**Alcoholism** 27% (96)	**Diabetes** 31% (58)	**Mental Health Issues** 29% (40)	**Heart disease** 28% (16)
5	**Diabetes** 25% (92)	**Heart Disease** 29% (55)	**Heart Disease** 19% (27)	**Mental Health Issues** 26% (15)

HEALTH ISSUES WALL CHART

Attendants of each community open house event had the opportunity to contribute to a health issues wall chart by selecting three health issues that matter most to them or most affect our community; providing an instantaneous impression of that community's individual concerns. Survey respondents were given three stickers after taking the survey and asked to place a sticker after three separate health issues. Stickers were also given to people who chose not to take the survey. There were 1,488 stickers placed onto the health wall charts at the community open house events by nearly 500 people.

The additional health issues listed on the wall chart provide further insight into the health issues that most affect our community. The three issues most selected in the health issues wall chart - diabetes, followed by obesity and mental health issues - corresponded with the survey responses, but in a different order. The next cluster of health issues were breast cancer, depression, and heart disease. The overall results are presented below.





In particular, diabetes and obesity, both of which were identified as top priorities, are strongly associated with one another. Type 2 diabetes mellitus has been linked to weight gain; 85% of diabetics are overweight[15]. Furthermore, diabetes is associated with certain complications such as heart disease and stroke, hypertension, kidney disease, and dental disease[16].

Mental health issues include a variety of diagnoses, including depression, anxiety, mood disorders, psychoses, and developmental disabilities. An estimated 26% of Americans ages 18 and older suffer from a diagnosable mental health issue (mental disorder)[17]. Depression is one of the most common mental health issues and encompasses several forms of depressive disorders. Alcohol and other substance abuse or dependence may also co-exist with depression[18].

[15] Harvard Gazette. Obesity? Diabetes? We've been set up. March 7, 2012: http://news.harvard.edu/gazette/story/2012/03/the-big-setup/

[16] Centers for Disease Control and Prevention. National Diabetes Fact Sheet, 2011: http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf

[17] National Institute of Mental Health. The Numbers Count: Mental Disorders in America. http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-America/index.shtml#KesslerPrevalence

[18] National Institute of Mental Health. Depression. http://www.nimh.nih.gov/health/publications/depression/index.shtml

Changes associated with aging include physical and sensory limitations (which increase the risk of falls and the likelihood of sedentary lifestyle), as well as increased risk of chronic diseases such as diabetes, heart disease, and hypertension. Additionally, aging is associated with changes in memory and recollection, as well as an increased risk for dementia. However, many physical and mental changes are a natural part of the aging process; complications and illness can often be lessened or avoided through continued active lifestyle and social engagement.

CONTRIBUTING FACTORS

Numerous factors play a role in the health of communities and individuals. Among these factors are individual traits (e.g., sex, age, and genes), individual behavior, social and economic circumstances, and the environment, both built and natural. All of these factors interact in complex ways and vary in their impact depending upon individual traits and social and economic circumstances.

Respondents were asked to identify the three most important contributing factors responsible for health issues in our community in each of three categories: individual behaviors; social and economic circumstances; and environmental issues.

INDIVIDUAL BEHAVIOR

The behaviors most frequently identified by respondents were poor nutrition/eating habits (45%), lack of exercise (39%), alcohol abuse (35%), and drug (or substance) abuse (26%). Life stress, lack of regular medical visits, driving under the influence, and tobacco use completed the top half of responses about individual behaviors most responsible for health issues.

Individual Behaviors Most Responsible for Health Issues in Our Community: Yolo County	Number	Percent	Rank
Poor nutrition/eating habits (diet)	405	45%	1
Lack of exercise	355	39%	2
Alcohol abuse	317	35%	3
Drug abuse	238	26%	4
Life stress/lack of coping skills	236	26%	5
Not getting regular check-ups by a healthcare provider	233	26%	6
Driving while drunk/on drugs	183	20%	7
Smoking/tobacco use	173	19%	8
Unsafe sex	88	10%	9
Distracted driving	72	8%	10
Crime/violence	71	8%	11
Teenage sex	67	7%	12
Domestic or intimate partner violence	50	6%	13
Not getting "shots" (vaccines) to prevent disease	45	5%	14
Using weapons/guns	30	3%	15
Other 1	29	3%	16
Suicide	24	3%	17
Other 2	5	1%	18
Total participants	**900**		

SOCIAL AND ECONOMIC CIRCUMSTANCES

Unemployment and lack of health insurance represented more than half of the responses for social and economic circumstances affecting health, followed by poverty, which represented 45% of respondents. A possible contributor to

these selections is the 2007 economic recession. Lack of education, homelessness, and food insecurity ranked fourth, fifth, and sixth, respectively. These six factors share a strong association with poverty.

Social and Economic Circumstances Most Responsible for Health Issues: Yolo County	Number	Percent	Rank
Unemployment	490	54%	1
No health insurance	469	52%	2
Poverty	407	45%	3
Lack of education/no high school education	298	33%	4
Homelessness	208	23%	5
Not enough food (food insecurity)	134	15%	6
Single parenting	133	15%	7
Cultural barriers	126	14%	8
Language barriers	126	14%	8
Racism and discrimination	108	12%	10
Other 1	38	4%	11
Other 2	6	1%	12
Total participants	**900**		

ENVIRONMENTAL ISSUES

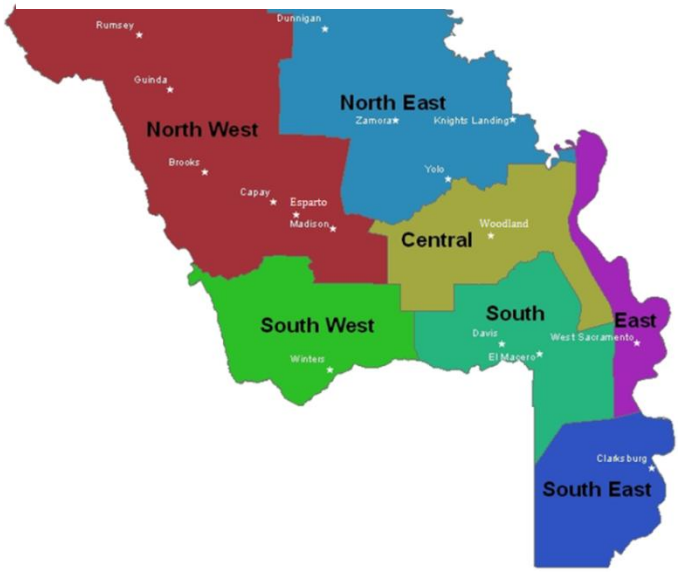
Yolo County is mostly a rural, agricultural community and faces some different health issues due to its remoteness and exposure to chemicals used in farming. Air pollution was identified as the most responsible environmental issue that affects our health. Pesticide use ranked fourth with 26% of responses. A lack of access to healthy foods, lack of access to places for physical activity, lack of safe walkways and bikeways, and lack of public transportation represented 14% to 20% of responses.

Environmental Issues Most Responsible for Health Issues: Yolo County	Number	Percent	Rank
Air pollution	351	39%	1
Lack of access to healthy foods	289	32%	2
Cigarette smoke	288	32%	3
Pesticide use	238	26%	4
Poor housing conditions	216	24%	5
Lack of access to places for physical activity	181	20%	6
Heat/hot days	160	18%	7
Lack of safe walkways and bikeways	127	14%	8
Lack of public transportation	127	14%	8
Contaminated drinking water	101	11%	10
Trash on streets & sidewalks	100	11%	11
Poor neighborhood design	63	7%	12
Traffic	63	7%	12
Other 1	39	4%	14
Flooding/drainage problems	36	4%	15
Other 2	5	1%	16
Total participants	**900**		

REGIONS

The top health issues and contributing factors are presented for each region. The top ranked health issues and contributing factors are ranked and compared to the Yolo County rankings. Only the top six to ten issues and factors are shown for each region.

Yolo County Regions



CENTRAL REGION

Twenty-nine to 42% of the respondents from the Central region identified obesity, mental health issues, health problems associated with aging, and diabetes as the health issues that most affect their community. Cancer and alcoholism both received 24% of the responses.

Rank	Health Issues that Most Affect Our Community: Central Region	Number	Percent	YC Rank
1	Obesity	69	42%	1
2	Mental Health Issues	68	42%	2
3	Health Problems assoc. with Aging	51	31%	4
4	Diabetes	47	29%	3
5	Cancer	39	24%	5
6	Alcoholism	39	24%	6
7	Heart Disease	33	20%	7
8	Child abuse and neglect	28	17%	8
9	Dental Problems	25	15%	8
10	Teenage pregnancy	22	13%	10

The Central region respondents identified contributing factors that most affect community health (Tables 18 to 20). Diet and lack of exercise represented 44% and 38% of respondents, respectively; and alcohol and drug abuse represented 42% and 26%, respectively. No health insurance, unemployment, and poverty represented 45% to 55% of responses about the social and economic circumstances affecting health. Of the environmental issues affecting health, air pollution, secondhand cigarette smoke, pesticide use, and access to healthy foods represented about one-third of responses, lack of access to physical activity 24%, and lack of safe walkways and bike paths 21%.

Rank	Individual Behaviors Most Responsible for Health Issues in Our Community: Central Region	Number	Percent	YC Rank
1	Poor nutrition/eating habits	72	44%	1
2	Alcohol abuse	68	42%	3
3	Lack of exercise	62	38%	2
4	Not getting regular check-ups by a healthcare provider	49	30%	6
5	Life stress/lack of coping skills	46	28%	5
6	Drug abuse	43	26%	4

Rank	Social and Economic Circumstances Most Responsible for Health Issues: Central Region	Number	Percent	YC Rank
1	No health insurance	89	55%	2
2	Unemployment	86	53%	1
3	Poverty	73	45%	3
4	Lack of education/no high school education	64	39%	4
5	Homelessness	35	21%	5

Rank	Environmental Issues Most Responsible for Health Issues: Central Region	Number	Percent	YC Rank
1	Air pollution	56	34%	1
2	Cigarette smoke	53	33%	3
3	Lack of access to healthy foods	53	33%	2
4	Pesticide use	50	31%	4
5	Poor housing conditions	44	27%	5
6	Lack of access to places for physical activity	39	24%	6

EAST REGION

Respondents from the East region selected obesity and diabetes as the top two health issues in their community with 46% and 33% of responses, respectively. Alcoholism was more of a concern in the East region ranking third compared to sixth for all of Yolo County. Conversely, mental health issues and health problems associated with aging were less of a concern ranking fifth and ninth, respectively, compared to second and fourth for all of Yolo County.

Rank	Health Issues that Most Affect Our Community: East Region	Number	Percent	YC Rank
1	Obesity	98	46%	1
2	Diabetes	71	33%	3
3	Alcoholism	66	31%	6
4	Cancer	63	29%	5
5	Mental Health Issues	49	23%	2
6	Heart Disease	44	20%	7
7	Child abuse and neglect	40	19%	8
8	Teenage pregnancy	39	18%	10
9	Health Problems assoc. with Aging	38	18%	4
10	Dental Problems	33	15%	8

The respondents of the East region ranked substance abuse slightly higher than the rest of the county (38%). Poor diet ranked highest whereas lack of exercise dropped slightly from a rank of second for all of Yolo County to fourth. Among all regions, the East region respondents ranked homelessness the highest. Unemployment and no health insurance represented 65% and 53% of responses, respectively. Due in part to the urban environment of the East region, pesticide use was less of a concern dropping from fourth countywide to seventh. Trash on the sidewalks and streets rose from eleventh countywide to sixth.

Rank	Individual Behaviors Most Responsible for Health Issues in Our Community: East Region	Number	Percent	YC Rank
1	Poor nutrition/eating habits	90	42%	1
2	Alcohol abuse	81	38%	3
3	Drug abuse	81	38%	4
4	Lack of exercise	79	37%	2
5	Smoking/tobacco use	44	20%	8
6	Not getting regular check-ups by a healthcare provider	44	20%	6

Rank	Social and Economic Circumstances Most Responsible for Health Issues: East Region	Number	Percent	YC Rank
1	Unemployment	140	65%	1
2	No health insurance	114	53%	2
3	Homelessness	90	42%	5
4	Poverty	88	41%	3
5	Lack of education/no high school education	67	31%	4

Rank	Environmental Issues Most Responsible for Health Issues: East Region	Number	Percent	YC Rank
1	Cigarette smoke	96	45%	3
2	Lack of access to healthy foods	87	40%	2
3	Air pollution	76	35%	1
4	Poor housing conditions	76	35%	5
5	Lack of access to places for physical activity	55	26%	6
6	Trash on streets & sidewalks	47	22%	11

NORTH EAST

Diabetes ranked first among North East respondents with cancer and obesity tied for second as the health issues of most concern. Dental problems ranked fourth in the region compared to eighth countywide. Mental health issues were ranked the lowest among all regions at seventh.

Rank	Health Issues that Most Affect Our Community: North East Region	Number	Percent	YC Rank
1	Diabetes	20	48%	3
2	Cancer	19	45%	5
3	Obesity	19	45%	1
4	Dental Problems	17	40%	8
5	Alcoholism	13	31%	6
6	Health Problems assoc. with Aging	10	24%	4
7	Mental Health Issues	9	21%	2
8	Heart Disease	6	14%	7
9	Child abuse and neglect	6	14%	8
10	Teenage pregnancy	5	12%	10

Diet and lack of exercise were perceived as the individual behaviors most responsible for health issues with 45% and 43%, respectively. Lack of regular check-ups was ranked higher, third, than the countywide ranking of sixth. Poverty, no health insurance, and unemployment were ranked by about half the respondents as the top three social and economic circumstances most likely to affect health. Pesticide use and secondhand cigarette smoke were selected as the two environmental issues most responsible for health issues. A lack of access to places for physical activity was ranked third compared to a ranking of sixth countywide.

Rank	Individual Behaviors Most Responsible for Health Issues in Our Community: North East Region	Number	Percent	YC Rank
1	Lack of exercise	19	45%	2
2	Poor nutrition/eating habits	18	43%	1
3	Not getting regular check-ups by a healthcare provider	15	36%	6
4	Drug abuse	13	31%	4
5	Alcohol abuse	12	29%	3
5	Driving while drunk/on drugs	12	29%	7

Rank	Social and Economic Circumstances Most Responsible for Health Issues: North East Region	Number	Percent	YC Rank
1	Poverty	23	55%	3
2	No health insurance	22	52%	2
3	Unemployment	21	50%	1
4	Homelessness	9	21%	5
4	Lack of education/no high school education	9	21%	4

Rank	Environmental Issues Most Responsible for Health Issues: North East Region	Number	Percent	YC Rank
1	Pesticide use	19	45%	4
2	Cigarette smoke	17	40%	3
3	Lack of access to places for physical activity	16	38%	6
4	Air pollution	12	29%	1
5	Poor housing conditions	10	24%	5
5	Lack of access to healthy foods	10	24%	2

NORTH WEST

Diabetes and obesity ranked as the top two health issues of concern for the North West region respondents. Mental health issues were rated less of a concern while dental problems and respiratory illnesses were ranked higher than the countywide rankings.

Rank	Health Issues that Most Affect Our Community: North West Region	Number	Percent	YC Rank
1	Diabetes	25	37%	3
2	Obesity	23	34%	1
3	Health Problems assoc. with Aging	22	32%	4
4	Cancer	18	26%	5
5	Mental Health Issues	17	25%	2
6	Dental Problems	14	21%	8
7	Respiratory illnesses/lung disease/asthma	13	19%	11
7	Alcoholism	13	19%	6
9	Heart Disease	12	18%	7
10	Teenage pregnancy	11	16%	10

Respondents from the North West region identified diet as the behavior most responsible for health issues while lack of exercise was ranked fifth compared to second for the countywide rankings. Substance abuse issues, driving while intoxicated, alcohol and drug abuse garnered about one-third of responses. Among social and economic factors, unemployment, no health insurance, and poverty were a big concern for respondents, with 40% to 60% of responses. Language barriers were also seen as a concern ranking fifth. Among environmental factors, a lack of safe sidewalks and lack of access to places for physical activity (both with 28% of responses) ranked second, the highest among any region.

Rank	Individual Behaviors Most Responsible for Health Issues in Our Community: North West Region	Number	Percent	YC Rank
1	Poor nutrition/eating habits	27	40%	1
2	Driving while drunk/on drugs	24	35%	7
3	Alcohol abuse	23	34%	3
4	Drug abuse	22	32%	4
5	Lack of exercise	22	32%	2
6	Not getting regular check-ups by a healthcare provider	19	28%	6

Rank	Social and Economic Circumstances Most Responsible for Health Issues: North West Region	Number	Percent	YC Rank
1	Unemployment	41	60%	1
2	No health insurance	37	54%	2
3	Poverty	27	40%	3
4	Lack of education/no high school education	24	35%	4
5	Language barriers	19	28%	8

Rank	Environmental Issues Most Responsible for Health Issues: North West Region	Number	Percent	YC Rank
1	Air pollution	27	40%	1
2	Lack of safe walkways and bikeways	19	28%	8
3	Lack of access to places for physical activity	19	28%	6
4	Pesticide use	17	25%	4
5	Cigarette smoke	15	22%	3
6	Lack of access to healthy foods	15	22%	2

SOUTH

The top four health issues that most affect our community identified by the South region respondents were similar to the countywide rankings with the top four getting 50% of the selections; however, motor vehicle and bicycle accidents ranked five places higher at seventh than the countywide ranking of twelfth.

Rank	Health Issues that Most Affect Our Community: South Region	Number	Percent	YC Rank
1	Obesity	112	46%	1
2	Mental Health Issues	102	42%	2
3	Health Problems assoc. with Aging	97	40%	4
4	Diabetes	62	25%	3
5	Heart Disease	61	25%	7
6	Cancer	58	24%	5
7	Motor vehicle/Bicycle accidents	42	17%	12
8	Alcoholism	41	17%	6
9	Respiratory illnesses/lung disease/asthma	28	11%	11
10	Child abuse and neglect	25	10%	8

The South region identified diet and lack of exercise as being the individual behaviors most responsible for health issues with 62% and 47% of responses, respectively. The third highest ranked individual behavior was life stress and lack of coping skills. The social and economic circumstances reflect the countywide rankings with the exception of unemployment, which was ranked third by South region respondents compared to first overall. This may be due in part by the University of California, Davis being one of the largest employers in the county. Environmental issues associated health problems included air pollution and pesticide use (51% and 31% of responses, respectively). Lack of access to healthy foods was also of concern ranking second.

Rank	Individual Behaviors Most Responsible for Health Issues in Our Community: South Region	Number	Percent	YC Rank
1	Poor nutrition/eating habits	152	62%	1
2	Lack of exercise	116	47%	2
3	Life stress/lack of coping skills	83	34%	5
4	Alcohol abuse	69	28%	3
5	Not getting regular check-ups by a healthcare provider	68	28%	6
6	Driving while drunk/on drugs	46	19%	7

Rank	Social and Economic Circumstances Most Responsible for Health Issues: South Region	Number	Percent	YC Rank
1	No health insurance	137	56%	2
2	Poverty	129	53%	3
3	Unemployment	115	47%	1
4	Lack of education/no high school education	91	37%	4
5	Cultural barriers	49	20%	8

Rank	Environmental Issues Most Responsible for Health Issues: South Region	Number	Percent	YC Rank
1	Air pollution	125	51%	1
2	Lack of access to healthy foods	87	36%	2
3	Pesticide use	77	31%	4
4	Heat/hot days	66	27%	7
5	Cigarette smoke	60	24%	3
6	Poor housing conditions	43	18%	5

SOUTH EAST

The number of respondents from the South East region was low with only 10 completing the survey; this is considered a low response rate and the results should be interpreted with caution. This region expressed most concern about respiratory illnesses, lung disease and asthma, ranking its importance fourth region-wide compared to eleventh overall. The top two issues, cancer and alcoholism, represented 50% of responses.

Rank	Health Issues that Most Affect Our Community: South East Region	Number	Percent	YC Rank
1	Cancer	5	50%	5
1	Alcoholism	5	50%	6
3	Health Problems assoc. with Aging	4	40%	4
4	Respiratory illnesses/lung disease/asthma	3	30%	11
4	Diabetes	3	30%	3
6	Heart Disease	2	20%	7
7	Obesity	2	20%	1

Lack of exercise was perceived as the individual behavior most responsible for health issues with 70% of responses. Also of concern was not getting regular medical check-ups ranking second. No health insurance and language barriers were ranked the highest among social and economic circumstances affecting health. Pesticide use and high temperatures were ranked highest among environmental issues.

Rank	Individual Behaviors Most Responsible for Health Issues in Our Community: South East Region	Number	Percent	YC Rank
1	Lack of exercise	7	70%	2
2	Not getting regular check-ups by a healthcare provider	5	50%	6
3	Alcohol abuse	4	40%	3

Rank	Social and Economic Circumstances Most Responsible for Health Issues: South East Region	Number	Percent	YC Rank
1	No health insurance	6	60%	2
1	Language barriers	6	60%	8
3	Unemployment	3	30%	1
4	Poverty	3	30%	3
5	Lack of education/no high school education	3	30%	4

Rank	Environmental Issues Most Responsible for Health Issues: South East Region	Number	Percent	YC Rank
1	Pesticide use	5	50%	4
2	Heat/hot days	4	40%	7

SOUTH WEST

Diabetes and obesity were ranked the highest among health issues, both with 41% of responses. Alcoholism, cancer, and dental problems were all ranked higher than the countywide rankings. Mental health issues were considered less of a concern ranking sixth compared to third countywide.

Rank	Health Issues that Most Affect Our Community: South West Region	Number	Percent	YC Rank
1	Diabetes	28	41%	3
1	Obesity	28	41%	1
3	Alcoholism	26	38%	6
4	Cancer	22	32%	5
5	Dental Problems	20	29%	8
6	Mental Health Issues	19	28%	3
7	Health Problems assoc. with Aging	13	19%	4
7	Heart Disease	13	19%	7
9	Respiratory illnesses/lung disease/asthma	12	17%	11
10	Child abuse and neglect	11	16%	8
10	Teenage pregnancy	11	16%	10

Lack of exercise and diet represented 45% and 32% of responses, respectively, while substance abuse issues represented 29%. Unemployment, no health insurance and poverty were the leading social and economic circumstances related to community health, followed by lack of education. Air pollution and pesticide use were the top environmental issues of concern with 41% and 35% of responses, respectively. Lack of public transportation was more of a concern to South West region respondents, ranking third compared to eighth overall.

Rank	Individual Behaviors Most Responsible for Health Issues in Our Community: South West Region	Number	Percent	YC Rank
1	Lack of exercise	31	45%	2
2	Alcohol abuse	26	38%	3
3	Poor nutrition/eating habits	22	32%	1
4	Drug abuse	20	29%	4
5	Life stress/lack of coping skills	20	29%	5
6	Driving while drunk/on drugs	17	25%	7

Rank	Social and Economic Circumstances Most Responsible for Health Issues: South West Region	Number	Percent	YC Rank
1	Unemployment	45	65%	1
2	No health insurance	35	51%	2
3	Poverty	29	42%	3
4	Lack of education/no high school education	22	32%	4
5	Homelessness	12	17%	5

Rank	Environmental Issues Most Responsible for Health Issues: South West Region	Number	Percent	YC Rank
1	Air pollution	28	41%	1
2	Pesticide use	24	35%	4
3	Lack of public transportation	23	35%	8
4	Cigarette smoke	22	32%	3
5	Lack of access to healthy foods	18	26%	2
6	Poor housing conditions	16	23%	5

IMPORTANT FACTORS OF A "HEALTHY COMMUNITY"

The CTSA survey respondents were asked to identify three important factors of a healthy community. The respondents were provided 17 options to choose from plus two write-in options.

The most important factor of a healthy community cited by respondents was a safe place to raise kids (40%). This was cited as the most important factor for every region except for the South, which cited access to healthcare as the most important. Job opportunities, access to healthcare, good schools, and low crime round out the top five factors of a healthy community. Of the 45 write-in responses, more than half (26) identified healthy behaviors and lifestyles.

Most Important Factors of a Healthy Community: Yolo County	Number	Percent	Rank
Safe place to raise kids	361	40%	1
Job opportunities	316	35%	2
Access to healthcare	310	34%	3
Good schools	269	30%	4
Low crime/safe neighborhoods	154	17%	5
Access to healthy food	148	16%	6
Well-informed community about health issues	139	15%	7
Affordable housing	132	15%	8
Community involvement	115	13%	9
Parks and recreation facilities	112	12%	10
Green/open spaces	95	11%	11
Support agencies (faith-based organizations, support groups, social worker outreach)	82	9%	12
Time for family	75	8%	13
Elderly care	62	7%	14
Air quality	59	7%	15
Tolerance for diversity	58	6%	16
Other 1	41	5%	17
Access to childcare	31	3%	18
Other 2	4	0.4%	19
Total participants	**900**		

STRENGTHS AND SUPPORTED POLICIES

Respondents were asked to identify strengths in our community (e.g., community groups, organizations, places, etc.) and what makes them most proud of our community. Additionally, respondents were asked what policies or funding opportunities to build a healthier community they would be most willing to support.

Responses regarding the strengths were sorted into three broad categories, infrastructure, community perception, and community environment. Responses were further sorted and organized based on 15 subcategories (see Appendix F).

CENTRAL

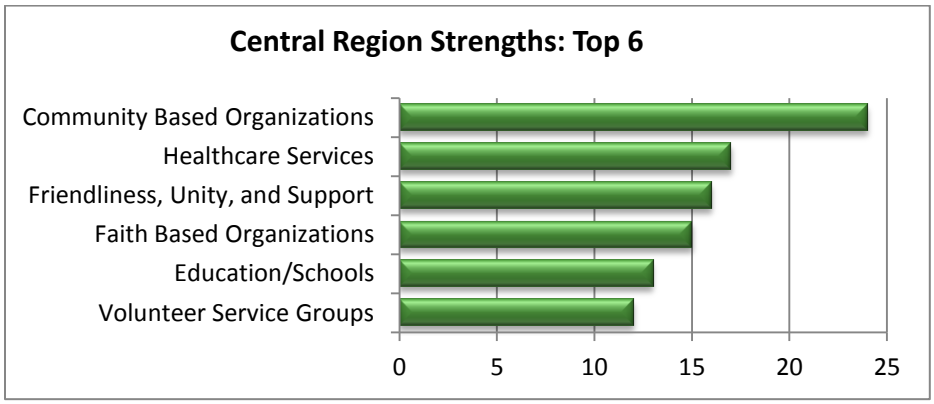
In total, 105 responses were recorded for Strengths; 124 responses for Sources of Pride; and 78 responses for Supported Policies were collected for the Central Region.

STRENGTHS

Community-based organizations were seen as a strength in the community mentioning in particular the local Family Resource Center and 4th and Hope. Respondents also mentioned healthcare services, and education and schools. Most respondents had positive views of their community. Community friendliness, unity, and support were mentioned in regards to their community as being small and having nice people with a sense of community. Faith-based organizations and volunteer service groups such as the Lions Club, Rotary Club, and Kiwanis were also in the top six strengths of the Central region. In addition, respondents also identified the senior center, library, and community center.

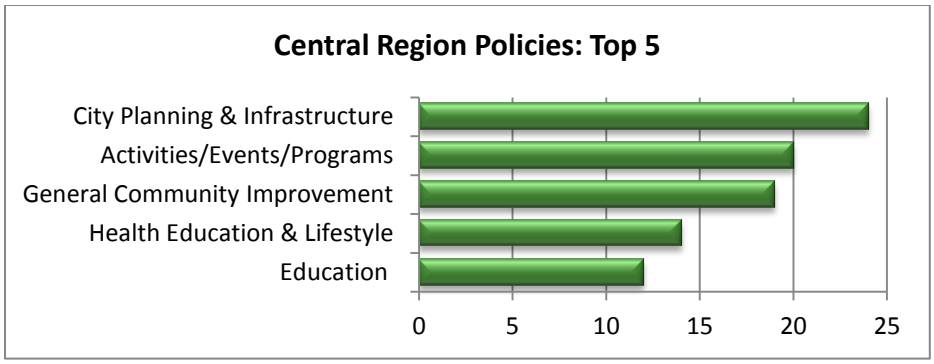
Respondents also took pride in community involvement, the community's progressive mindset, and volunteerism. Responses reflected pride in cultural diversity and tolerance as well as the "small-town feel".

The local agriculture and its heritage were often cited as well as schools and education. Respondents were also proud of the community's parks and outdoor spaces.



POLICY

When asked which actions, policies, or funding priorities would entice community members to become involved in building a healthier community, city planning and infrastructure garnered the most responses. In particular, a public swimming pool, bike lanes, places for family gatherings, public sanitation, and public transportation ranked high on the priority list. Community activities/events/programs also received a high response rate. General community improvement had a wide range of responses that included policies to take care of the homeless and addressing domestic/child abuse. Respondents also indicated promoting health education classes pertaining to nutrition and physical fitness. Finally, education ranked in the top five categories, as respondents indicated improving schools and providing funding for schools.



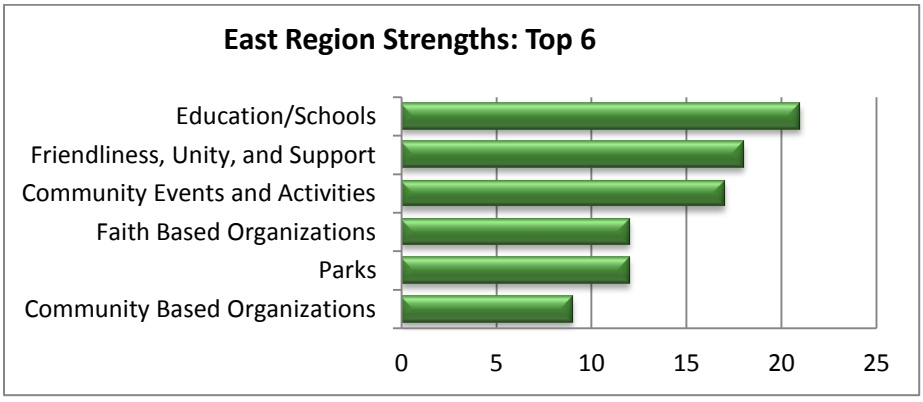
EAST REGION

In total, 138 responses were recorded for the Strengths component of the survey; 154 responses for the Proud component; and 131 responses for the Policy component were collected for the East region.

STRENGTHS

Education and schools were seen as a major strength in the community along with Friday Night Live events. Respondents also had positive views about the community. Community friendliness, unity, and support often referred to the helpful and trusting people in their community. Parks and community events, in particular cultural festivities, were also highly regarded. Faith-based organizations and community-based organizations (e.g., BB Can and Family Resource Center) also ranked in the top six strengths of the East region. Additionally, respondents indicated local fitness facilities, safe environment, local food markets, the library, and teen center as strengths.

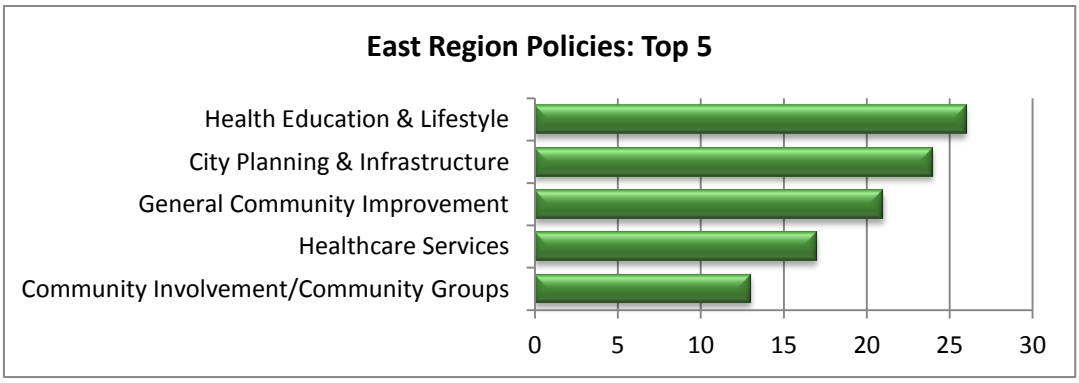
The East region respondents mentioned that the community is improving and frequently commented on how friendly people are and how they are willing to work together. Respondents appreciated the cultural diversity of their community and that they feel safe in their community. Education and schools also ranked in the top five responses of pride for the East region.



POLICY

Respondents would support policies to increase health education at health fairs and to establish community groups for healthy activities. City planning and infrastructure received the second most responses, which included responses such as improving public sanitation and transportation, maintaining parks and running trails, and constructing community facilities.

The general community improvement had a wide range of responses, in particular to increase police involvement, clean up the streets, and employment opportunities. Improving healthcare services was mentioned as well. Finally, respondents would support efforts to improve community involvement to promote a healthy environment.



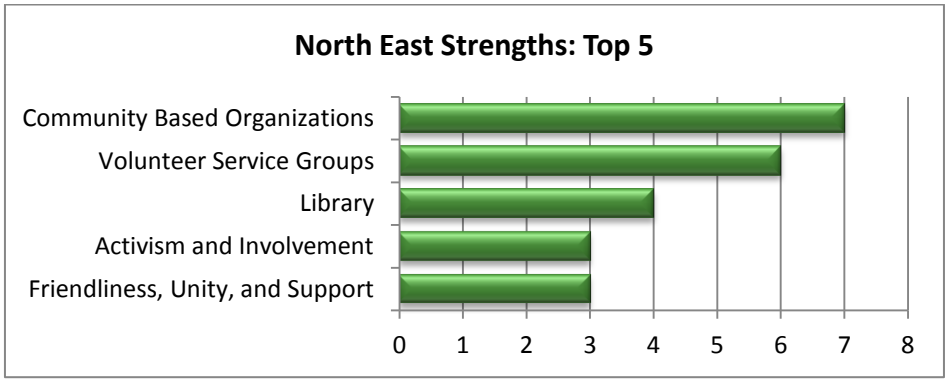
NORTH EAST REGION

In total, 26 responses were recorded for the Strengths component of the survey; 31 responses for the Proud component; and 23 responses for the Policy component were collected for the North East Region.

STRENGTHS

Community-based organizations, in particular the Family Resource Center, were indicated by respondents as a major strength in the community. Volunteer service groups were also indicated as a top strength in the community as was the library. Respondents had positive views about their community, frequently citing community unity and involvement. In addition, the fire department and schools were indicated as strengths in the community.

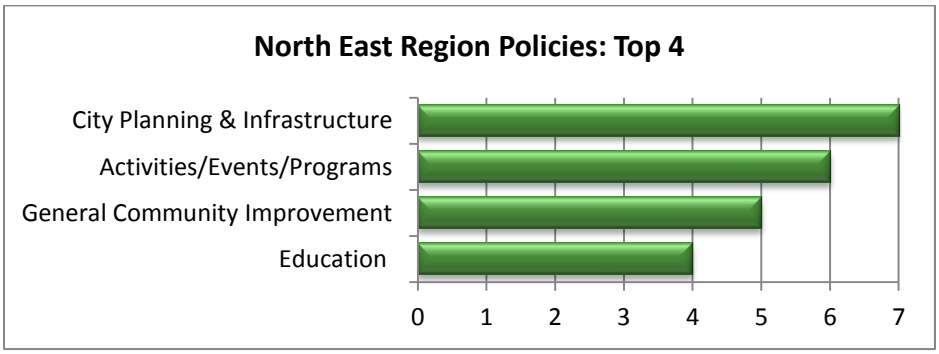
The North East respondents cited the close-knit community, its overall unity, and the tranquil and peaceful atmosphere. Community activism, involvement, and safety were also mentioned in the top five sources of pride. CommuniCare and the Family Resource Center were seen as sources of pride in the community.



POLICY

When asked which actions, policies, or funding priorities would entice community members to become involved in building a healthier community, city planning and infrastructure garnered the most responses. Reponses included improving public

transportation, and constructing community facilities/gyms. General community improvement had a wide range of responses that included policies to increase activities for kids and teens. Respondents also indicated promoting health education classes pertaining to nutrition and physical fitness. Finally, education ranked in the top five categories, as respondents indicated improving schools and providing funding for schools.



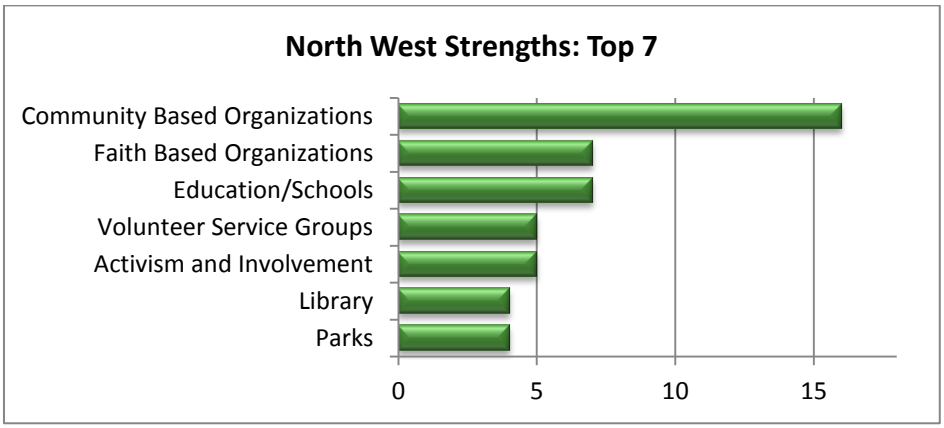
NORTH WEST REGION

In total, 41 responses from the North West Region were recorded for the Strengths component of the survey; 54 responses for the Proud component; and 31 responses for the Policy component.

STRENGTHS

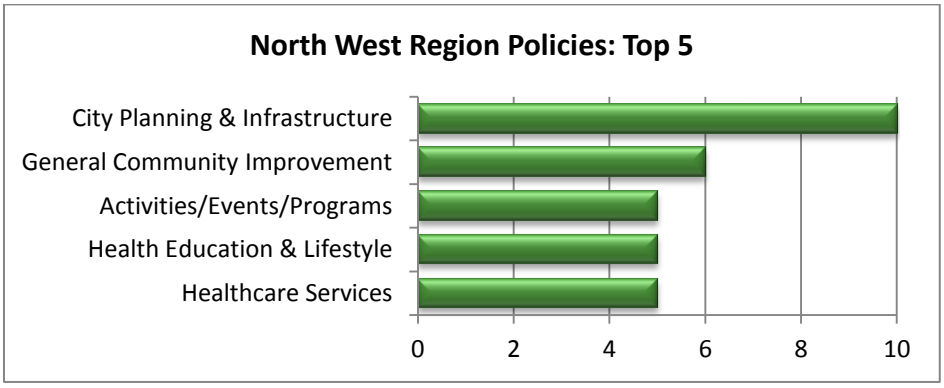
Community-based organizations were seen as a strength in the community, specifically, Rise, Inc. (15). Faith-based organizations, schools, and volunteer service groups in general were indicated as top strengths in the community. Respondents also mentioned community activism and involvement. Libraries and parks round out the top six strengths for the North West region. Additionally, respondents identified government programs/services and food banks as strengths in their community.

The North West respondents mentioned community friendliness, unity, and support. Respondents referred to their community as a quiet and tranquil town. Community activism and involvement were also mentioned as a source of pride. Rise, Inc., local agriculture, and schools are sources of pride for the North West region.



POLICY

Creating community facilities, particularly for teens and tutoring, were policies respondents would support. Also mentioned were policies to have more community activities and programs as well and business and job opportunities. Respondents indicated health education, particularly about healthy nutrition and fitness as well as improved healthcare services for the North West region as being policy issues they would support.



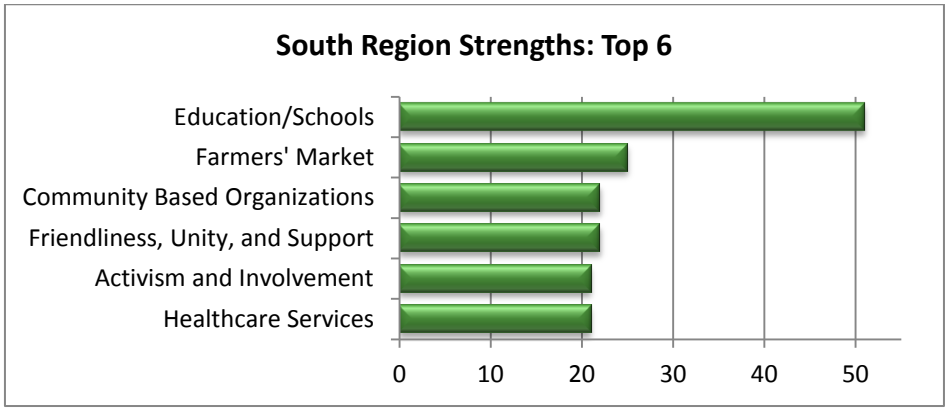
SOUTH REGION

Overall, the South Region represents the highest number of respondents for the CTSA survey. In total, 166 responses were recorded for the Strengths component of the survey; 194 responses for the Proud component; and 125 responses for the Policy component.

STRENGTHS

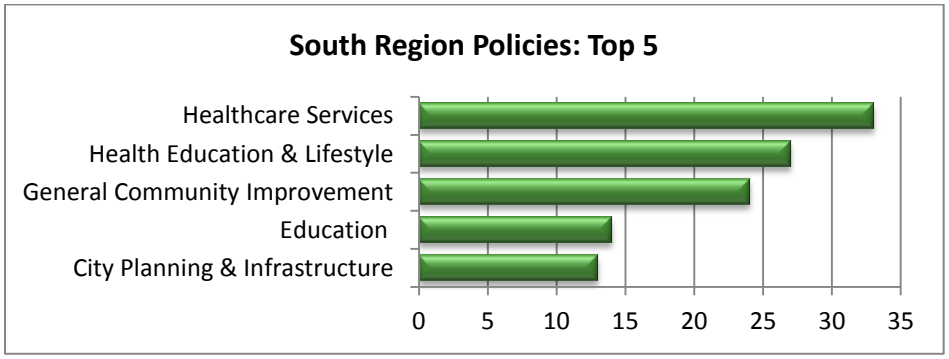
Education and schools were seen as a major strength in the community. The University of California, Davis (UCD) was cited 27 times. Farmer's markets were indicated as a strength in the community. Respondents also cited community-based organizations and volunteer service groups such as Davis Community Meals, Rotary Club, and the League of Women Voters. Community friendliness, unity and support, and community activism and involvement were mentioned citing a caring community that is involved and engaged. Additionally, respondents indicated parks, bike paths, and greenbelts as strengths.

Respondents cited volunteerism and a progressive mindset as well as environmentally friendly, cleanliness, safety, and good surroundings and conditions. As sources of pride in the community, a strong educational system and UCD were cited. Bike paths, parks, cultural diversity, healthcare services, and public transportation were also mentioned.



POLICY

Respondents indicated increasing access to healthcare services as a policy measure they would become more involved in, while a significant number of responses indicated mental health awareness/programs/services. Health education responses focused on nutrition and physical fitness education. General community improvement had a wide range of responses, which included policy actions regarding poverty prevention, overall care for the homeless, and help for migrant workers and undocumented individuals. Finally, city planning and infrastructure included efforts to improve public transportation and overall city planning.

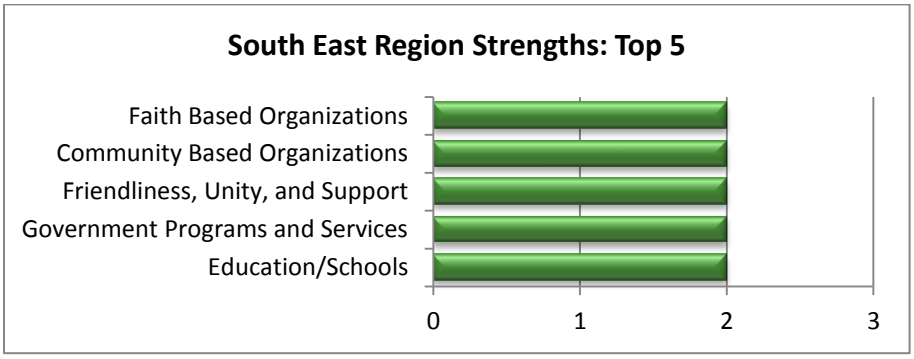


SOUTH EAST

Overall, the South East Region represents the lowest number of respondents for the CTSA survey. In total, eight responses were recorded for the Strengths component of the survey; eight responses for the Proud component; and three responses for the Policy component.

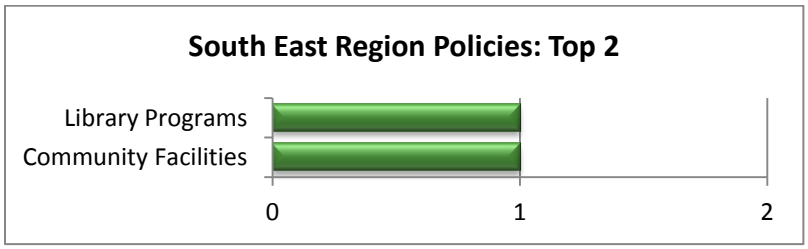
STRENGTHS

Community-based organizations and faith-based organizations were indicated as strengths in the community. Education, schools, and government programs and services were indicated as top strengths in the community. Respondents also had positive views about community support and a tranquil environment. Respondents cited the tranquil, healthy community and a sense of community and unity.



POLICY

As mentioned previously, only three responses were collected for Policy. Library programs and a family sport hall were each mentioned once.



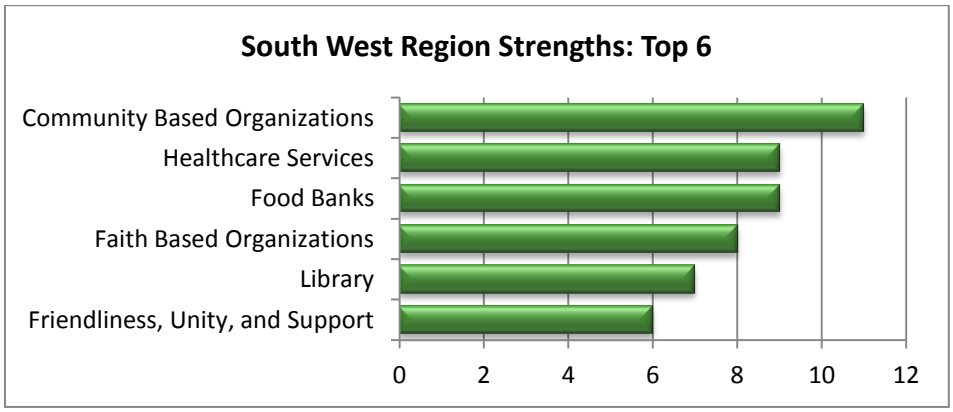
SOUTH WEST

In total, 41 responses were recorded for the Strengths component of the survey; 54 responses for the Proud component; and 38 responses for the Policy component.

STRENGTHS

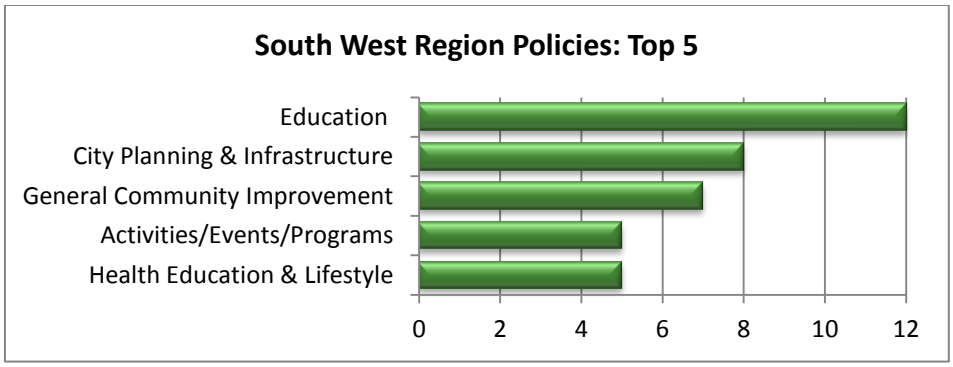
Community-based organizations were seen as a strength in the community, in particular Rise, Inc. and the local Family Resource Center. Winters Healthcare, food banks, and faith-based organizations also received a significant number of responses. Community friendliness, unity, and support were mentioned as strengths in the community, as was the local library. In addition, respondents identified community events and recreational activities within their communities.

Respondents stated that their community has a small town atmosphere and is very tranquil, happy, and a good place to live. Community activism and involvement, and a safe community were mentioned as sources of pride. Education and schools also ranked in the top five sources of pride for the South West region.



POLICY

Respondents identified improving schools and offering youth leadership development as the top policies they would support. City planning and infrastructure included support for community parks, gardens, and recreation facilities. Responses included policies to improve relations with the police department and increasing health education classes and health fairs.


South West Region Policies: Top 5
Education
City Planning & Infrastructure
General Community Improvement
Activities/Events/Programs
Health Education & Lifestyle
0
2
4
6
8
10
12

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

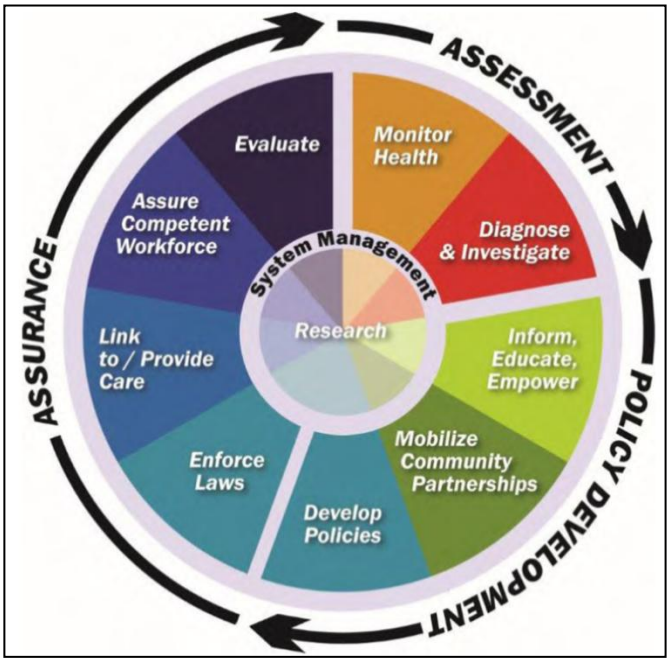
NATIONAL PUBLIC HEALTH PERFORMANCE STANDARDS

The National Public Health Performance Standards (NPHPS) provide a framework to assess capacity and performance of local public health systems and public health governing bodies. The performance standards help public health agencies answer questions such as "What are the components, activities, competencies, and capacities of our local public health system?" and "How well are the 10 essential public health services (Essential Services) being provided in our system?"[19] There are four concepts that frame the performance standards[20]:

1. The standards are designed around the 10 Essential Services to assure that the standards fully cover the gamut of public health action needed at state and community levels.

2. The standards focus on the overall public health system – all public, private, and voluntary entities that contribute to public health activities within a given area – rather than a single organization. This assures that the contributions of all entities are recognized in assessing the provision of Essential Services.

3. The standards describe an optimal level of performance rather than provide minimum expectations. Optimal standards can set benchmarks by which the public health system can be assessed and improved.



4. The standards are intended to support a process of quality improvement. System partners use the assessment process and the performance standards results as a guide for learning about public health activities throughout the system and determining how to make improvements.

Healthy Yolo employed the Local Public Health System Performance Assessment Instrument (Local Instrument), which focuses on the local public health system (LPHS) to assess the overall, current delivery of the 10 Essential Services. The process of conducting a LPHS assessment allows members of the LPHS to come together and engage in dialogue to build relationships and make connections; share information about what each agency is doing; and identify opportunities and plan together.

The 10 essential public health services describe the public health responsibilities and activities of public health agencies and institutions.

[19] National Association of County & City Health Officials (NACCHO), Local Implementation Guide, Version 3

[20] National Public Health Performance Standards Program (NPHPSP), Fact Sheet, http://www.cdc.gov/nphpsp/PDF/FactSheet.pdf

1. MONITOR HEALTH STATUS TO IDENTIFY AND SOLVE COMMUNITY HEALTH PROBLEMS.
2. DIAGNOSE AND INVESTIGATE HEALTH PROBLEMS AND HEALTH HAZARDS IN THE COMMUNITY.
3. INFORM, EDUCATE, AND EMPOWER PEOPLE ABOUT HEALTH ISSUES.
4. MOBILIZE COMMUNITY PARTNERSHIPS AND ACTION TO IDENTIFY AND SOLVE HEALTH PROBLEMS.
5. DEVELOP POLICIES AND PLANS THAT SUPPORT INDIVIDUAL AND COMMUNITY HEALTH EFFORTS.
6. ENFORCE LAWS AND REGULATIONS THAT PROTECT HEALTH AND ENSURE SAFETY.
7. LINK PEOPLE TO NEEDED PERSONAL HEALTH SERVICES AND ASSURE THE PROVISION OF HEALTH CARE WHEN OTHERWISE UNAVAILABLE.
8. ASSURE COMPETENT PUBLIC AND PERSONAL HEALTH CARE WORKFORCE.
9. EVALUATE EFFECTIVENESS, ACCESSIBILITY, AND QUALITY OF PERSONAL AND POPULATION-BASED HEALTH SERVICES.
10. RESEARCH FOR NEW INSIGHTS AND INNOVATIVE SOLUTIONS TO HEALTH PROBLEMS.

Each Essential Service consists of two to four Model Standards. Overall, there are 30 Model Standards discussed during the assessment that serve as quality indicators.

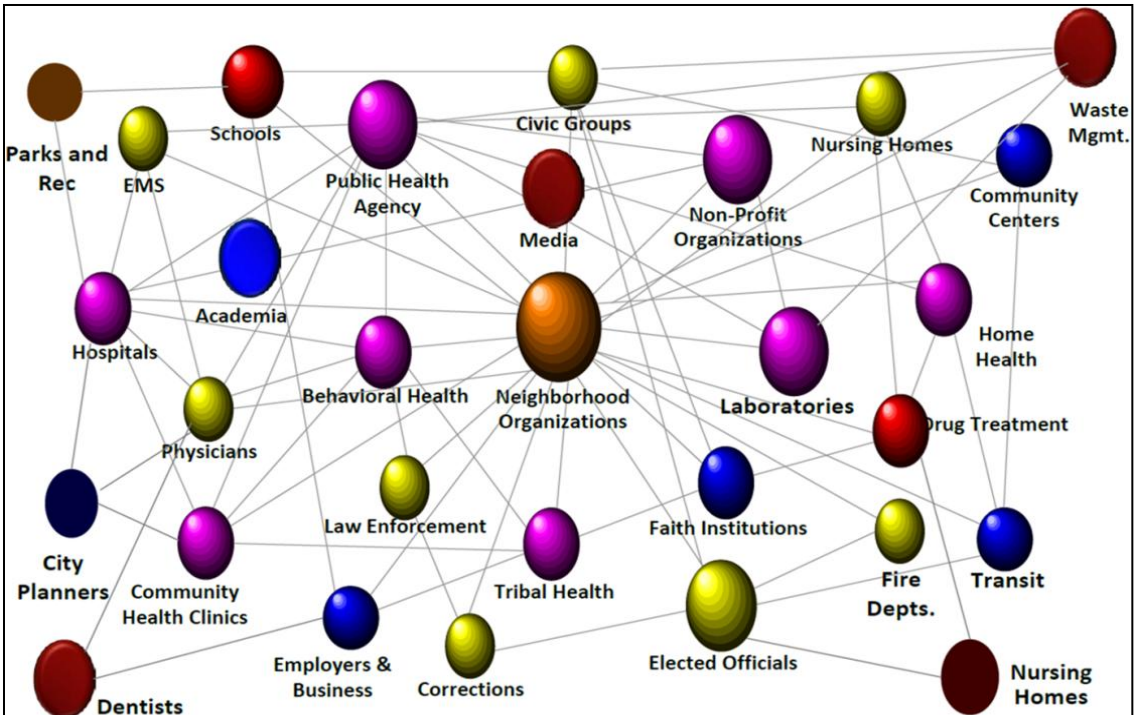
LOCAL PUBLIC HEALTH SYSTEM

The LPHS consists of a variety of public, private, and voluntary entities with differing roles, relationships, and interactions that contribute to the health and well-being of communities through the delivery of the Essential Services. Since the Essential Services span such a broad spectrum of activities, entities that typically would not be considered involved in public health or health care do perform some of the Essential Services. The public health system includes[21]:

- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies and organizations

Thus, regardless of the entity, the service provided, or the population served; they all are a part of the LPHS because of their involvement in carrying out at least one of the Essential Services. The figure below illustrates the local public health system and the interconnectedness of the entities.

[21] CDC, The Public Health System and the 10 Essential Public Health Services, http://www.cdc.gov/nphpsp/essentialservices.html



PROCESS METHODOLOGY

Following an initial orientation, the work groups reviewed the Essential Services and related activities. A general discussion ensued where group members cited partners commonly involved in the performance of activities and shared specific examples in the community to address the activities. For each Model Standard, the work groups followed a protocol: define the Model Standard; share local efforts to address the Model Standard; have a dialogue based on the discussion questions; score the current level of activity within the LPHS; gather consensus on a final score; and record the strengths and weaknesses of and improvement opportunities for the LPHS.

SCORING METHODOLOGY

Participants were asked to vote on their perception of the level at which the LPHS is performing each of the Performance Measures. A rating scale ranging from a minimum of 0% (no activity) to 100% (optimal activity) was used to score the Performance Measure. The goal was to obtain group consensus on the score for each Performance Measure of a Model Standard. The table below details the scoring definitions.

LPHS Assessment Scoring Definitions	
Ranking	**Definition**
Optimal Activity (76–100%)	Greater than 75% of the activity described within the question is met.
Significant Activity (51–75%)	Greater than 50% but no more than 75% of the activity described within the question is met.
Moderate Activity (26–50%)	Greater than 25% but no more than 50% of the activity described within the question is met.

Minimal Activity (1–25%)	Greater than zero but no more than 25% of the activity described within the question is met.
No Activity (0%)	0% or absolutely no activity.

Participants were asked to vote by using voting cards. Each participant was provided with five voting cards based on the scoring criteria of the Local Instrument. An additional card was used if further discussion was needed. If the initial vote did not result in a consensus, participants who voted at both ends of the spectrum were asked to explain their rationale and, if possible, provide examples. After group discussion, a second vote would occur until a consensus was formed.

Directly following the voting of each Model Standard, a discussion was facilitated to identify the strengths and weaknesses of the LPHS in performing the various activities of that Model Standard. An opportunity was also provided to record improvement opportunities, both short-term and long-term, that the LPHS could conduct as a quality improvement effort. The work groups repeated this process for the second essential public health service assigned to their group.

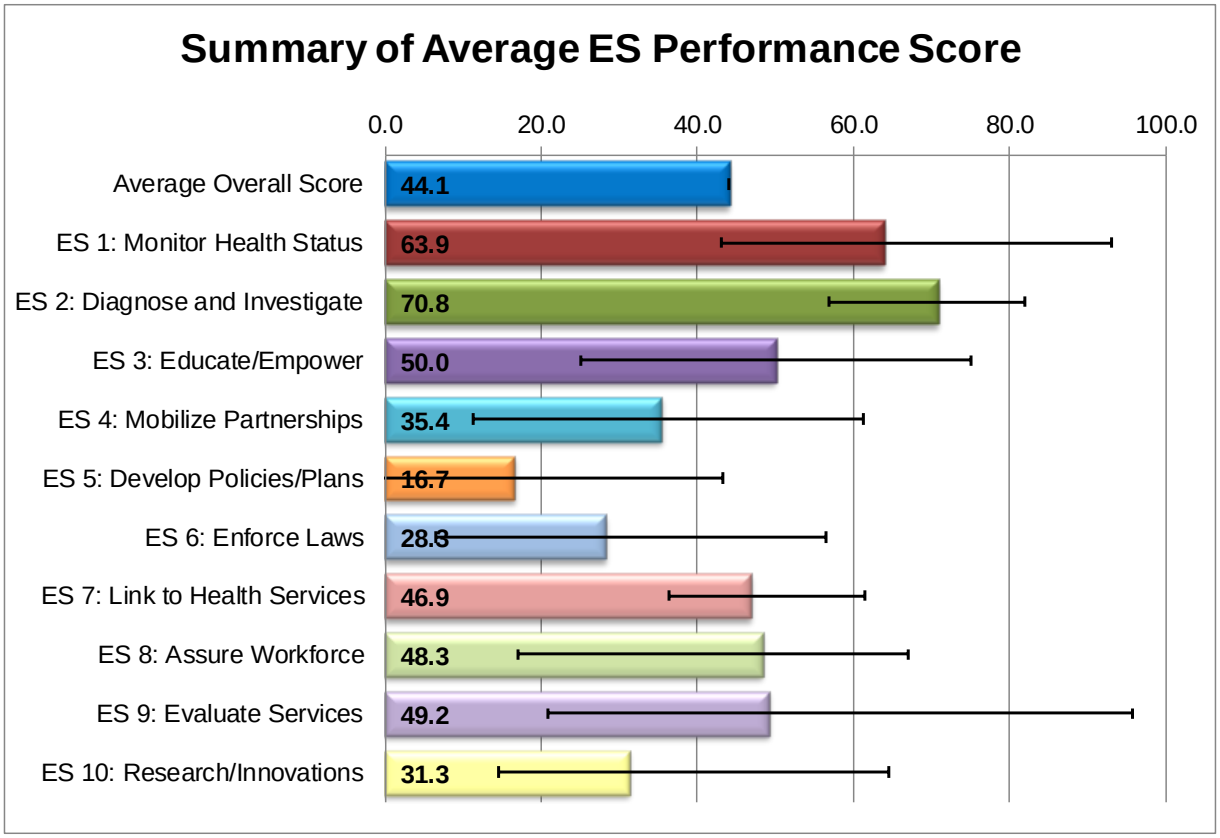
After the Model Standards were scored and the issues summarized, participants were asked to take a walking tour of the other groups to view the strengths, weaknesses, and improvement opportunities. A group member from each group reported to the entire group regarding the strengths, weaknesses, and improvement opportunities for each Model Standard.

LIMITATIONS

The Local Instrument requests participants to rate their perception of the LPHS performance in conducting the 10 Essential Services. Each participant's rating reflects his or her own breadth and knowledge of the Essential Services being conducted within and outside of the participant's agency, which may vary broadly. The responses to the Performance Measures involve an element of subjectivity and perhaps bias that does not necessarily reflect the actual performance or capacity of the LPHS or of any individual agency or organization.

SUMMARY OF FINDINGS

The overall assessment score is the average of the 10 Essential Services scores. The individual Essential Service scores are an average of the Model Standard scores within that Essential Service. The Model Standard scores are an average of the Performance Measure question scores within that Model Standard. The graph below provides a summary of the composite scores for each Essential Service (ES) based on the scoring criteria: No Activity, 0; Minimal Activity, 1-25; Moderate Activity, 26-50; Significant Activity, 51-75; and Optimal Activity, 76 or higher.

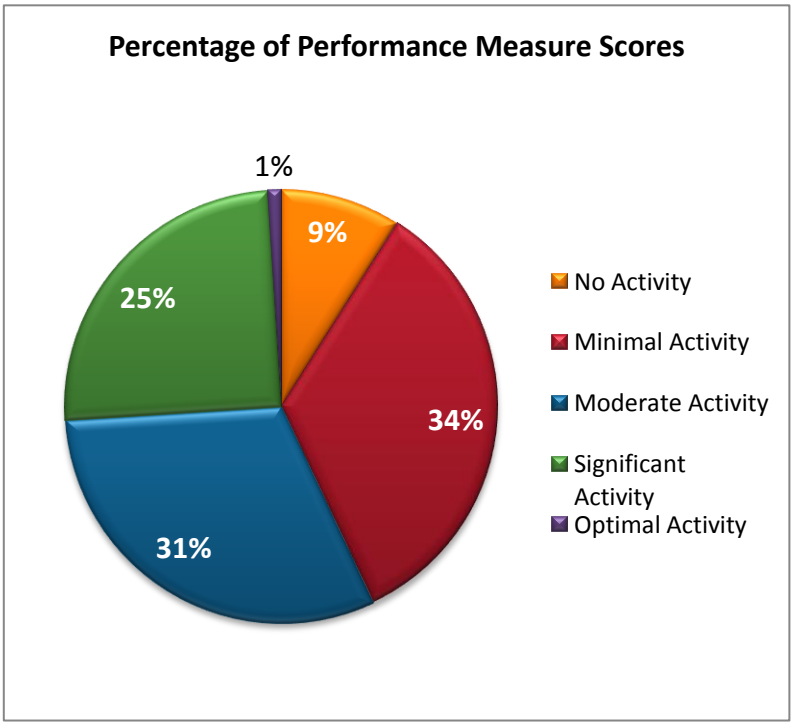


The overall score of the Yolo County LPHS was 44% level of activity for all 10 Essential Services, which is situated within the Moderate Activity range. The common threads throughout the work session involved greater collaboration among the LPHS partners; increased communication; sharing of information; and community input and engagement.

Each Essential Service score can be interpreted as the overall degree to which the Yolo County LPHS meets the Performance Standards.

The highest overall Essential Service score was 70.8% level of activity for Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards situated within the Significant Activity range.

The lowest overall score was 16.7% level of activity for Essential Service 5: Develop Policies and Plans that Support Individual and Community Health Efforts situated within the Minimal range. Two Model Standards within Essential Service 5 were perceived to have No Activity; public health policy development and community health improvement process and strategic planning.



There were 108 Performance Measures scored with slightly over one-third (34%) of the votes for Minimal Activity and 31% for Moderate Activity.

Following is the individual rankings for each of the Model Standards and Performance Measures from the work groups along with summary notes for each Model Standard.

ESSENTIAL SERVICE 1: MONITOR HEALTH STATUS TO IDENTIFY COMMUNITY HEALTH PROBLEMS

MODEL STANDARD 1.1: POPULATION-BASED COMMUNITY HEALTH ASSESSMENT (CHA)[22]

The LPHS completes a detailed CHA to allow an overall look at the community's health. The CHA provides the foundation for improving and promoting the health of the community and should be completed at least every three years. CHA data and information are shared, displayed, and updated continually.

Measure	At what level does the local public health system:	Performance Score
1.1.1	Conduct regular community health assessments?	Moderate Activity
1.1.2	Continuously update the community health assessment with current information?	Moderate Activity
1.1.3	Promote the use of the community health assessment among community members and partners?	Moderate Activity

The Yolo County Health Department conducts its Maternal, Child, and Adolescent Health (MCAH) assessment every five years; however, it is not all encompassing. Work group members indicated that data were not used to its fullest potential, especially on a comprehensive community-wide scale.

It was noted that there are many data sources available (e.g., CHIS, CalREDIE, Census, etc.) though most of the data are at the county level making it difficult to obtain city level data. There is a need to promote the community assessment to community members and partners more than what is being done as well as utilization of the findings to guide interventions.

Improvement opportunities were seen in gathering additional data that address the diversity and the distance among towns in a rural county. Mainly improvements can be made in evaluating the data to determine priority areas, focus interventions, and identify future funding opportunities.

MODEL STANDARD 1.2: CURRENT TECHNOLOGY TO MANAGE AND COMMUNICATE POPULATION HEALTH DATA

The LPHS provides the public with a clear picture of the current health of the community. Health problems are looked at over time and the information is displayed in clear ways. Current software tools and technology are used to gather, organize, analyze, display, and disseminate public health data to understand where health problems occur allowing the community to plan effectively.

[22] All Model Standard definitions are from the National Association of County & City Health Officials (NACCHO), Local Assessment Instrument, Version 3

Measure	At what level does the local public health system:	Performance Score
1.2.1	Use the best available technology and methods to display data on the public's health?	Significant Activity
1.2.2	Analyze health data, including geographic information, to see where health problems exist?	Moderate Activity
1.2.3	Use computer software to create charts, graphs, and maps to display complex public health data (trends over time, sub-population analyses, etc.)?	Significant Activity

Overall, the LPHS does utilize good software tools and technology (e.g., GIS) to analyze and illustrate health data. The work group mentioned that they often lack the technical support staff and LPHS staff may have limited access and training on technology. Public access is limited to mostly what is made available to them by a few select organizations. The work group noted a need for greater dissemination of information and to increase access to data.

MODEL STANDARD 1.3: MAINTENANCE OF POPULATION HEALTH REGISTRIES

The LPHS collects data on health-related events for use in population health registries. These registries allow more understanding of major health concerns. Registries also allow the LPHS to give timely information to at-risk populations. The LPHS ensures accurate and timely reporting of all the information needed for health registries.

Measure	At what level does the local public health system:	Performance Score
1.3.1	Collect data on specific health concerns to provide the data to population health registries in a timely manner, consistent with current standards?	Significant Activity
1.3.2	Use information from population health registries in community health assessments or other analyses?	Significant Activity

Fragmentation of data collection and utilization is a challenge in Yolo County. Some providers are more vigilant in reporting health data than others. The work group cited that real-time hospital data are lacking and difficult to access. A possible improvement opportunity would be to establish data user agreements with facilities and better use of the California Reportable Disease Information Exchange (CalREDIE), which may involve upgrades and training for physicians on reporting in CalREDIE.

ESSENTIAL SERVICE 2: DIAGNOSE AND INVESTIGATE HEALTH PROBLEMS AND HEALTH HAZARDS

MODEL STANDARD 2.1: IDENTIFICATION AND SURVEILLANCE OF HEALTH THREATS

The LPHS conducts surveillance for outbreaks of disease, disasters, and emergencies, and other emerging threats to public health. The LPHS uses surveillance data to detect changes or patterns right away, determine the factors that influence these patterns, investigate the potential dangers, and find ways to lessen the effect on the public's health. To ensure the most effective and efficient surveillance, the LPHS connects its surveillance systems with state and national systems.

Measure	At what level does the local public health system:	Performance Score

2.1.1	Participate in a comprehensive surveillance system with national, state, and local partners to identify, monitor, share information, and understand emerging health problems and threats?	**Significant Activity**
2.1.2	Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies and emerging threats (natural and manmade)?	**Moderate Activity**
2.1.3	Assure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?	**Significant Activity**

The work group noted that there is good collaboration among the LPHS with good communication at the state and county levels. There were some roadblocks to collecting surveillance data from hospitals. Necessary improvements included increased awareness in clinics and other facilities concerning reporting, additional resources and staff, and conducting more preparedness exercises in the community.

MODEL STANDARD 2.2: INVESTIGATION AND RESPONSE TO PUBLIC HEALTH THREATS AND EMERGENCIES

As a threat or emergency develops, a team of LPHS professionals works closely together to collect and understand related data. The response to an emergent event is in accordance with current emergency operations coordination guidelines.

Measure	At what level does the local public health system:	Performance Score
2.2.1	Maintain written instructions on how to handle communicable disease outbreaks and toxic exposure incidents, including details about case finding, contact tracing, and source identification and containment?	**Moderate Activity**
2.2.2	Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?	**Significant Activity**
2.2.3	Designate a jurisdictional Emergency Response Coordinator?	**Optimal Activity**
2.2.4	Prepare to rapidly respond to public health emergencies according to emergency operations coordination guidelines?	**Significant Activity**
2.2.5	Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or and nuclear public health emergencies?	**Moderate Activity**
2.2.6	Evaluate incidents for effectiveness and opportunities for improvement?	**Significant Activity**

The work group noted that the LPHS is performing well in responding to health hazards and emergencies. They noted there are response volunteers available, written plans, and after action reports to evaluate incidents.

It was suggested that improvements in logistics and coordination be made and to increase collaboration with other counties. There are several response manuals that need updating; ATD Policy, Communicable Disease Response, and Food-Borne Disease Response.

MODEL STANDARD 2.3: LABORATORY SUPPORT FOR INVESTIGATION OF HEALTH THREATS

The LPHS has the ability to produce timely and accurate laboratory results for public health concerns and sees that the correct testing is done and that the results are made available. Any laboratory used by public health meets all licensing and credentialing standards.

Measure	At what level does the local public health system:	Performance Score
2.3.1	Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?	Significant Activity
2.3.2	Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?	Significant Activity
2.3.3	Use only licensed or credentialed laboratories?	Significant Activity
2.3.4	Maintain a written list of rules related to laboratories, for handling samples (collecting, labeling, storing, transporting, and delivering), for determining who is in charge of the samples at what point, and for reporting the results?	Significant Activity

Laboratory support is seen as a strength of the LPHS with guidelines in place and backup laboratories available in case of an emergency. The work group noted that universality between laboratory systems could improve accessibility. Additional education should be conducted to improve laboratory rules for handling samples and reporting the results.

ESSENTIAL SERVICE 3: INFORM, EDUCATE, AND EMPOWER PEOPLE ABOUT HEALTH ISSUES

MODEL STANDARD 3.1: HEALTH EDUCATION AND PROMOTION

The LPHS designs and puts in place health promotion and health education activities to create environments that support health. The LPHS includes the community in identifying needs, setting priorities, and planning health promotional and education activities.

Measure	At what level does the local public health system:	Performance Score
3.1.1	Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?	Minimal Activity
3.1.2	Coordinate health promotion and health education activities to reach individual, interpersonal, community, and societal levels?	Moderate Activity
3.1.3	Engage the community throughout the process of setting priorities, developing plans, and implementing health education and health promotion activities?	Moderate Activity

There are a number of health and advisory boards throughout the county that serve the culturally and linguistically diverse population of Yolo County. The work group agreed that more health data must be shared with policy makers and there is a lack of communication between organizations about specific issues.

The size and rural nature of much of the county are challenges in coordinating health activities. County libraries often serve as a hub for coordinating health activities, especially in a rural community. Though transportation issues and time availability may hinder opportunities for community engagement, there is a need for the LPHS to be more flexible and infuse authentic, sincere community engagement into LPHS' processes and activities.

MODEL STANDARD 3.2: HEALTH COMMUNICATIONS

The LPHS uses health communication strategies to contribute to healthy living and healthy communities. Health communication efforts use a broad range of strategies, including print, radio, television, the Internet, media campaigns, social marketing, and interactive media. The LPHS works with many groups to understand the best was to present health messages in each community setting.

Measure	At what level does the local public health system:	Performance Score
3.2.1	Develop health communication plans for relating to media and the public and for sharing information among LPHS organizations?	Moderate Activity
3.2.2	Use relationships with different media providers (e.g. print, radio, television, and the internet) to share health information, matching the message with the target audience?	Minimal Activity
3.2.3	Identify and train spokespersons on public health issues?	Minimal Activity

The work group concluded that the LPHS has many communication tools available such as Facebook, Twitter, websites, and print materials. However, the effective use of these tools has been lacking. Improved relationships with media providers would increase the effectiveness of the communication tools within the LPHS. In addition, multilingual messages should be increased to reach more of the population. The work group felt that the communication tools are an underutilized resource.

A weakness of the LPHS was the lack of spokespersons to communicate public health issues and activities. The LPHS can improve health communications through sharing of how to use communication tools, supplying more bandwidth to the county, and having spokespersons communicate public health issues and activities in a relevant and appropriate fashion.

MODEL STANDARD 3.3: RISK COMMUNICATION

The LPHS uses health risk communications strategies to allow individuals, groups, organizations, or an entire community to make optimal decisions about their health and well-being in emergency events. The LPHS works together to identify potential risks that may affect the community and develops plans to effectively communicate information about these risks.

Measure	At what level does the local public health system:	Performance Score
3.3.1	Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?	Significant Activity
3.3.2	Make sure resources are available for a rapid emergency communication response?	Significant Activity
3.3.3	Provide risk communication training for employees and volunteers?	Significant Activity

The LPHS has systems and mechanisms in place and resources are available for a rapid emergency communication response. The increase of the frequency of risk communication training and of available communication methods to the public would improve upon health risk communications.

ESSENTIAL SERVICE 4: MOBILIZE COMMUNITY PARTNERSHIPS TO IDENTIFY AND SOLVE HEALTH PROBLEMS

MODEL STANDARD 4.1: CONSTITUENCY DEVELOPMENT

The LPHS actively identifies and involves community partners with opportunities to contribute to the health of communities. These stakeholders may include health, transportation, housing, environmental, non-health related groups, and community members. The LPHS manages the process of establishing collaborative relationships among these and other potential partners.

Measure	At what level does the local public health system:	Performance Score
4.1.1	Maintain a complete and current directory of community organizations?	Moderate Activity
4.1.2	Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?	Minimal Activity
4.1.3	Encourage constituents to participate in activities to improve community health?	Moderate Activity
4.1.4	Create forums for communication of public health issues?	Minimal Activity

There are fractured directories, but no current, complete directory of community organizations for the entire county. There has been an increase in certain mandates and regulations that establish processes for partnership development. Improved communications and outreach would also benefit partnership development. Due to the size and rural aspects of the county, strategic planning forums and meetings are needed as well as the use of virtual meetings (e.g., webinars, blogs, and dialogue apps).

MODEL STANDARD 4.2: COMMUNITY PARTNERSHIPS

The LPHS encourages individuals and groups to work together so that community health may be improved. By sharing responsibilities, resources, and rewards, community partnerships allow each member to share its expertise with others, strengthen the LPHS as a whole, and strategically align their interests to achieve a common purpose.

Measure	At what level does the local public health system:	Performance Score
4.2.1	Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	Moderate Activity
4.2.2	Establish a broad-based community health improvement committee?	Minimal Activity
4.2.3	Assess how well community partnerships and strategic alliances are working to improve community health?	Minimal Activity

According to the work group, there are many alliances in place. They also found it encouraging that people are willing to talk and break down silos. Currently, there is no list or directory of community partnerships and/or strategic alliances, which provides an opportunity to develop one.

ESSENTIAL SERVICE 5: DEVELOP POLICIES AND PLANS THAT SUPPORT INDIVIDUAL AND COMMUNITY HEALTH EFFORTS

MODEL STANDARD 5.1: GOVERNMENTAL PRESENCE AT THE LOCAL LEVEL

The LPHS works with the community to make sure a strong local health department exists and that it is doing its part in providing the 10 Essential Services. The local health department is accredited through the Public Health Accreditation Board's accreditation program.

Measure	At what level does the local public health system:	Performance Score
5.1.1	Support the work of a local health department dedicated to the public health to make sure the essential public health services are provided?	Minimal Activity
5.1.2	See that the local health department is accredited through the national voluntary accreditation program?	No Activity
5.1.3	Assure that the local health department has enough resources to do its part in providing essential public health services?	No Activity

The work group recognized the talented staff within the LPHS who support the work of the local health department. The county elected officials support the LPHS and the local public health department. The work group noted that everyone is doing things on their own resulting in a lack of interconnectedness. Members referred to this as the silo effect. Budget limitations have restricted the resources available in providing the Essential Services.

The Yolo County Health Department has not applied for public health accreditation, but is working on the application prerequisites. Improvement efforts should be focused around increased collaboration between departments and organizations, have organizations co-locate at the same facility, and combine community events.

MODEL STANDARD 5.2: PUBLIC HEALTH POLICY DEVELOPMENT

The LPHS develops policies that will prevent, protect, or promote the public's health. Public health problems, possible solutions, and community values are used to inform the policies and any proposed actions. The LPHS' ability to make informed decisions is strengthened by community member input.

Measure	At what level does the local public health system:	Performance Score
5.2.1	Contribute to public health policies by engaging in activities that inform the policy development process?	No Activity
5.2.2	Alert policymakers and the community of the possible public health impacts (both intended and unintended) from current and/or proposed policies?	No Activity
5.2.3	Review existing policies at least every three to five years?	No Activity

The work group views public health policy development as lacking in structure and limited awareness of current policies and processes. Education and outreach to community members, LPHS organizations, and policymakers were seen as improvement opportunities to enhance policy development. Furthermore, the creation of a LPHS Policy Council to review existing policies and potential policies would be beneficial.

This Model Standard is one of two that were perceived as having No Activity. The LPHS should conduct a review of all current public health policies in the county. The LPHS and constituents should begin working together to identify and analyze issues to ensure that public health is implemented all policies.

MODEL STANDARD 5.3: COMMUNITY HEALTH IMPROVEMENT PROCESS AND STRATEGIC PLANNING

The LPHS leads a community-wide effort to improve community health by gathering information on health problems, identifying the community's strengths and weaknesses, setting goals, and increasing overall awareness of and interest in improving the health of the community. This community health improvement process provides ways to develop a community-owned community health improvement plan that will lead to a healthier community.

Measure	At what level does the local public health system:	Performance Score
5.3.1	Establish a community health improvement process, with broad- based diverse participation, that uses information from both the community health assessment and the perceptions of community members?	No Activity
5.3.2	Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?	No Activity
5.3.3	Connect organizational strategic plans with the Community Health Improvement Plan?	No Activity

The LPHS has not developed a community health improvement process. Most of the work group was uninformed of such a process and requested more education about the process and planning among their agencies and the community.

This is the second Model Standard perceived as having No Activity. The local public health department is beginning a community health improvement process and strategic planning. More outreach and communication regarding the process and involvement of the LPHS and community members is warranted.

MODEL STANDARD 5.4: PLAN FOR PUBLIC HEALTH EMERGENCIES

The LPHS adopts an emergency preparedness and response plan that describes what each organization in the system should be ready to do in a public health emergency. The LPHS practices for possible events through regular exercises or drills.

Measure	At what level does the local public health system:	Performance Score
5.4.1	Support a workgroup to develop and maintain preparedness and response plans?	Minimal Activity
5.4.2	Develop a plan that defines when it would be used, who would do what tasks, what standard operating procedures would be put in place, and what alert and evacuation protocols would be followed?	Minimal Activity
5.4.3	Test the plan through regular drills and revise the plan as needed, at least every two years?	Minimal Activity

The work group identified there was an emergency preparedness plan; however, the plan is not well known among the LPHS and there seems to be a lack of coordination. Improvement opportunities were to increase awareness among the LPHS of the emergency preparedness plan and to have more drills.

ESSENTIAL SERVICE 6: ENFORCE LAWS AND REGULATIONS THAT PROTECT HEALTH AND ENSURE SAFETY

MODEL STANDARD 6.1: REVIEW AND EVALUATION OF LAWS, REGULATIONS, AND ORDINANCES

The LPHS looks at federal, state, and local laws to understand the authority provided to the system and the potential impact of laws, regulations, and ordinances on the health of the community. The LPHS also looks at any challenges involved in complying with laws, regulations, or ordinances (e.g., community concerns and necessary updates).

Measure	At what level does the local public health system:	Performance Score
6.1.1	Identify public health issues that can be addressed through laws, regulations, or ordinances?	Minimal Activity
6.1.2	Stay up-to-date with current laws, regulations, and ordinances that prevent, promote, or protect public health on the federal, state, and local levels?	Minimal Activity
6.1.3	Review existing public health laws, regulations, and ordinances at least once every five years?	Minimal Activity
6.1.4	Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?	Minimal Activity

The work group identified that obesity and the inspection of well and septic tanks can best be addressed through laws, regulations, and ordinances. The work group agreed that reviews and updates should occur every three to five years, but this is not occurring. The work group also cited minimal access to legal counsel and that the state is unresponsive and not leading any public health initiatives.

Laws, regulations, and ordinances should be reviewed and updated on a regular basis. An improvement opportunity would be to create a council that performs the review and update, and communicates its findings with the LPHS and community. Relations with the state should be fostered to help implement ideas from the county level.

MODEL STANDARD 6.2: INVOLVEMENT IN THE IMPROVEMENT OF LAWS, REGULATIONS, AND ORDINANCES

The LPHS works to change existing laws, regulations, or ordinances – or to create new ones – when they have determined that changes or additions would better prevent health problems or protect or promote public health. To promote public health, the LPHS helps to draft the new or revised legislation, regulations, or ordinances; takes part in public hearings; and talks with lawmakers and regulatory officials.

Measure	At what level does the local public health system:	Performance Score
6.2.1	Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?	Minimal Activity

6.2.2	Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote the public health?	Minimal Activity
6.2.3	Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?	Minimal Activity

There are certain areas or pockets that are the driving force of regulation, but there is no consistent, system-wide level process in place to improve laws, regulations, and ordinances. Elected officials seek the expertise of the LPHS to aid drafting language. To improve the performance in this area, the LPHS should work collaboratively with other agencies, elected officials, and state representatives. The work group suggested a forum be created among the LPHS and elected officials to review existing laws, regulations, and ordinances; ultimately to participate in changing or creating new laws, regulations, and ordinances.

MODEL STANDARD 6.3: ENFORCEMENT OF LAWS, REGULATIONS, AND ORDINANCES

The LPHS knows which governmental agency or other organization has the authority to enforce any given public health-related requirement within its community, supports all organizations tasked with enforcement responsibilities, and ensures that the enforcement is conducted within the law. The LPHS also makes sure that individuals and organizations understand the requirements of relevant laws, regulation, and ordinances.

Measure	At what level does the local public health system:	Performance Score
6.3.1	Identify organizations that have the authority to enforce public health laws, regulations, and ordinances?	No Activity
6.3.2	Assure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?	Significant Activity
6.3.3	Assure that all enforcement activities related to public health codes are done within the law?	Minimal Activity
6.3.4	Educate individuals and organizations about relevant laws, regulations, and ordinances?	Moderate Activity
6.3.5	Evaluate how well local organizations comply with public health laws?	Minimal Activity

The work group could not identify any organization that has authority to enforce public health laws, regulations, and ordinances. All agreed the local health department is the agency that has the authority to act in public health emergencies. The enforcement activities related to public health codes lack collaboration and coordination. The evaluation component lacks data or data collaboration. Work group members felt that this was due to limited time and lack of resources.

ESSENTIAL SERVICE 7: LINK PEOPLE TO NEEDED PERSONAL HEALTH SERVICES AND ASSURE THE PROVISION OF HEALTH CARE WHEN OTHERWISE UNAVAILABLE.

MODEL STANDARD 7.1: IDENTIFICATION OF PERSONAL HEALTH SERVICE NEEDS OF POPULATIONS

The LPHS identifies the personal health service needs of the community and identifies the barriers to receiving these services, especially among particular groups that may have difficulty accessing personal health services. The LPHS has

defined roles and responsibilities for the local health department and other partners in relation to overcoming these barriers and providing services.

Measure	At what level does the local public health system:	Performance Score
7.1.1	Identify groups of people in the community who have trouble accessing or connecting to personal health services?	Significant Activity
7.1.2	Identify all personal health service needs and unmet needs throughout the community?	Moderate Activity
7.1.3	Defines partner roles and responsibilities to respond to the unmet needs of the community?	Moderate Activity
7.1.4	Understand the reasons that people do not get the care they need?	Minimal Activity

The work group cited that the LPHS has identified groups of people who have trouble accessing specific types of personal health service such as teens, immigrants, homeless, seniors, and women and children living in poverty. A general understanding that language and cultural barriers; mental health; and substance abuse may result in people not getting needed health services was discussed, though a more thorough understanding is warranted. First 5 of Yolo County has conducted an assessment to identify unmet needs throughout the community. However, the assessment is primarily focused on mothers and children.

The LPHS should attempt to understand the barriers to personal health services in a more broad based approach. The work group suggested conducting focus groups in migrant centers and schools and connecting with local leaders of a specific community or culture for a more comprehensive understanding. The LPHS would benefit through greater networking and sharing of materials and information plus having multilingual documents.

MODEL STANDARD 7.2: ASSURING THE LINKAGE OF PEOPLE TO PERSONAL HEALTH SERVICES

The LPHS partners work together to meet the diverse needs of all populations. Partners see that persons are signed up for all benefits available to them and know where to refer people with unmet personal health service needs. The LPHS develops working relationships between public health, primary care, oral health, social services, mental health systems, and organizations that are not traditionally part of the personal health service system, such as housing, transportation, and grassroots organizations.

Measure	At what level does the local public health system:	Performance Score
7.2.1	Connect (or link) people to organizations that can provide the personal health services they may need?	Moderate Activity
7.2.2	Help people access personal health services, in a way that takes into account the unique needs of different populations?	Moderate Activity
7.2.3	Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?	Moderate Activity
7.2.4	Coordinate the delivery of personal health and social services so that everyone has access to the care they need?	Minimal Activity

The work group noted that there were multiple points of entry. 2-1-1 Yolo is a free telephone information service that provides referrals for people to connect to personal health services. Many of the community clinics and case management services help people access personal health services.

The coordination of delivery was perceived as a weakness of the LPHS as well as staff turnover and funding limitations. Improvement to the referral process was seen as an opportunity. This could be achieved through partner education, resource training, cultural outreach, client benefit advocates, and the promotion of 2-1-1 Yolo.

ESSENTIAL SERVICE 8: ASSURE A COMPETENT PUBLIC AND PERSONAL HEALTH CARE WORKFORCE

MODEL STANDARD 8.1: WORKFORCE ASSESSMENT, PLANNING, AND DEVELOPMENT

The LPHS assesses the local public health workforce by looking at what knowledge, skills, and abilities the workforce needs and the numbers and kinds of jobs the system should have to adequately prevent health problems and prevent and promote health in the community. Based on the assessment, the LPHS determines appropriate training and the number and types of positions necessary.

Measure	At what level does the local public health system:	Performance Score
8.1.1	Set up a process and a schedule to track the numbers and types of LPHS jobs and the knowledge, skills, and abilities that they require whether those jobs are in the public or private sector?	Minimal Activity
8.1.2	Review the information from the workforce assessment and use it to find and address gaps in the local public health workforce?	Minimal Activity
8.1.3	Provide information from the workforce assessment to other community organizations and groups, including governing bodies and public and private agencies, for use in their organizational planning?	Minimal Activity

The work group was not aware of any LPHS workforce assessment. One work group member noted that her department conducted a workforce assessment a few years ago; identifying that there are individual departments assessing their own needs, but not a countywide assessment of staff at the LPHS.

The work group agreed that the workforce data are fragmented and outdated. The LPHS should review state and national assessments to use as guidelines. The LPHS may work more closely with universities and schools to perform regular LPHS workforce assessments in order to rebuild the workforce more deliberately.

MODEL STANDARD 8.2: PUBLIC HEALTH WORKFORCE STANDARDS

The LPHS maintains standards to see that workforce members are qualified to do their jobs, with the required certificates, licenses, and education. Information about the knowledge, skills, and abilities that are needed to provide the Essential Services are used in personnel systems, so that position descriptions, hiring, and performance evaluations are based on public health competencies.

Measure	At what level does the local public health system:	Performance Score

8.2.1	Make sure that all members of the public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and meet the law?	**Significant Activity**
8.2.2	Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the essential public health services?	**Significant Activity**
8.2.3	Base the hiring and performance review of members of the public health workforce in public health competencies?	**Minimal Activity**

The work group agreed that all agencies have their own ways of making sure that every position has the required documentation; however, there is not a way to check for core competencies (i.e., skills). The job descriptions reflect the core job functions and human resource departments are trained to look for specific job documentation. The hiring and performance review are typically mandated, but the performance review sheets are too generic and do not assess whether performance is linked to public health competencies. The work group suggested that performance reviews be based on the specific job description and linked to public health competencies.

MODEL STANDARD 8.3: LIFE-LONG LEARNING THROUGH CONTINUING EDUCATION, TRAINING, AND MENTORING

The LPHS encourages formal and informal opportunities in education and training are available to the workforce. The LPHS trains its workforce to recognize and address the unique culture, language, and health literacy of diverse consumers and communities and to respect all members of the community. The LPHS also educates its workforce about the many factors that can influence health.

Measure	At what level does the local public health system:	Performance Score
8.3.1	Identify education and training needs and encourage the workforce to participate in available education and training?	**Moderate Activity**
8.3.2	Provide ways for workers to develop core skills related to essential public health services?	**Significant Activity**
8.3.3	Develop incentives for workforce training, such as tuition reimbursement, time off for class, and pay increases?	**Moderate Activity**
8.3.4	Create and support collaborations between organizations within the public health system for training and education?	**Significant Activity**
8.3.5	Continually train the public health workforce to deliver services in a cultural competent manner and understand social determinants of health?	**Moderate Activity**

Most departments and organizations encourage education and training opportunities, which focus on the direct service provided and not necessarily the Essential Public Health Services. Partners in the LPHS contract with the UC system for education and training needs. The work group also mentioned inter-departmental training and e-mail blasts to notify workers of training opportunities. Work group members felt that there were no major incentives for continuing education and a lack of on-going funding limits training opportunities. To improve on this model standard, the work group suggested that the LPHS should seek federal funding for public health training and focus on educating the public health workforce on the social determinants of health outcomes.

MODEL STANDARD 8.4: PUBLIC HEALTH LEADERSHIP DEVELOPMENT

Leadership within the LPHS is demonstrated by organizations and individuals that are committed to improving the health of the community. The LPHS encourages the development of leaders that represent the diversity of the community and respect community values.

Measure	At what level does the local public health system:	Performance Score
8.4.1	Provide access to formal and informal leadership development opportunities for employees at all organizational levels?	Moderate Activity
8.4.2	Create a shared vision of community health and the public health system, welcoming all leaders and community members to work together?	Moderate Activity
8.4.3	Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?	Significant Activity
8.4.4	Provide opportunities for the development of leaders representative of the diversity within the community?	Minimal Activity

The work group acknowledged that there were a number of leadership opportunities in the county. There is a lack of broad based collaborations within the LPHS; this would provide leadership opportunities to spread despite the agency's functions. One member stated that if we had a shared vision, we would not be here – meaning that we would not be assessing the LPHS because we would be working together. There is no shared vision at this time, the Healthy Yolo project is working on developing a shared vision. The work group felt that it is important to develop community leaders that reflect the culture of the community and saw this as an improvement opportunity for the LPHS.

ESSENTIAL SERVICE 9: EVALUATE EFFECTIVENESS, ACCESSIBILITY, AND QUALITY OF PERSONAL AND POPULATION-BASED HEALTH SERVICES

MODEL STANDARD 9.1: EVALUATION OF POPULATION-BASED HEALTH SERVICES

The LPHS evaluates population-based health services, which are aimed at disease prevention and health promotion for the entire community. The LPHS uses data to evaluate whether population-based services are meeting the needs of the community and the satisfaction of those they are serving. Based on the evaluation, the LPHS may make changes and may reallocate resources to improve population-based health services.

Measure	At what level does the local public health system:	Performance Score
9.1.1	Evaluate how well population-based health services are working, including whether the goals that were set for programs were achieved?	Minimal Activity
9.1.2	Assess whether community members, including those with a higher risk of having a health problem, are satisfied with the approaches to preventing disease, illness, and injury?	Minimal Activity
9.1.3	Identify gaps in the provision of population-based health services?	Significant Activity
9.1.4	Use evaluation findings to improve plans and services?	Moderate Activity

The LPHS evaluates population-based health services using patient satisfaction surveys, pre and post surveys, and tracks the results over time. The work group stated that multi-level coordination exists with many committees resulting in the sharing of best practices. There is a need to follow through on the evaluation findings. The work group also noted that the evaluations would be improved if there were standardized evaluations, increased sharing of results, and training opportunities. A lack of resources and funding were seen as some of the barriers.

MODEL STANDARD 9.2: EVALUATION OF PERSONAL HEALTH SERVICES

The LPHS regularly evaluates the accessibility, quality, and effectiveness of personal health services. The LPHS see that the personal health services in the area match the needs of the community, with available and effective care for all ages and groups of people. The LPHS uses findings from the evaluation to improve services and program delivery.

Measure	At what level does the local public health system:	Performance Score
9.2.1	Evaluate the accessibility, quality, and effectiveness of personal health services?	Moderate Activity
9.2.2	Compare the quality of personal health services to established guidelines?	Significant Activity
9.2.3	Measure satisfaction with personal health services?	Moderate Activity
9.2.4	Use technology, like the internet or electronic health records, to improve quality of care?	Significant Activity
9.2.5	Use evaluation findings to improve services and program delivery?	Moderate Activity

The work group noted that local hospitals conduct satisfaction surveys and that the State has strong, established guidelines for comparison. The availability of technology was seen as an asset along with the Health Insurance Portability & Accountability Act (HIPAA) in improving the quality of care. The work group did not cite any improvement opportunities for this Model Standard.

MODEL STANDARD 9.3: EVALUATION OF THE LOCAL PUBLIC HEALTH SYSTEM

The LPHS evaluates itself to see how well it is working as a whole. Representatives of the LPHS evaluate LPHS activities and identify areas of the LPHS that need improvement.

Measure	At what level does the local public health system:	Performance Score
9.3.1	Identify all public, private, and voluntary organizations that provide essential public health services?	Significant Activity
9.3.2	Evaluate how well LPHS activities meet the needs of the community at least every five years, using guidelines that describe a model LPHS and involving all entities contributing to essential public health services?	Minimal Activity
9.3.3	Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?	Moderate Activity
9.3.4	Use results from the evaluation process to improve the LPHS?	Minimal Activity

The identification of those public, private, and voluntary organizations that provide the Essential Services are well documented. The work group for Essential Service 4 disagreed stating there are fractured directories, but no complete, countywide directory.

The evaluation of the LPHS that encompasses all Essential Services and the entire population is very limited. The work group felt that there was a lack of communication among the LPHS. Though it was noted that coordinating services was a strength of the LPHS, the work group also believed that coordination needed to be expanded. An improvement opportunity would be to provide a follow through step that utilized the results from the evaluation to improve the LPHS.

ESSENTIAL SERVICE 10: RESEARCH FOR NEW INSIGHTS AND INNOVATIVE SOLUTIONS TO HEALTH PROBLEMS

MODEL STANDARD 10.1: FOSTERING INNOVATION

LPHS organizations try new and creative ways to improve public health practice. In both academic and practice settings new approaches are studied to see how well they work.

Measure	At what level does the local public health system:	Performance Score
10.1.1	Provide staff with the time and resources to pilot test or conduct studies to test new solutions to public health problems and see how well they actually work?	Minimal Activity
10.1.2	Suggest ideas about what currently needs to be studied in public health to organizations that do research?	No Activity
10.1.3	Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?	Moderate Activity
10.1.4	Encourage community participation in research, including deciding what will be studied, conducting research, and in sharing results?	Moderate Activity

The work group commented that there is little or no funding to conduct pilot tests or studies to test innovative solutions. Some programs must follow certain guidelines according to the funders and many have placed restrictions on such tests or studies. The work group felt that there is no current practice of suggesting public health research ideas to the academic community. There is a need for cross-agency collaboration, more community input and participation, and an increase in community education. These findings lead to ideas about what needs to be studied in public health – community engagement and participation, and collaboration methods in a diverse rural county.

MODEL STANDARD 10.2: LINKAGE WITH INSTITUTIONS OF HIGHER LEARNING AND/OR RESEARCH

The LPHS establishes relationships with colleges, universities, and other research organizations. They freely share information and best practices and set up formal or informal arrangements to work together. The LPHS works with one or more colleges, universities, or other research organizations to co-sponsor continuing education programs.

Measure	At what level does the local public health system:	Performance Score

10.2.1	Develop relationships with colleges, universities, or other research organizations, with a free flow of information, to create formal and informal arrangements to work together?	**Minimal Activity**
10.2.2	Collaborate with colleges, universities, or other research organizations to do public health research, including community-based participatory research?	**Minimal Activity**
10.2.3	Encourage colleges, universities, and other research organizations to work together with LPHS organizations to develop projects, including field training and continuing education?	**Minimal Activity**

The work group agreed that Yolo County is near great schools to develop partnerships – UCD, CSUS, and schools in the Bay Area. There are relationships with these schools: CSUS Nursing Program, and practicum experiences for UCD students. The work group suggested in order to maintain and improve the current relationships, work needs to be done to identify the barriers to community-based participatory research and to utilize students in the Master of Public Health and other public health training programs more frequently.

MODEL STANDARD 10.3: CAPACITY TO INITIATE OR PARTICIPATE IN RESEARCH

The LPHS takes part in research to help improve the performance of the LPHS. Research capacity includes access to libraries and information technology, the ability to analyze complex data, and ways to share research findings with the community and use them to improve public health practice.

Measure	At what level does the local public health system:	Performance Score
10.3.1	Collaborate with researchers who offer the knowledge and skills to design and conduct health-related studies?	**Minimal Activity**
10.3.2	Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?	**Moderate Activity**
10.3.3	Share findings with public health colleagues and the community broadly, through journals, websites, community meetings, etc.?	**Moderate Activity**
10.3.4	Evaluate public health systems research efforts throughout all stages of work from planning to impact on local public health practice?	**Minimal Activity**

There is little collaboration among researchers to design and conduct health-related studies and a lack of longitudinal research capabilities. The work group cited a lack of resources for staffing and felt there was a need to improve collaboration with UC Davis and to improve communication throughout the entire county.

LPHSA SUMMARY

The Local Instrument relies on the work groups' perceptions of the performance of the LPHS, which may be limited. The breadth and depth of public health efforts makes it difficult to ascertain with certainty the level of performance for each Model Standard. Based upon the LPHS self-assessment of our performance according to the Performance Standards our LPHS is strongest in (a) maintenance of population health registries; (b) laboratory support for investigation of health threats; and (c) risk communication. Our LPHS is weakest in (a) public health policy development; (b) a government presence at the local level; and (c) community health improvement process and strategic planning.

At the end of the work session, participants were asked to summarize the most significant strengths of the LPHS, biggest challenges, and system level changes needed.

MOST SIGNIFICANT STRENGTHS

Staff
Availability of media/communication methods
Availability of technology
Existing evidence-based models
Full scope of services provided

BIGGEST CHALLENGES

Minimal community involvement in the processes and policies of public health
Lack of funding or limited funding
Agency silos. Agencies and individuals focus on agency-provided service instead of a broad perspective
Interventions restricted by grantor's rules and regulations instead of community-driven
Referral infrastructure to link people to services
Lack of quality improvement efforts to reduce duplication of services among LPHS

SYSTEM LEVEL CHANGES NEEDED

Interagency collaboration
Infrastructure that supports cultural sensitivity and the needs of diverse populations
Re-educating our LPHS partners on messaging and communication
Wider dissemination of health data to the community and LPHS partners

IDENTIFIED PRIORITIES

Following the LPHS assessment work session, invitees (LPHS representatives) were sent a questionnaire regardless of whether they attended the work session or not. The LPHS representatives were provided with a draft of this LPHS Assessment report for their review and a hyperlink to the questionnaire. The questionnaire asked the LPHS representatives to consider the priority of each Model Standard, using a scale of 1 to 10, which allowed respondents to consider the Performance Standards themselves and priorities within the Model Standards. The draft LPHS Assessment report and questionnaire were sent to 47 people and 16 responded to the questionnaire.

The priority ratings were compared to the performance of each Model Standard. The results were ranked and separated into four quadrants. The four quadrants, which are based on how the performance of each Model Standard compares with the priority rating, provides guidance in considering areas for attention and next steps for improvement.

Four Quadrants Priority Ratings Definitions	
Quadrant A	**(High Priority and Low Performance)** – These activities may need increased attention.
Quadrant B	**(High Priority and High Performance)** – These activities are being done well, and it is important to maintain efforts.
Quadrant C	**(Low Priority and High Performance)** – These activities are being done well; consideration may be given to reducing effort in these areas.

Quadrant D	**(Low Priority and Low Performance)** – These activities could be improved, but are of low priority. They may need little or no attention at this time.

The table below prioritizes the Model Standards based on their performance score and priority rating.

Quadrant	Model Standard	Performance Score (%)	Priority Rating
Quadrant A	10.2 Academic Linkages	25.0	7
Quadrant A	10.1 Foster Innovation	31.3	7
Quadrant A	6.3 Enforce Laws	35.0	7
Quadrant A	6.2 Improve Laws	25.0	7
Quadrant A	6.1 Review Laws	25.0	7
Quadrant A	5.3 CHIP/Strategic Planning	0.0	7
Quadrant A	5.2 Policy Development	0.0	7
Quadrant A	4.2 Community Partnerships	33.3	7
Quadrant A	4.1 Constituency Development	37.5	7
Quadrant A	3.1 Health Education/Promotion	41.7	7
Quadrant B	9.3 Evaluation of LPHS	43.8	8
Quadrant B	9.1 Evaluation of Population Health	43.8	7
Quadrant B	8.4 Leadership Development	50.0	7
Quadrant B	8.3 Continuing Education	60.0	7
Quadrant B	8.2 Workforce Standards	58.3	7
Quadrant B	7.2 Assure Linkage	43.8	7
Quadrant B	7.1 Personal Health Services Needs	50.0	7
Quadrant B	3.3 Risk Communication	75.0	7
Quadrant B	2.3 Laboratories	75.0	8
Quadrant B	2.2 Emergency Response	70.8	7
Quadrant B	2.1 Identification/Surveillance	66.7	8
Quadrant B	1.3 Registries	75.0	8
Quadrant B	1.2 Current Technology	66.7	7
Quadrant B	1.1 Community Health Assessment	50.0	7
Quadrant C	9.2 Evaluation of Personal Health	60.0	6
Quadrant D	10.3 Research Capacity	37.5	6
Quadrant D	8.1 Workforce Assessment	25.0	6
Quadrant D	5.4 Emergency Plan	25.0	6
Quadrant D	5.1 Governmental Presence	8.3	6
Quadrant D	3.2 Health Communication	33.3	6

The 10 Model Standards listed in Quadrant A are considered priority areas for the LPHS. Three deal directly with collaboration: academic linkages; community partnerships; and constituency development. Through this type of collaboration, the LPHS can address the remaining Model Standards. The linchpin to these collaborative efforts is communication. Establishing means and methods of communication will open up the avenues of collaboration among the community and the LPHS.

FORCES OF CHANGE

The Forces of Change (FoC) assessment is a simple yet comprehensive way of assessing the positive and negative forces within and outside our county, so we can better prepare to act effectively - to take advantage of opportunities and counteract threats or avoid pitfalls.

While it may not seem obvious at first, the broader contextual environment is constantly affecting communities. State and federal legislation, rapid technological advances, changes in the organization of health care services, shifts in economic and employment forces, and changing family structures are all examples of forces of change. They are important because they affect, either directly or indirectly, the health and quality of life in our community and the effectiveness of our local public health system[23].

The forces of change are broad all-encompassing categories that include:

- **Trends.** Patterns over time, such as migration in and out of a community or a growing interest in locally grown produce.
- **Factors.** Discrete elements, such as a community's large ethnic population, an urban setting, or a county's proximity to a major waterway.
- **Events.** One-time occurrences, such as a hospital closure, a natural disaster, or the passage of new legislation.

These categories of forces can occur in the social, economic, political, technological, environmental, and legal realm. The FoC assessment focuses on identifying the trends, factors, and events that are likely to influence community health and quality of life, or affect the work of the local public health system.

ASSESSMENT RESULTS

The forces of change work group identified six forces of change categories: the food environment; technology; economic equity; demographics; health services; and education equity. The following sections provide the overall collection of work generated from the forces of change work session.

FOOD ENVIRONMENT

1. Environment Contributing to Obesity

1.1. OPPORTUNITIES

1.1.1. With flat land and good weather, our communities can be designed to encourage walking and biking (i.e., bike friendly / walk friendly communities).
1.1.2. Organized sports/leagues and walk/bike/run events
1.1.3. Access to parks
1.1.4. Access to Farmers' Markets
1.1.5. Easy access to nature

1.2. THREATS

1.2.1. Media & advertising promote unhealthy lifestyle and food marketing/labeling can be misleading
1.2.2. Car obsessed: people prefer to drive and community is designed around the automobile
1.2.3. Easy & cheap access to junk food

[23] NACCHO, "Forces of Change Assessment At-A-Glance". http://www.naccho.org/topics/infrastructure/mapp/upload/foc.pdf

1.2.4. Difficult to access healthy foods
1.2.5. Unsafe areas and pathways

2. Drought

2.1. OPPORTUNITIES

2.1.1. Conservation efforts
2.1.2. Develop more community gardens

2.2. THREATS

2.2.1. Agriculture/local crops production
2.2.2. Cost of food may increase
2.2.3. Increased preference for cheaper and unhealthier foods due to the higher cost of fresh produce

3. Food Access

3.1. OPPORTUNITIES

3.1.1. Building communities with access to food and other resources
3.1.2. Incorporate and promote healthy foods at schools (farm to school)
3.1.3. Increase public drinking water access
3.1.4. Promote Farm-to-Fork
3.1.5. Utilize UC Davis – School of Agriculture
3.1.6. Develop/support food distribution centers

3.2. THREATS

3.2.1. Neighborhoods without food stores
3.2.2. Free unhealthy food through government programs (juice, high sodium content of canned foods)

TECHNOLOGY

1.1. OPPORTUNITIES

1.1.1. Bridge technology gaps for disabled individuals
1.1.2. Use Solar technology and energy devices
1.1.3. Work to increase speed of Internet service to remote locations
1.1.4. Provide technical training centers countywide
1.1.5. In-home tech aids and other personal tech health devices are becoming more available and popular
1.1.6. Social media as a tool to increase local communications
1.1.7. Improve integrated healthcare through electronic health records

1.2. THREATS

1.2.1. Decrease in person-to-person communication - lower social skills. Potential for miscommunication
1.2.2. Technology crash or virus
1.2.3. More vulnerable to identity theft and digital crime
1.2.4. Public craves efficiency and instant gratification
1.2.5. Lack of infrastructure in certain areas (e.g., rural)
1.2.6. Digital immigrant vs. digital natives. Older population may be unwilling to use or unfamiliar with recent technology
1.2.7. Poor internet service and lack of personal devices
1.2.8. Expense: cost for services and devices
1.2.9. Waste disposal of electronic devices
1.2.10. Loss of print based business

ECONOMIC EQUITY

1. **Housing**
   - 1.1. OPPORTUNITIES
     - 1.1.1. Creative in-fill development
     - 1.1.2. Housing quality
     - 1.1.3. Increase safety
   - 1.2. THREATS
     - 1.2.1 Increase in housing prices due to limited housing development
2. **Economic Uncertainty**
   - 2.1 OPPORTUNITIES
     - 2.1.1 Government/business partnerships
     - 2.1.2 "Crowd funding" & entrepreneurship (especially reaching diverse groups)
     - 2.1.3 Agriculture/agri-business partnerships with University California, Davis
   - 2.2 THREATS
     - 2.2.1 Losing jobs due to change, business/economic environment (especially entry level)
     - 2.2.2 Climate change affecting agricultural jobs
3. **Affordable Childcare**
   - 3.1 OPPORTUNITIES
     - 3.1.1 Active Community Organizations (LCPC, First 5)
     - 3.1.2 Train & employ early childhood educators
     - 3.1.3 Collaborate with county services (i.e., Welfare to Work)
     - 3.1.4 On-site childcare development
   - 3.2 THREATS
     - 3.2.1 Lack of child care slots for working parents
     - 3.2.2 Aspects/contributing factors are out of local control (i.e., state funding decisions)
4. **Interdependence – Collaboration**
   - 4.1 OPPORTUNITIES
     - 4.1.1 Integration of health & social services.
     - 4.1.2 Grants (seeking out grants collaboratively)
     - 4.1.3 Bringing more contributors/stakeholders into general planning process
     - 4.1.4 Community leaders, law enforcement, & service provider collaboration
   - 4.2 THREATS
     - 4.2.1 Collaboration & lack of communication between businesses, local government, and CBOs
     - 4.2.2 Unsafe neighborhoods & lack of community cohesion

DEMOGRAPHICS

- 1.1 OPPORTUNITIES
  - 1.1.1 Reach out to undocumented population
  - 1.1.2 Educate population about Yolo County's history and diversity
  - 1.1.3 Large college student population. Use of interns
  - 1.1.4 Yolo Hospice to help care for the elderly
  - 1.1.5 Connect the urban and rural communities using non-profits, community-based organizations (CBOs), and chambers of commerce
  - 1.1.6 Education: highlight the unique identity of each community

1.1.7 Funding for cultural awareness training
1.1.8 Culturally competent workforce
1.1.9 Education on migrant worker life increased involvement by our communities

1.2 THREATS

1.2.1 Aging population
1.2.2 Need for caregivers
1.2.3 Lack of transportation for elderly
1.2.4 Diverse demographics in a large area (urban & rural)
1.2.5 Language barriers may block access to resources
1.2.6 Lack of a coherent policy on immigration

HEALTH SERVICES

1. **Electronic Health Records**

1.1 OPPORTUNITIES

1.1.1 Increased funding opportunities
1.1.2 Advanced security technology

1.2 THREATS

1.2.1. Availability of systems to deliver secure, appropriate health records
1.2.2. Hacking

2. **Mental Health**

2.1 OPPORTUNITIES

2.1.1 Increased access via Affordable Care Act
2.1.2 Reduce the stigma associated with mental health issues
2.1.3 Create and provide new drug and alcohol programs
2.1.4 New job opportunities

2.2 THREATS

2.2.1 Lack of mental health providers & services
2.2.2 Increased need for mental health services
2.2.3 Increase in drug & alcohol use

3. **Affordable Care Act (ACA)**

3.1 OPPORTUNITIES

3.1.1 Increased access to medical care may result in a healthier population
3.1.2 Providers will have new altered services to reflect requirements of ACA
3.1.3 New job opportunities

3.2 THREATS

3.2.1 Change
3.2.2 Fear in community
3.2.3 Lack of understanding
3.2.4 Provider shortage

EDUCATION EQUITY

1. **Increase in the Number of Special Education Students**

1.1 OPPORTUNITIES

1.1.1. Increase in self-sufficiency through programs

1.2. THREATS

1.2.1. Lack of funding: Staff and facility space

1.2.2. Schools may not be ADA compliant

2. Increase in English Language Learners

2.1 OPPORTUNITIES

2.1.1 Increase language immersion in schools

2.1.2 Involve families to help learn English as a second language

2.2 THREATS

2.2.1 English Language Learners may be overlooked and fall behind in school

2.2.2 Lack of funding: programs (ESL) and bilingual staff

3. Increase in Students with Conduct Disorders

"Conduct disorder" refers to a group of behavioral and emotional problems in youngsters. Children and adolescents with this disorder have great difficulty following rules and behaving in a socially acceptable way. Other children, adults, and social agencies often view them as "bad" or delinquent, rather than mentally ill[24].

3.1 OPPORTUNITIES

3.1.1 Increase self-sufficiency through programs

3.1.2 Universal screening for mental health issues for all students

3.2 THREATS

3.2.1 Increase in class disruptions and possibly violence

3.2.2 Students may fall behind both socially and academically

4. Local Control Funding Formula (School Funding Reform 2013)

4.1 OPPORTUNITIES

4.1.1 Increase funding for k-12 schools

4.1.2 Identify priorities for high needs students

4.1.3 More local control to cater to the needs of the student population

4.1.4 Increase in parent involvement

4.2 THREATS

4.2.1 Time to fully implement is 2021

[24] American Academy of Child and Adolescent Psychiatry, Conduct Disorder, "Facts for Families". http://www.aacap.org/App_Themes/AACAP/docs/facts_for_families/33_conduct_disorder.pdf (2012)

CONCLUSION

HEALTH STATUS

The Community Health Assessment has helped illuminate the powerful influences that shape the health of individuals and our community. The health issues that arose from this assessment are many. They reveal an interwoven thread that runs throughout all of the health indicators and outcomes - that of socioeconomic status.

Socioeconomic status (SES) is often measured as a combination of education, income, and occupation. The SES of individuals and regions greatly influence many aspects of the physical, social, economic, and political environments of our community. The individuals and groups of low SES consist of lower educational attainment, poverty, under or unemployed, and therefore have fewer resources and social capital. When SES is categorized as high, medium, and low, health issues display as a gradient with varying effects on each level of SES.

This underscores the realization that individual behavior does not take place in a vacuum. Conversely, it takes place in the context of a historical, cultural, political, and physical environment and in communities with varying economic and social circumstances. Personal behavior is a byproduct of these dynamic interactive components.

Focusing solely on individual behavior and making the claim that people are making poor decisions is an oversimplification of the dynamic nature and complexity of the health of communities. Discussing lifestyle changes without discussing the socioeconomic conditions that give rise to them is misleading. As Wallack and Lawrence suggest, "when these contextual issues are not discussed…their importance is implicitly diminished and efforts to improve the health of populations are weakened."[25] A perspective and approach lacking consideration of socioeconomic conditions does a disservice to individuals, communities, and the local public health system. We must take a broader perspective when addressing the health of our community.

Protecting and promoting the health and well-being of our community requires changing the conditions in which we live, improving the quality of the environment, both natural and built, and reforming public policy. The physical, social, and political environments must be the primary level of intervention. The solutions require collective action and the acknowledgement that we are all interconnected as community. What affects people in one part of our county affects us all and that we will only succeed when all communities within Yolo County flourishing.

THEMES AND STRENGTHS

Surveying community members revealed that there are areas in which more can be done to improve health and well-being than has been done in the past, especially to address the needs of diverse groups.

The results of the CTSA survey revealed a great deal about the concerns and issues that stand out in each individual community. Perhaps more importantly, they are telling in terms of the diversity present within the county. This diversity spans several dimensions: racial and ethnic, economic, geographic, ideological, and many others.

As we learned in our solicitation of the community's voice, there is a vast array of strengths and sources of pride in each community that could serve as potential assets and allies in the pursuit of improving public health. While many of the

[25] Wallack, L. & Lawrence, R. Talking About Public Health: Developing America's "Second Language". American Journal of Public Health. April 2005, Vol. 95, No. 4. P.569

larger and well-known staples of Yolo County such as the County Fair and University of California, Davis, were frequently recognized, community members also recognized community organizations and libraries, as well as qualities of the community itself such as acceptance of diversity, safety, and friendliness.

Working with community members as equal partners, health professionals and government officials can proceed with a greater understanding of the public's needs and the circumstances that shape them. Rather than identifying health issues on the disease-by-disease categorical nature based on funding opportunities or immediate short-term issues, we must allow communities multiple opportunities to voice their concerns and recommendations. This will allow for an interchange between communities and the local public health system where each is changed through coming together. Doing so will help make connections, such as the link between poor health, strengths of the community, environmental factors, and institutional policies and politics.

In order to effect positive change, we cannot adopt blanket solutions for individual communities based solely on external perspectives and analyses. Effective public health practice requires a paradigm shift in our approach to creating change in our communities. It is a shift from an authoritarian, paternalistic approach to a collaborative approach. Valuable information is attainable not by stepping outside, but rather by stepping inside communities, particularly those which have generally been isolated from the public discourse.

This shift from authoritative to collaborative public health efforts creates the opportunity to educate and empower community members, approaching them as active partners who play a role in identifying health issues, advocating for their concerns, and creating community change from within.

The following trends and issues from the CTSA survey are worth reiteration:

- The young and the economically disadvantaged generally express poorer perceptions of their quality of life than their older and more affluent counterparts do.
- A growing proportion of individuals require resources and services for mental health issues such as substance abuse and depression.
- The aging population has distinct concerns, dealing with the physical and mental effects of aging, and the need to maintain autonomy and engagement in their later years.
- Many concerns across communities can be traced back to economic inequality: access to good schools, food, and needed services.

LOCAL PUBLIC HEALTH SYSTEM

A focus on increased effective and efficient communication efforts among the LPHS and community will lay the groundwork for effective partnerships and collaborative efforts. Two entities are affected by poor collaboration and communication: the LPHS and community. To reach its potential and to improve the quality of life and well-being of all Yolo County residents, a concerted, collaborative effort is needed among the LPHS.

The priority areas for the LPHS are those that deal directly with collaboration: academic linkages; community partnerships; and constituency development. The linchpin to these collaborative efforts is communication. Establishing means and methods of communication will open up the avenues of collaboration among the community and the LPHS.

The LPHS would benefit through improved collaboration and communication by sharing data and information. The information would guide interventions and policies, establish best practices, and reduce duplicative efforts among the LPHS. Community engagement and involvement with public health issues would benefit from improved collaboration and communication from the LPHS. The sharing of data and information will inform and foster collaboration among community

members. The guiding principles of community engagement must be fairness, justice, empowerment, participation, and self-determination. The LPHS must work towards involving community further; ultimately leading to a shared leadership via strong partnerships.

The Yolo County LPHS possesses many strengths; however, in most instances the LPHS must utilize these strengths more effectively and efficiently. The size and rural nature of much of the county pose a challenge to specific communication methods and technologies. Rural community gathering points may serve as a hub for coordinating public health efforts and the sharing of information. The Yolo County Health Department in partnership with the Yolo County Library System, Family Resource Centers, and other community-based organizations must collaborate to establish and sustain these hubs.

Community empowerment and ultimately community health requires the effective communication and collaboration of all people in the community and the LPHS. To seek and share the input, talents, and resources of our community and the LPHS will strategically align us all for the benefit of our community and our future.

FORCES OF CHANGE

Yolo County is a very diverse region and it is important to celebrate the diversity and heritage of our county. We must work to understand certain populations (e.g., migrant workers, aging population) to better protect and promote their health and well-being. Efforts of Healthy Yolo should take advantage of the strengths of the community such as parks, community events, UCD, and Farm to Fork efforts. It may be beneficial to use counter-marketing tactics when promoting Healthy Yolo efforts.

In this ever-increasing technological society, we must not fully abandon the value of face-to-face communication. In our rural community, it is important to travel to the various communities and conduct outreach efforts. We need to start thinking of new ways of doing things and take advantage of new technology. We can enhance our communications and collaborations by combining technology and personal communications. In this manner, we can build community cohesion and increase community involvement.

The School Funding Reform offers opportunities to address our student population who are English language learners, special needs, and students with conduct disorders. Other funding opportunities and possible job opportunities may rise from the Affordable Care Act; however, this may also lead to shortages of medical and mental health services and providers.

APPENDIX A: DATA SOURCES

Demographics		
Health Indicator	**Data Description**	**Data Source**
Net change in population	Changes in population size and make-up.	US Decennial Census, DP-1: Profile of General Demographic Characteristics: 2000 & 2010
Age	Age distribution of members of population	U.S. Census Bureau, 2007-2011 American Community Survey.
Sex	Sex distribution of members of population	
Race/Ethnicity	Racial/ethnic distribution of members of population	
Foreign Born	Place of birth/citizen status	
Primary Language Spoken at Home and Proficiency	Percentage of the population aged 5 and older who speak a language other than English at home and speak English less than "very well."	
English Language Learners	Percentage of public school students who are English Learners or not English Learners. English Learners are students with a primary language other than English and who lack the defined English skills of listening comprehension, speaking, reading, and writing necessary to succeed in regular school instructional programs.	California Dept. of Education, English Learners by Grade and Language Data Files. Accessed through kidsdata.org.
Household Composition	Households by type	U.S. Census Bureau, 2007-2011 American Community Survey.
Other Populations	Number of individuals defined as “migrant” AND Number and percentage of individuals defined as homeless by U.S. Department of Housing and Urban Development	U.S. Census, 2012, ACS AND U.S. Department of Housing & Urban Development, 2011
Social and Economic Circumstances		
Health Indicator	**Data Description**	**Data Source**
Income	Income & benefits	U.S. Census Bureau, 2007-2011 American Community Survey
Median Household Income	Estimated median household income	
Below Poverty Level (children, families, total)	Estimated number of persons living below the poverty line	
Household Costs	Selected monthly owner costs as a percentage of household income AND gross rent as a percentage of household income	
Unemployment	Civilian non-institutionalized population age 16+ reporting unemployment or looking for work	US Department of Labor, Bureau of Labor Statistics.
Educational Attainment	Level of educational attainment	U.S. Census Bureau, 2007-2011 American Community Survey

Graduation Rate	Number of persons 18 to 24 years old not currently enrolled in high school who reports that they have received a high school diploma or its equivalent	California Department of Education, DataQuest. Cohort Outcome Summary Report by Race/Ethnicity 2011-12
3rd Grade Proficiency	Percentage of all public school students tested in 3rd grade who scored proficient or advanced on the English Language Arts California Standards Test	California Dept. of Education, Standardized Testing and Reporting (STAR) Results. Accessed through kidsdata.org
Algebra I Proficiency	Percentage of all public school students tested in grades 7-11 who scored proficient or advanced on the Algebra I California Standards Test (CST)	California Dept. of Education, Standardized Testing and Reporting (STAR) Results. Accessed through kidsdata.org
Social and Mental Health		
Health Indicator	**Data Description**	**Data Source**
Place to Live	Respondents were asked to rate their local community and Yolo County as a place to live as either excellent, good, ok, poor, very poor, or not sure	Healthy Yolo Community Themes and Strengths Survey
Sense of Community Involvement	Respondents were asked to rate the sense of community involvement and responsibility in their local community and Yolo County as either excellent, good, ok, poor, very poor, or not sure	
Healthy Community	Respondents were asked to rate their local community and Yolo County as a “healthy community” as either excellent, good, ok, poor, very poor, or not sure	
Quality of Life	Respondents were asked to rate the quality of life in their local community and Yolo County as either excellent, good, ok, poor, very poor, or not sure	
Mentally Unhealthy Days	Average number of reported mentally unhealthy days during past 30 days among adults age 18 and over. "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"	Behavioral Risk Factor Surveillance System. Accessed through Health Indicators Warehouse
Depression Related Feelings - Youth	Incidence of youth reporting depression-related feelings in the past 12 months	California Department of Education, California Healthy Kids Survey. Accessed through kidsdata.org
Did Not Receive Adequate Social/Emotional Support	Percent of adults 18 years and older who report not receiving sufficient social-emotional support. Respondents were asked, "How often do you get the social and emotional support you need?” Persons were considered to be receiving sufficient emotional/social support if they reported getting social/emotional support all or most of the time.	Behavioral Risk Factor Surveillance System. Accessed through Health Indicators Warehouse.

Needed Help for Mental/Emotional Health or Use of Alcohol/ Drugs	Respondents were asked: "Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your mental health emotions or nerves or your use of alcohol or drugs?"	UCLA Center for Health Policy Research, California Health Interview Survey.
Needed & Sought Help for Mental/Emotional and/or Alcohol-Drug Issues	Respondents answered yes to "Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your mental health emotions or nerves or your use of alcohol or drugs?" and were asked the following, "In the past 12 months have you seen your primary care physician or any other professional, such as a counselor, psychiatrist, or social worker for problems with your mental health, emotions, nerves or your use of alcohol or drugs?"	
Reason for Seeking Treatment	Reason for seeking treatment from physician or mental health professional. Respondents were asked: "Did you seek help for your mental or emotional health or for an alcohol or drug problem?"	
Psychiatric Admissions	Psychiatric admissions were admits with a principal diagnosis of Major Diagnostic Category (MDC) 19 for mental diseases and disorders. Drug and alcohol were admits with a principal diagnosis of MDC 20 for alcohol, drug use and alcohol- or drug-induced organic mental diseases.	Office of Statewide Health Planning & Development (OSHPD), county-of-residence patient discharge data provided on CD, 2012 and statewide summary AND OSHPD, 2011 (Yolo County) and 2012 Annual Utilization Report of Hospitals Database (ALIRTS reporting system) for the statewide summary
Mental Health Issues - Youth	Number of hospitalizations for mental health issues among children and youth ages 5-19, by age group.	Special Tabulation by the State of California, Office of Statewide Health Planning and Development (Nov. 2013), California Department of Finance, 2000-2010 Estimates of Population by Race/Ethnicity with Age and Gender Detail and State and County Population Projections by Race/Ethnicity and 5-year Age Groups, 2010-2060(by year). Accessed through kidsdata.org
Self-Inflicted Hospitalizations	Number of hospitalizations due to non-fatal self-inflicted injuries among children/youth ages 5-20.	California Dept. of Public Health, Office of Statewide Health Planning and Development, Patient Discharge Data; California Dept. of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060; CDC, WISQARS (May 2013). Accessed through kidsdata.org

Seriously Considered Suicide	Percentage of students who responded "yes" to the question, "did you ever seriously consider attempting suicide?"	California Healthy Kids Survey - Yolo County Secondary 2009-2011 Main Report
Suicide Rate	The suicide rate is the number of intentionally self-inflicted injuries that resulted in death per 100,000 population.	The county Death Statistical Master File (DSMF) obtained from CDPH Health Information and Strategic Planning (HISP).
Community Connectedness	Percentage of public school students in grades 7, 9, and 11, and non-traditional students, by level of total community assets. This is a summary measure that includes student reports of caring adults, high expectations from adults, and meaningful participation in the community. The grade levels included in school district-level data depend on the grades offered in each district.	California Department of Education, California Healthy Kids Survey (WestEd). Accessed through kidsdata.org
School Connectedness	Percentage of public school students in grades 7, 9, and 11, and non-traditional students, by level of school connectedness. This is a summary measure based on student reports of being treated fairly, feeling close to people, feeling happy, feeling part of, and feeling safe at school. The grade levels included in school district-level data depend on the grades offered in each school district; for example, high school districts do not include7th grade data. "Non-traditional" students are those enrolled in Community Day Schools or Continuation Education.	California Department of Education, California Healthy Kids Survey (WestEd). Accessed through kidsdata.org
Felony Crimes and Arrests	Violent crime is composed of four offenses: murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. Violent crimes are defined in the UCR Program as those offenses that involve force or threat of force.	State of California Department of Justice, Office of the Attorney General. Criminal Justice Profiles: Crimes and Clearances.
	Property crime includes the offenses of burglary, larceny-theft, motor vehicle theft, and arson. The object of the theft-type offenses is the taking of money or property, but there is no force or threat of force against the victims.	
	An arrest occurs when a person is taken into custody because an officer has reason to believe the person violated the law. Not all arrests result in persons being jailed.	
Juvenile Felony Arrests	Percent of juvenile felony arrests among youth under age 18.	California Dept. of Justice, Criminal Justice Statistics Center, Monthly Arrest and Citation Register (MACR) Data Files; CJSC published tables. Accessed through kidsdata.org

Child Abuse and Neglect: Reports and Cases	Abuse and neglect reports for children under age 18. A child is counted only once (per year, per county). Reports include substantiated, inconclusive, unfounded, and assessment-only referrals, as well as those "not yet determined."	Child Welfare Services Reports for California, U.C. Berkeley Center for Social Services Research. Accessed through kidsdata.org
	Number of substantiated cases of child abuse and neglect.	
Domestic Violence Calls	Number of domestic violence calls for assistance per 1,000 adults ages 18-69.	California Dept. of Justice, Criminal Justice Statistics Center, Domestic Violence-Related Calls for Assistance Database (1998-2009) and California Criminal Justice Profiles, 2010, 2011, and 2012. Accessed through kidsdata.org
Physical Environment		
Health Indicator	**Data Description**	**Data Source**
Air Quality - Ozone	Number of days with ozone concentrations above the U.S. standard (0.075 parts per million). Ozone concentrations are measured and averaged over each 8-hour testing period; then, the number of days per year exceeding the standard is calculated. State-level data, which are averaged from county-level data, should be treated with caution.	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network (Jul. 2013). Accessed through kidsdata.org
Air Quality - Particulate Matter 2.5	Annual average concentration of fine particulate matter in the air. "Fine particulate matter" refers to particles with a diameter of less than 2.5 microns, or about 1/10,000 of an inch. The current annual fine particle standard is 15 micrograms per cubic meter, which refers to the density of particles in the air. Concentrations at or above 15.0 micrograms are considered potentially harmful. State-level data, which are averaged from county-level data, should be treated with caution.	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network (Jul. 2013); Environmental Protection Agency, National Trends in Particulate Matter Levels (Jul. 2013). Accessed through kidsdata.org
Amount of pesticides per area	Pounds of pesticides used. California has a broad legal definition of "agricultural use" so the reporting requirements include pesticide applications to parks, golf courses, cemeteries, rangeland, pastures, and along roadside and railroad rights-of-way. In addition, all postharvest pesticide treatments of agricultural commodities must be reported along with all pesticide treatments in poultry and fish production as well as some livestock applications.	California Department of Pesticide Regulation, Pounds of active ingredient by county.
Water Quality Violations	Number of water quality violations for California public water systems, by type of violation.	California Dept. of Public Health, Division of Drinking Water and Environmental Management. Accessed through kidsdata.org

Waterborne Disease	Reported occurrences of waterborne illness reported in CalREDIE	California Reportable Disease Information Exchange (CalREDIE)
Fast Food Access	Number of fast-food establishments	US Census Bureau, County Business Patterns: 2011. Additional data analysis by CARES. Accessed through Community Commons, Full Health Indicators Report.
Liquor Store Access	Number of liquor stores	
Low Food Access	A population is defined as having limited food access if they are living more than 1 mile from a supermarket or large grocery store if in an urban area, or more than 10 miles from a supermarket or large grocery store if in a rural area.	US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas: 2010. Accessed through Community Commons, Full Health Indicators Report.
Park Access	The percentage of population living within 1/2 mile of a park.	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network: 2010. Accessed through Community Commons, Full Health Indicators Report.
Walkability	Measured in terms of "Walk Score" Walk Score is a number between 0 and 100 that measures the walkability of any address or city. Walk Score analyzes hundreds of walking routes to nearby amenities. Points are awarded based on the distance to amenities in each category. Walk Score also measures pedestrian friendliness by analyzing population density and road metrics such as block length and intersection density.	Walk Score
Pedestrian and Bicycle Accidents	Motor vehicle accidents with pedestrians or bicycles. The primary collision factor is a general category based on the officer's opinion that best describes the primary or main cause of the collision.	Statewide Integrated Traffic Records Systems maintained by the California Highway Patrol. Accessed through the Transportation Injury Mapping System.
Health Care and Preventive Services		
Health Indicator	**Data Description**	**Data Source**
Licensed Primary Care Physicians	Number of physicians in primary care (general practice, internal medicine, obstetrics and gynecology, or pediatrics)	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2011. Accessed using Community Commons.
Licensed Dentists	Number of total professionally active dentists	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File: 2011. Accessed using Community Commons.
Licensed Hospital Beds	The number of beds (acute and specialty) and percentage of licensed beds occupied during a reporting period.	Office of Statewide Health Planning & Development (OSHPD) Hospital Utilization Data.

Long-term Care Facility Beds	The number of beds and percentage of licensed beds occupied during a reporting period.	Office of Statewide Health Planning & Development (OSHPD) Hospital Utilization Data.
Health Insurance	Percent of persons under 18 and 18 to 65 years of age without health insurance.	The U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE) program produces estimates of health insurance coverage for states and all counties. Accessed using the Health Indicators Warehouse.
Regular Source of Primary Care	Number of persons who report having a specific source of primary care	UCLA Center for Health Policy Research, California Health Interview Survey.
Primary care services by community and migrant health centers	Percentage of respondents reporting having receive primary care from community clinics and migrant health centers	OSHPD PCC Utilization data.
Inability or Delay in Obtaining Necessary Medical Care, or Prescription Medicines	Percent of population reporting delays or inability to reach necessary medical care	UCLA Center for Health Policy Research, California Health Interview Survey.
Age Appropriate Immunizations	Estimated percentage of children ages 4-6 in kindergarten with all required immunizations.	California Department of Public Health, Immunization Branch, Kindergarten Assessment Results. Accessed through kidsdata.org
Dental Care Utilization	Percentage of adults aged 18 and older who self-report that they have not visited a dentist, dental hygienist, or dental clinic within the past year.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-10. Accessed through Community Commons
Cervical Cancer Screening (Pap Test)	Percentage of women aged 18+ who self-report having a Pap test in the past three years.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed using the Health Indicators Warehouse.
Breast Cancer Screening (Mammogram)	Women respondents age 50+ who report having mammogram in past 2 years	
Colon Cancer Screening (Sigmoid/Colonoscopy)	Asked of adults 50 years and older if they ever had a sigmoidoscopy, colonoscopy or FOBT	UCLA Center for Health Policy Research, California Health Interview Survey.
Diabetes Management (Hemoglobin A1c Test)	Number of persons aged 18+ who report they have ever been diagnosed with diabetes and report that a doctor, nurse, or other health professional has checked the respondent's glycosylated hemoglobin (HbA1c) two or more times in the past year	
High Blood Pressure Management	Asked of respondents who have ever been told by a doctor that they have high blood pressure: "Are you currently taking any medications to control your high blood pressure?"	
Maternal and Child Health		
Health Indicator	**Data Description**	**Data Source**

Entrance into Prenatal care in 1st trimester	Number of births to females receiving prenatal care in the first trimester (three months) of pregnancy in states that use the 2003 standard certificate of birth	California Department of Public Health, Center for Health Statistics, Vital Statistics Section, Birth Statistical Master Files. Accessed through kidsdata.org
Breastfeeding Support Initiation (in-hospital)	Percentage of newborns fed breast milk during their hospitalization. "Any Breastfeeding" includes infants who breastfeed exclusively and those who breastfeed and receive formula. "Exclusive Breastfeeding" includes those who only breastfeed.	CDPH In-Hospital Breastfeeding Initiation Data
Live Birth Rate	Number of live births per 1,000 women.	California Department of Public Health, Vital Statistics Section Health Information, and Strategic Planning (HISP). Local birth data accessed through Automated Vital Statistics System (AVSS).
Births to Adolescents	Number of births per 1,000 young women under age 20, by age of mother.	California Dept. of Public Health, Office of Health Information and Research, Vital Statistics Query System.
Repeat Births to Teens	Number of births second or greater in sequence to teen mothers	Yolo County Health Department: Live Birth Profile Public, Yolo County 2012.
Very Low & Low Birth Weight	A baby is defined as having a low birth weight if its weight is less than 2,500 grams at delivery. A baby is defined as having very low birth weight if its weight is less than 1,500 grams (or about 3lbs, 5 0z) at delivery.	California Department of Public Health, 2010 Birth Statistical Master File (BSMF). Accessed through the Improved Perinatal Outcome Data Reports, County Profile Reports.
Infant Mortality	Number of deaths of infants aged 1 years and younger	California Department of Public Health, 2009 Birth Cohort File. Accessed through the Improved Perinatal Outcome Data Reports, County Profile Reports.
Neonatal Mortality	Number of deaths of infants aged 27 days and under	
Post Neonatal Mortality	Number of deaths of infants aged 28 days to less than 1 year	
Health Behaviors		
Health Indicator	**Data Description**	**Data Source**
Tobacco Use	Percentage of adults who are current smokers.	UCLA Center for Health Policy Research, California Health Interview Survey.
Adolescent Smoking	Percentage of public school students in grades 7, 9, and 11 reporting the number of days in which they smoked cigarettes in the past 30 days.	California Department of Education, California Healthy Kids Survey (WestEd). Accessed through kidsdata.org
Binge Drinking	Respondents aged >=18 years who report having 5 or more drinks (men) or 4 or more drinks (women) on one or more occasions during the previous 30 days	Behavioral Risk Factor Surveillance System. Accessed through Health Indicators Warehouse.
Adolescent Use of Alcohol	Percentage of public school students in grades 7, 9, and 11 reporting the number of days in which they drank alcohol in the past 30 days.	California Department of Education, California Healthy Kids Survey (WestEd). Accessed through

Marijuana Use	Percentage of public school students in grades 7, 9, and 11 reporting the number of days in which they used marijuana in the past 30 days.	kidsdata.org.
Fruit & Vegetable Consumption	Respondents who reported eating more than 5 servings of fruit/vegetables per day.	Behavioral Risk Factor Surveillance System. Accessed through Health Indicators Warehouse (adults). UCLA Center for Health Policy Research, California Health Interview Survey (children).
Fast Food Consumption	Respondents were asked, "In the past 7 days, how many times did you eat fast food.	UCLA Center for Health Policy Research, California Health Interview Survey.
Soda Consumption	Respondents were asked: "Yesterday, how many glasses or cans of soda or other sweetened drinks (such as fruit punch) did you drink? Do not count diet and sugar-free drinks."	
No Exercise	Respondents who reported no exercise in the past month. "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"	Behavioral Risk Factor Surveillance System. Accessed through Health Indicators Warehouse
Physical Activity at Least One Hour in Typical Week	Respondents were asked: "During a typical week, on how many days are you physically active for at least 60 minutes total per day? Do not include PE."	UCLA Center for Health Policy Research, California Health Interview Survey.
Youth Aerobic Capacity	Aerobic Capacity. This is perhaps the most important indicator of physical fitness and assesses the capacity of the cardiorespiratory system by measuring endurance. The formulas used to estimate VO2max can be found in the PFT Reference Guide on the PFT Web page at http://www.pftdata.org/resources.aspx	California Department of Education, DataQuest - Physical Fitness Test.
Communicable Disease		
Health Indicator	**Data Description**	**Data Source**
Syphilis (primary and secondary) Cases	Number of new reported cases of primary and secondary syphilis in the past 12 months	California Department of Public Health, STD Control Branch. Sexually Transmitted Diseases Data Tables.
Gonorrhea Cases	Number of gonorrhea cases	
Chlamydia Cases	Number of reported chlamydia cases	
Tuberculosis	Number of confirmed new cases of tuberculosis reported to CDC by local health departments	Yolo County Health Department, Communicable Disease Statistics.
Hepatitis A Cases	Number of Hepatitis A cases reported to public health departments	
Hepatitis B Cases	Number of symptomatic hepatitis B cases reported in the past 12 months	
Hepatitis C Cases	Number of new symptomatic hepatitis C cases reported in the past 12 months	

AIDS	Number of reported AIDS cases among persons aged 13 years and older	National HIV Surveillance System. Accessed through Health Indicators Warehouse.
Health Outcomes		
Health Indicator	**Data Description**	**Data Source**
Overall Health	Respondents were asked to rate their overall health as either excellent, good, ok, poor, or very poor	Healthy Yolo Community Themes and Strengths Survey
Dental Care Utilization	Percentage of adults aged 18 and older who self-report that they have not visited a dentist, dental hygienist, or dental clinic within the past year.	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-10. Accessed through Community Commons
Poor Dental Health	Percentage of adults age 18 and older who self-report that six or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection.	
Asthma Diagnoses and Emergency Room/Urgent Care Visits	Percentage of respondents 1 year of age and older who report that they have ever been diagnosed with asthma by a doctor. Asked of current asthmatics if they had visited emergency/urgent care for asthma within the last 12 months, all ages.	UCLA Center for Health Policy Research, California Health Interview Survey.
Asthma Hospitalizations	Number of asthma hospitalizations.	California Breathing, Environmental Health Investigations Branch, California Dept. of Public Health using data from the California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Database, the California Dept. of Finance, and the U.S. Census Bureau (March 2013).
Obesity	Respondents aged >=18 years who have a body mass index (BMI) >=30.0 kg/m² calculated from self-reported weight and height	UCLA Center for Health Policy Research, California Health Interview Survey; As cited on kidsdata.org, Babey, S. H., et al. (2011). A patchwork of progress: Changes in overweight and obesity among California 5th-, 7th-, and 9th-graders, 2005-2010. UCLA Center for Health Policy Research and California Center for Public Health Advocacy; California Department of Education, Physical Fitness Testing Research Files.
Overweight	Respondents aged >=18 years who have a body mass index (BMI) between 25 and 29.9	
Overweight and Obese Students	Percentage of public school students in grades 5, 7, and 9 with Body Mass Indices (BMIs) in the overweight or obese ranges of the 2000 Centers for Disease Control and Prevention sex-specific BMI-for-age growth charts.	Babey, S. H., et al. (2011). A patchwork of progress: Changes in overweight and obesity among California 5th-, 7th-, and 9th-graders, 2005-2010. Accessed through kidsdata.org

Youth Body Composition	Body composition results provide an estimate of the percent of a student's weight that is fat in contrast to the "fat-free" body mass made up of muscles, bones, and organs. The FITNESSGRAM uses age and sex specific growth charts. Skinfold Measurements. The thickness of the skinfold is measured using a device called a skinfold caliper. Bioelectric Impedance Analyzer. Is a handheld or scale-like device that estimates the student's percent body fat. Body Mass Index. This test provides an indication of the appropriateness of a student's weight relative to his or her height. Height and weight measurements are used to calculate a body mass index.	California Department of Education, DataQuest - Physical Fitness Test.
Diabetes	Sample respondents age 18+ who report being told they have diabetes	UCLA Center for Health Policy Research, California Health Interview Survey.
Heart Disease	Percentage of adults who report that they have ever been diagnosed with heart disease by a doctor.	UCLA Center for Health Policy Research, California Health Interview Survey.
High Blood Pressure	Percentage of adults who report that they have ever been diagnosed with high blood pressure by a doctor.	
Stroke	Percentage of adults who report that they have been told by a doctor that they had a stroke.	
Chronic Lung Disease	Measured in terms of hospitalization for Chronic Lung Disease, ICD-9 Codes 490-496	OSHPD ED exit data.
All Cancers	Number of cancer cases reported in California Cancer Registry	California Cancer Registry, 2006-2010
Breast		
Colon and Rectum		
Lung and Bronchus		
Prostate		
Urinary Bladder		
Uterus and Cervix		
All Other Cancers		
Hospital Discharges	Ten most common primary diagnoses for hospital stay for children ages 0-17, excluding childbirth.	Special Tabulation by the State of California, Office of Statewide Health Planning and Development (Nov. 2012). Accessed through kidsdata.org
Mortality		
Health Indicator	**Data Description**	**Data Source**
Life Expectancy	The average period that a person may expect to live.	Institute for Health Metrics and Evaluation, US Health Map, Life Expectancy.
Number of Deaths	Number of deaths	California Department of Public Health, Office of Health Information and Strategic Planning, Vital Statistics Query System.
Death Rates	Deaths from all causes. The age and race/ethnicity specific rates are per 100,000 in specified group.	

Leading Causes of Death	Leading causes of death are based on the ICD Sub-Chapter	CDPH, Death Statistical Data Tables, Ten Leading Causes of Death.
Leading Causes of Death by Age, Sex, Ethnicity	Leading causes of death are based on the ICD Sub-Chapter	Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2010 on CDC WONDER Online Database
All Cancers	Number of deaths due to cancer (ICD-10 codes C00-C97).	California Cancer Registry.
Breast	Number of female deaths due to breast cancer (ICD-10 code C50)	
Colon and Rectum	Number of deaths due to colorectal cancer (ICD-10 codes C18-C21)	
Lung and Bronchus	Number of deaths due to lung cancer (ICD-10 codes C33-C34)	
Prostate	Number or deaths due to prostate cancer	
Urinary Bladder	Number of deaths due to urinary bladder cancer	
Uterus and Cervix	Number of deaths due to uterine and cervical cancer	
All Other Cancers	Number of deaths due to other types of cancer	
Years of Potential Life Lost (YPLL)	Premature death is represented by the years of potential life lost before the age of 75.	Yolo County Health Department, Death Statistical Master File

APPENDIX B: DATA NOTES

Age-Adjusted Rates (AAR)	The age distribution of a population (the number of people in particular age categories) can change over time and can be different in different geographic areas. Age-adjusting the rates ensures that differences in incidence or deaths from one year to another, or between one geographic area and another, are not due to differences in the age distribution of the populations being compared.
California Cancer Registry	The California Cancer Registry (CCR) is a statewide population-based cancer surveillance system that collects information about almost all cancers diagnosed in California.
California Department of Education: Cohort Outcome Summary Report	Data regarding graduation, enrollment, and academic success
California Department of Public Health (CDPH)	The CDPH deals with aspects of public health such as healthcare quality, infectious disease, and health promotion in order to create healthy families and communities.
California Healthy Kids Survey (CHKS)	The California Healthy Kids Survey (CHKS) is a comprehensive, youth risk behavior and resilience data collection service available to all California local education agencies, and is funded by the California Department of Education.
CalREDIE	The California Reportable Disease Information Exchange (CalREDIE) is a computer application that the California Department of Public Health (CDPH) uses for web-based disease reporting and surveillance
CDC Behavioral Risk Factor Surveillance System	The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, on-going telephone health survey system.
CDC National Environment Public Health Tracking Network	The National Environmental Public Health Tracking Network (Tracking Network) is a system of integrated health, exposure, and hazard information and data from a variety of national, state, and city sources.
CDPH Birth Cohort File	The Birth Cohort Files contain data for all live births that occurred in a calendar year, death information for those infants who were born in that year but subsequently died within 12 months of birth, and all fetal deaths that also occurred during that calendar year.
CDPH Birth Statistical Master File	The Birth Statistical Master Files are the largest and most comprehensive of the birth data files. These files contain detailed demographic information related to the child, mother, and father, as well as medical data related to the birth.
Centers for Disease Control and Prevention (CDC)	The CDC deals with monitoring health and disease, especially in disseminating information, preventing transmission, and assuring safety.

Community Commons	Community Commons is an interactive information tool which presents GIS data and other community information
County Death Statistical Master File	Vital statistics for births and deaths are collected from each county and are compiled into the Statistical Master files on an annual basis.
Health Indicators Warehouse	The Health Indicators Warehouse (HIW) is an online repository of data that aims towards understanding of a community's health status and determinants, and facilitates the prioritization of interventions.
Healthy People 2020	*Healthy People* is a government program that sets science-based objectives every 10 years with the goal of improving the health of Americans.
Office of Statewide Health Planning and Development (OSHPD) Hospital Utilization Data	The OSHPD compiles an annual report of data related to hospital occupancy rates, discharges, lengths of stay, etc.
Poverty Guidelines	
Rates	Most measures are proportions (%) or rates per 1,000 or per 100,000 residents.
Suppression of Data	For some indicators, the number of events is too small to report at a locality level so data from either the combined City-County area are included.
U.S. Census Bureau: County Business Patterns	Community Business Patterns is a yearly report detailing the state of businesses in an area; include the numbers of establishments, employment, and other data points.
U.S. Census: American Community Survey	The American Community Survey (ACS) provides new data every year, but not with the same detail and depth as the U.S. Decennial Census
U.S. Decennial Census	The U.S. Decennial Census occurs every 10 years, in years ending with "0"
UCLA Center for Health Policy Research, California Health Interview Survey (CHIS)	The California Health Interview Survey (CHIS) is the largest state health survey in the nation. It is a random-dial telephone survey that asks questions on a wide range of health topics
Yolo County Health Department, Communicable Disease Statistics	State law requires providers to report certain communicable disease to their local county health departments for monitoring and management.
Yolo County Health Department, Death Statistical Master File	Contains comprehensive demographic data on deaths within the county

HEALTHY YOLO SURVEY

Please take a moment to complete the survey below. The purpose of this survey is to better understand your opinions about community health issues in Yolo County. The HEALTHY YOLO project will use this survey and other information to collaborate with the community to prioritize public health issues, and determine goals and strategies to achieve a healthier Yolo County. If you have any questions, please contact us.

1. What do you think are the three health issues that most affect our community? **Choose three (3):**

- ☐ Health problems associated with aging
- ☐ Cancer
- ☐ Dental problems
- ☐ Heart disease
- ☐ Infectious diseases (e.g., hepatitis, tuberculosis, etc.)
- ☐ Mental health issues
- ☐ Child abuse and neglect
- ☐ Motor vehicle/Bicycle accidents
- ☐ Poor birth outcomes
- ☐ Respiratory illnesses/lung disease/asthma
- ☐ Sexually transmitted diseases
- ☐ Homicide
- ☐ Stroke
- ☐ Teenage pregnancy
- ☐ Sexual abuse
- ☐ Alcoholism
- ☐ Diabetes
- ☐ Obesity
- ☐ Other_____
- ☐ Other_____

2. What do you think are the three individual **behaviors** that are most responsible for health issues in our community? **Choose three (3):**

- ☐ Alcohol abuse
- ☐ Driving while drunk/on drugs
- ☐ Drug abuse
- ☐ Lack of exercise
- ☐ Poor nutrition/eating habits
- ☐ Not getting "shots" (vaccines) to prevent disease
- ☐ Smoking/tobacco use
- ☐ Unsafe sex
- ☐ Using weapons/guns
- ☐ Not getting regular check-ups by a healthcare provider
- ☐ Distracted driving
- ☐ Crime/violence
- ☐ Suicide
- ☐ Life stress/lack of coping skills
- ☐ Teenage sex
- ☐ Domestic or intimate partner violence
- ☐ Other_____
- ☐ Other_____

3. What do you think are the three **social and economic** circumstances that are most responsible for health issues in our community? **Choose three (3):**

- ☐ Unemployment
- ☐ Poverty
- ☐ Homelessness
- ☐ Lack of education/no high school education
- ☐ Cultural barriers
- ☐ Racism and discrimination
- ☐ No health insurance
- ☐ Language barriers
- ☐ Not enough food (food insecurity)
- ☐ Single parenting
- ☐ Other_____
- ☐ Other_____

4. What do you think are the three **environmental** issues that are most responsible for health issues in our community? **Choose three (3):**

- ☐ Air pollution
- ☐ Pesticide use
- ☐ Poor housing conditions
- ☐ Poor neighborhood design
- ☐ Heat/hot days
- ☐ Lack of safe walkways and bikeways
- ☐ Cigarette smoke
- ☐ Trash on streets & sidewalks
- ☐ Flooding/drainage problems
- ☐ Contaminated drinking water
- ☐ Lack of access to healthy foods
- ☐ Lack of access to places for physical activity
- ☐ Lack of public transportation
- ☐ Traffic
- ☐ Other_____
- ☐ Other_____

5. What do you think are the three most important factors of a "healthy community"? **Choose three (3):**

- ☐ Safe place to raise kids
- ☐ Green/open spaces
- ☐ Job opportunities
- ☐ Good schools
- ☐ Access to healthcare
- ☐ Access to healthy food
- ☐ Low crime/safe neighborhoods
- ☐ Parks and recreation facilities
- ☐ Affordable housing
- ☐ Support agencies (faith-based organizations, support groups, social worker outreach)
- ☐ Tolerance for diversity
- ☐ Air quality
- ☐ Elderly care
- ☐ Well-informed community about health issues
- ☐ Community involvement
- ☐ Time for family
- ☐ Access to childcare
- ☐ Other _____
- ☐ Other _____

6. How would you rate your local community and Yolo County as a place to live?

	Excellent	Good	OK	Poor	Very Poor	Not Sure
Local Community	○	○	○	○	○	○
Yolo County:	○	○	○	○	○	○

7. How would you rate the sense of community involvement and responsibility in our local community and in all of Yolo County?

	Excellent	Good	OK	Poor	Very Poor	Not Sure
Local Community	○	○	○	○	○	○
Yolo County:	○	○	○	○	○	○

8. How would you rate the quality of life in our community and in all of Yolo County?

	Excellent	Good	OK	Poor	Very Poor	Not Sure
Local Community	○	○	○	○	○	○
Yolo County:	○	○	○	○	○	○

9. How would you rate our community and all of Yolo County as a "healthy community"?

	Excellent	Good	OK	Poor	Very Poor	Not Sure
Local Community	○	○	○	○	○	○
Yolo County:	○	○	○	○	○	○

10. How would you rate your overall health?

Excellent	Good	Fair	Poor	Very Poor
○	○	○	○	○

11. What are the strengths in our community (community groups, organizations, places) that you think most improve quality of life for our entire community?

_____

_____

12. What makes you most proud of our community?

_____

_____

13. What actions, policies, or funding priorities would excite you enough to become involved (or more involved) in building a healthier community?

_____

_____

14. What is your age?

□ Under 18	□ 35-44	□ 65- 74
□ 19-24	□ 45-54	□ 75-84
□ 25-34	□ 55-64	□ 85 or older

15. What language(s) do you speak at home?

□ English □ Spanish Other: _____

16. How long have you lived in Yolo County?

□ Less than 1 year	□ 10 – 20 years
□ 1 - 5 years	□ Over 20 years
□ 5 – 10 years	□ I have lived here all my life

17. Please indicate your gender:

□ Female □ Male □ Transgender

18. What city do you live in?

- ☐ Clarksburg
- ☐ Davis
- ☐ Dunnigan
- ☐ Esparto
- ☐ Guinda
- ☐ Knights Landing
- ☐ West Sacramento
- ☐ Winters
- ☐ Woodland
- ☐ Other (please specify) _____

19. What race do you most identify with?

- ☐ Asian
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Native American/Indigenous Persons
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other _____

20. Are you Hispanic or Latino?

☐ Yes ☐ No

21. What is your annual household income?

- ☐ Less than $10,000
- ☐ $10,000 to $14,999
- ☐ $15,000 to $24,999
- ☐ $25,000 to $34, 999
- ☐ $35,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $149,000
- ☐ $150,000 to $199,999
- ☐ $200,000 or more

If you would like to be entered to win a gift card, please enter your name and e-mail address below.

Name: _____

E-Mail: _____

THANK YOU!

Please hand this survey in before you leave or you may take it with you to complete later and mail or fax the survey to the Yolo County Health Department.

137 N. Cottonwood Street, Suite 2100
Woodland, CA 95695

Fax: (530) 666-7337

Our Community Our Future

APPENDIX D: LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT PARTICIPANTS

Name	Organization
Amina Richards	Partnership HealthPlan
Anna Sutton	Yolo County Health Department
Blanca Barba	California Human Development
Constance Caldwell	Yolo County Health Department
Diane Parro	Yolo County Board of Supervisors
Diane Sommers	Suicide Prevention and Crisis Services Yolo
Haydee Dabritz	Yolo County Health Department
Heidi Mazeres	Woodland Healthcare
Jan Babb	Yolo County Health Department
Joan Beesley	Yolo County Alcohol, Drug, and Mental Health
Joan Plannell	Yolo County Department of Employment and Social Services
Lisa Musser	Davis Joint Unified School District
Marbella Colimote	Yolo County Health Department
Michelle Rivera	Fourth and Hope
Michelle Washington	Fourth and Hope
Nolan Sullivan	Yolo County Department of Employment and Social Services
Patty Wong	Yolo County Library
Raquel Simental	Planned Parenthood Mar Monte
Vicky Fletcher	Yolo County Sheriff Animal Services
Viola DeVita	Yolo County Office of Education
Yaminah Bailey	CommuniCare Health Centers

APPENDIX E: FORCES OF CHANGE ASSESSMENT PARTICIPANTS

Name	Organization
Alicia Ruiz	Yolo County Housing
Beth Gabor	Yolo County
Cecilia Aguiar-Curry	City of Winters
Constance Caldwell	Yolo County Health Department
George Pennebaker	Capay Valley Vision
Hermenegildo Varela	Woodland Healthcare
Jan Babb	Yolo County Health Department
Jill Cook	Yolo County Health Department
Louise Joyce	Yolo Hospice
Lynn Zender	
Maria Contreras	Woodland Bike Campaign
Nilofer Chollampat	Yolo County Health Department
Patricia Valenzuela	Yolo County
Ronda Adams	Yolo County Office of Education
Tiffany Neal	Kaiser Permanente
Tracy Fauver	Yolo County CASA
Trisha Stanionis	Yolo Family Service Agency
Yaminah Bailey	CommuniCare Health Centers
Cynthia Wolff	Yolo Hospice
Susan Wang	Yolo County Health Department
Victoria Conlu	Yolo County Health Department

APPENDIX F: COMMUNITY THEMES AND STRENGTHS ASSESSMENT SURVEY - QUALITATIVE CATEGORIZATION

Responses were sorted into three major categories per discussion with the Healthy Yolo Core Team: Infrastructure, Community Perception, and Community Environment. Responses were further sorted and organized into sections under these three categories as needed, for which the definitions and explanations are listed below.

Strengths and Proud Responses

1) **Infrastructure**
   a) Food System such as gardens, farmers' markets, local food, etc.
   b) Education such as public schools and higher education
   c) Healthcare Services
   d) Public Transportation
   e) Housing
   f) Government Offices and Services
   g) Physical Environment such as bike paths, parks, etc.
   h) Public Safety
2) **Characteristics & Perceptions of the Community**
   a) Community Characteristics such as friendly, united, etc.
   b) Community Activism and Involvement
   c) Community Friendliness, Unity, and Support
   d) Environmentally Friendly/Cleanliness
   e) Safe Community
   f) Quality of Life Components
   g) Cultural Diversity
3) **Community Environment**
   a) Community Facilities such as pools, gyms, and recreation centers and other community centers
   b) Community Events
   c) Community-Based Organizations (CBOs)
   d) Volunteer Service Groups (VSG's) such as bike clubs, senior groups, Lions Club, Kiwanis, etc.
   e) Faith Based Organizations
   f) Recreational Activities such as youth sports

Policy Responses

1) **City Planning and Infrastructure**: regarding infrastructure, improving and/or informing the public about specific components of a community's infrastructure.
2) **General Community Improvement**: responses cover a wide range of policy topics and issues.
3) **Elderly**: includes all responses pertaining to the Elderly/Senior Community.
4) **Education**: includes responses involving schools, education, educational funding, and other education related responses.
5) **Healthcare Services**: includes responses related to healthcare, healthcare services, and healthcare access.
6) **Health Education & Lifestyle**: includes responses that pertain to health education and promoting a healthy lifestyle.
7) **Food System**: includes all responses that pertain to aspects of the Food System, from healthier food options to distribution of food.
8) **Support Groups/Community Involvement/Community Groups**: pertains to responses involving community life and involvement.
9) **Activities/Events/Programs**: pertains to all responses regarding activities, events, and programs.