

HEALTHY YOLO



Our Community  Our Future

DECEMBER 18TH, 2015

2015- 2020 YOLO COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN

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INTRODUCTION

In 2013, Yolo County initiated a community planning process to help with the creation and implementation of a Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). The CHA was completed in August 2014 and integrated a year’s worth of data collection and assessment conducted by the Yolo County Health and Human Services Agency, specifically the Community Health Branch. This effort included collaboration with many community leaders, residents and agency partners.

The CHA was then presented to the Yolo County Board of Supervisors, community health fairs and events, CHIP work groups and shared widely on our website. Electronic copies of the CHA are accessible on the Yolo County Health and Human Services [website](#).

The purpose of the CHA was to identify priority health issues in Yolo County. After the CHA was completed, community partners as well as internal and external stakeholders reconvened to select the priority health issues.

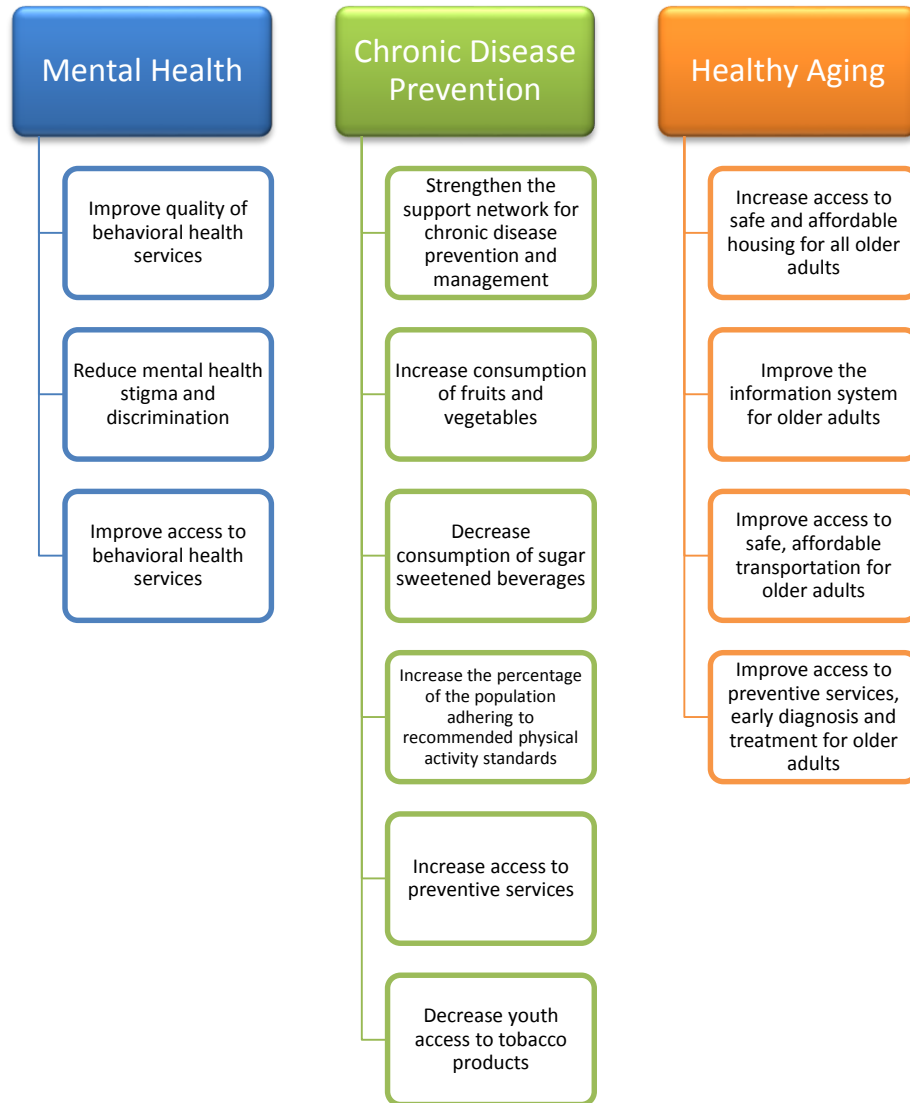
Through a community meeting, brainstorming internally and reviewing the data gathered as a part of the CHA, the priority issues of mental health, chronic disease prevention and healthy aging were selected. Below, you can see a table displaying the top 5 health issues identified by Yolo County residents as a part of the Community Health Assessment.



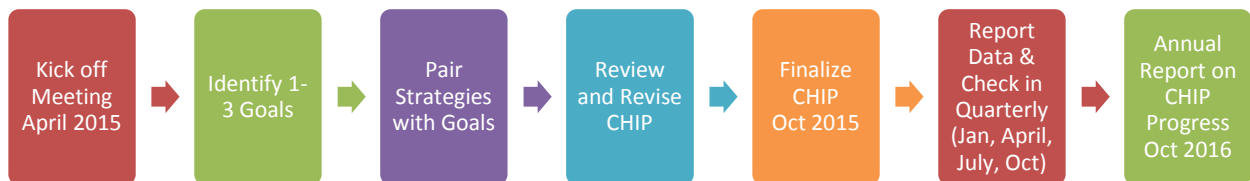
Top 5 Health Issues of Concern, by Age Group

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)

Work groups then convened around each of those issues, for approximately 6 months. We began by reviewing the data collected as a part of the CHA, we collaborated with Sacramento State University nursing students working on their public health rotation, to provide an overview of the data at our kick off meeting. We then discussed the current assets, resources and gaps which lead to the identification of goals, strategies, and discussion of available data.



A visual display of the approximate timeline and process can be seen below.



ABOUT THE COMMUNITY HEALTH IMPROVEMENT PLAN

The Yolo County 2015-2020 Community Health Improvement Plan is a collaborative effort of many providers and organizations in the community with a commitment to the health of everyone who lives in Yolo County. Listed below are the organizations represented by individuals who have been a part of the Community Health Assessment and/or Community Health Improvement Planning process.

- 2-1-1 Yolo
- American Medical Response (AMR)
- Area 4 Agency on Aging
- Bryte and Broderick Community Action Network (BBCAN)
- Cal Senior Legislature
- Capay Valley Vision
- City of Winters
- City of Woodland
- Comfort Keepers
- CommuniCare Health Centers
- Community Members
- Dairy Council of California
- Dignity Health Care
- Elderly Nutrition Program
- Health Council
- Yolo Healthy Aging Alliance
- In Home Support Services Advisory Committee
- Latino Information Network
- Local Mental Health Board
- Multipurpose Senior Services
- National Alliance on Mental Illness
- Partnership HealthPlan of California
- Phoenix House
- St. John’s Retirement Village
- Sutter Health
- Turning Point
- UC Cooperative Extension
- Woodland Health Care
- Yolo Court Appointed Special Advocates
- Yolo Commission on Aging
- Yolo County Administrator Office
- Yolo Family Service Agency
- Yolo Hospice



The process of moving toward collective impact, in which all community members see their role in the improvement of health in their community, is never finished. We will continue to engage partners to enhance the effectiveness of the 2015-2020 Community Health Improvement Plan.

GUIDING PRINCIPLES

While working with the Community Health Assessment findings in trying to identify Strategic Priorities, we wanted to be intentional in the construction and framework for our work in the Community Health Improvement Plan in order to insure we were aware of and attempting to address more distal influences of health. Below are those guiding principles.

UPSTREAM INVESTMENTS

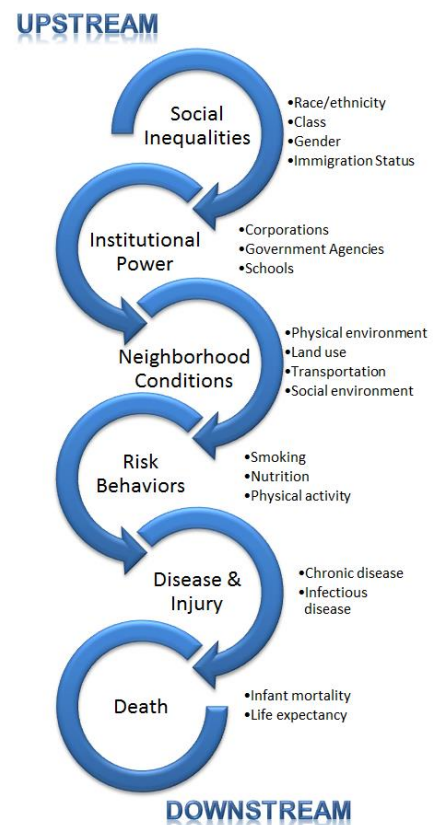
Public health uses a proactive, preventive approach that focuses on the entire community. Overall, public health is concerned with protecting and promoting the health of entire populations through population-based strategies. The goals of population-based strategies are to address the community as a 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 injured¹. 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.¹

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.



¹ Center for Disease Control and Prevention (CDC), *What Is Public Health?* www.cdcfoundation.org/content/what-public-health

SOCIAL DETERMINANTS OF HEALTH

The Social Determinants of Health (SDOH) is a place-based framework created by Healthy People 2020 to capture key areas that influence health. In order to support change in individual behavior, it is critical to establish policies that enhance social and economic conditions. This can lead to improved health for large numbers of people that is sustainable.²



HEALTH EQUITY

Healthy People 2020 defines health equity as the “attainment of the highest level of health for all people.” In order to achieve health equity, health inequities and disparities must be eliminated with a focus on the Social Determinants of Health and Upstream Investments.³

LIFECOURSE PERSPECTIVE

“Life Course looks at health as an integrated continuum and suggests that a complex interplay of biological, behavioral, psychological, social, and environmental factors contribute to health outcomes across the course of a person's life. It builds on recent social science and public health literature that posits that each life stage influences the next and that social, economic, and physical environments interacting across the life course have a profound impact on individual and community health.”⁴

² Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020. Healthy People 2020: An Opportunity to Address the Societal Determinants of Health in the United States. July 26, 2010. Available from: <http://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm>

³ Healthy People 2020, Disparities <http://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>

⁴ Health Resources and Services Administration, MCH Life Course Resource Guide <http://mchb.hrsa.gov/lifecourse/>

COMMUNITY ENGAGEMENT AND EMPOWERMENT

“Community empowerment is about having the conditions in place that allow local people to make a difference to improve their localities, and that encourage them to believe that it is both possible and worth it. There are strong democratic reasons for involving local people as much as possible in the decisions that shape their communities. Their input ensures services are better suited to local needs. For councils, community empowerment is important as it demonstrates the result of effective community engagement between service providers and the public. “

As health is greatly driven by lifestyle choices, it is crucial to engage the community in the assessment of and planning for improved health in their community.⁵

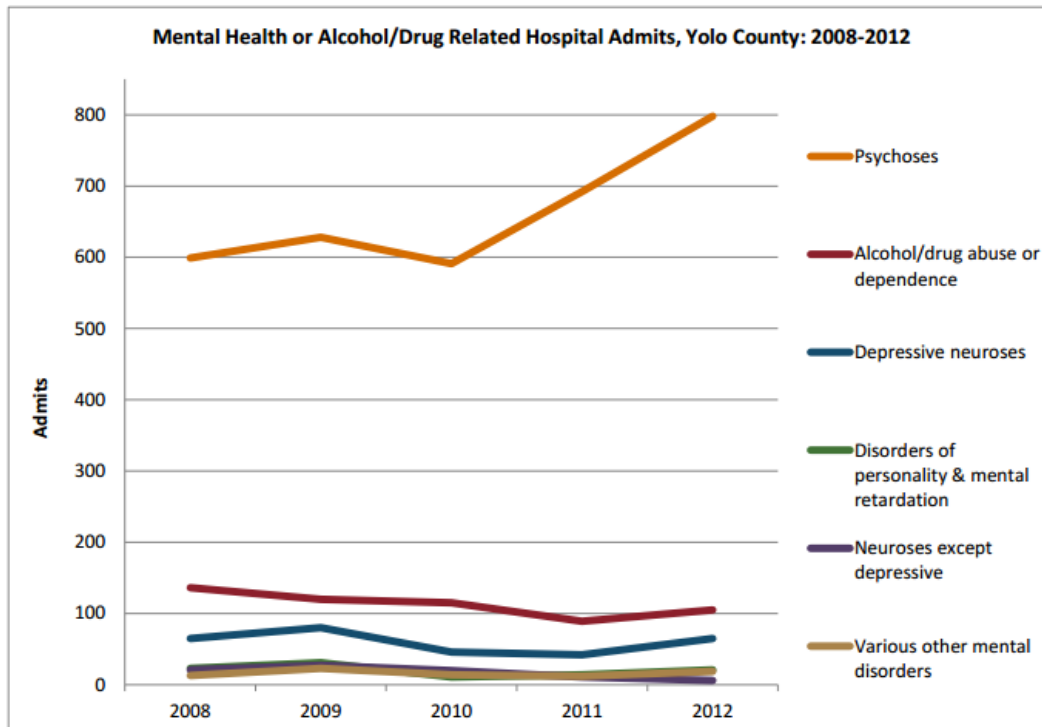
⁵ Community Development Foundation (CDF), Community Engagement and Empowerment: A Guide for Councilors
<http://www.cdf.org.uk/nep-microsite/files/resources/Guidance/engagement%20and%20empowerment%20for%20councillors.pdf>

PRIORITY HEALTH ISSUE: MENTAL HEALTH

SITUATIONAL ANALYSIS: WHY IS THIS A CONCERN?

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. Through the process of conducting the Community Health Assessment (CHA), several key concerns were brought to light.

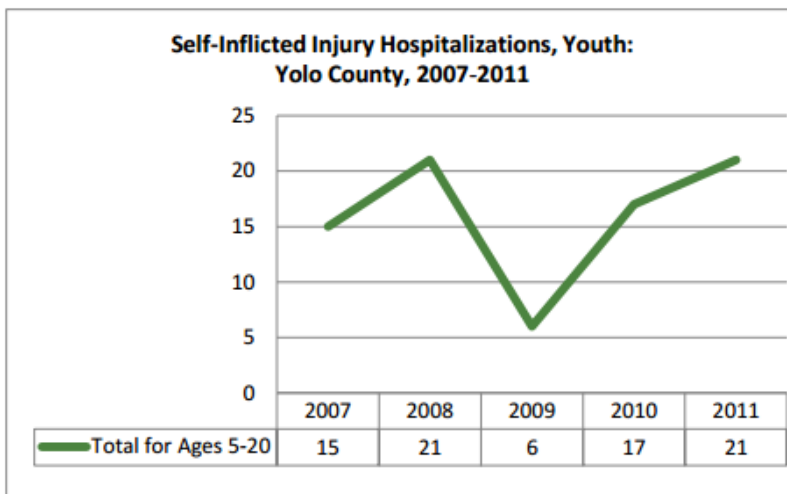
Overall, the rate of hospitalizations for mental health diagnoses has been trending upward since 2008. Most significantly, among the diagnostic groups for mental health or substance abuse-related hospital admissions, hospitalizations related to alcohol abuse or dependence have decreased, while hospitalization 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 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.

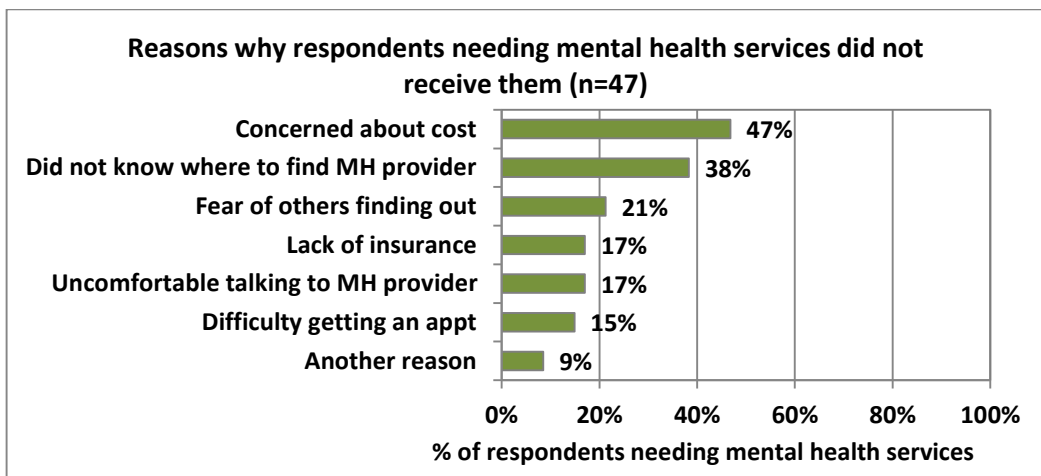
In Yolo County, there has been a net increase in hospitalizations of youth aged 5 to 20 for self-inflicted injuries. Compared to adults, adolescents are at heightened risk for self-injurious behavior (e.g., cutting, scratching, etc.), but these behaviors typically are not suicide attempts. The reasons for adolescent self-injurious behavior are not

fully understood, though it may occur for a variety of reasons, such as coping with intense psychological distress⁶. 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 attempt.



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Additionally, there are many issues regarding access to services that were identified as part of the Healthy Yolo Health Care Access Survey completed in 2014.



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By working to improve access to quality services and reducing stigma, the mental health of residents in Yolo County should be greatly improved.

⁶ 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

⁷ 1. Yolo County Health Department (2014) *Healthy Yolo: Community Health Assessment*. Retrieved from <http://www.yolocounty.org/home/showdocument?id=27029>

⁸ Yolo County Health Department (2014) *Healthy Yolo: Health Care Access Survey*. Retrieved from <http://www.yolocounty.org/home/showdocument?id=30638>

GOAL 1: IMPROVE QUALITY OF BEHAVIORAL HEALTH SERVICES

HEALTH INDICATORS

Annual Office of Statewide Health Planning and Development (OSHPD)

- Suicide rate
- Mental health or alcohol/drug related hospital admissions

STRATEGY A: INCREASE CLIENT SATISFACTION

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE CLIENT SATISFACTION AMONG CHILDREN AND TRANSITIONAL AGE YOUTH (AGES 16-25)	% of clients reporting satisfaction with services	2015: 40%	2016 48% 2017 56% 2018 64% 2019 72% 2020 80%	Consumer Perception Survey	HHSA - Samantha Fusselman	Semiannually
INCREASE CLIENT SATISFACTION AMONG ADULTS	% of clients reporting satisfaction with services	2015: 38%	2016 48% 2017 59% 2018 69% 2019 80% 2020 90%	Consumer Perception Survey	HHSA - Samantha Fusselman	Semiannually

STRATEGY B: REDUCE RE-HOSPITALIZATIONS

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
REDUCE RATE OF RE-HOSPITALIZATIONS WITHIN 30 DAYS OF DISCHARGE	% of hospital discharges that result in readmission within 30 days	TBD	2016 2017 2018 2019 2020 10%	External Quality Review Organization (EQRO) - Annual breakdown of medical beneficiary claims	HHSA - Samantha Fusselman	Annually

GOAL 2: REDUCE MENTAL HEALTH STIGMA AND DISCRIMINATION

HEALTH INDICATORS

Semiannual California Health Interview Survey (CHIS)

- Reason for seeking treatment
- Did not receive adequate social/emotional support

Every 2 years Health Care Access Survey

- Adults who received mental health treatment
- Reasons for not getting mental health treatment

STRATEGY: INCREASE AWARENESS OF MENTAL HEALTH DISORDERS AND TREATMENT

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE AWARENESS OF PERINATAL MOOD DISORDERS	# of Facebook likes for Blue Dot Campaign	2015: 313 Likes on 14 posts with a reach of 5020	2016.... 329 likes, 5271 reach 2017.... 345 likes, 5522 reach 2018.... 361 likes, 5773 reach 2019.... 377 likes, 6024 reach 2020.... 393 likes, 6275 reach	Maternal, Child and Adolescent Health (MCAH) Program	HHS – Anna Sutton	Annually
	# of Facebook shares for Blue Dot Campaign	2015: 40 shares on 14 posts	2016.....42 shares 2017.....44 shares 2018.....46 shares 2019.....48 shares 2020.....50 shares	Maternal, Child and Adolescent Health (MCAH) Program	HHS – Anna Sutton	Annually
	# of partners who took Blue Dot photo	2015: 14 Blue Dot photos taken	2016..... 15 photos/posts 2017..... 16 photos/posts 2018..... 17 photos/posts 2019..... 18 photos/posts 2020..... 19 photos/posts	Maternal, Child and Adolescent Health (MCAH) Program	HHS – Anna Sutton	Annually

GOAL ACTIVITIES

- Complete perinatal mental health mapping survey

Note: In the analysis of the Yolo County Health Care Access Survey, we found that one of the top reasons for people not seeking mental health treatment, even when they needed, was stigma. By trying to raise awareness of the prevalence of perinatal mood disorders, our hope is that stigma will be reduced, and individuals will be more likely to seek treatment when needed.

GOAL 3: IMPROVE ACCESS TO BEHAVIORAL HEALTH SERVICES

HEALTH INDICATORS

Annual Office of Statewide Health Planning and Development (OSHPD)

- Self-inflicted injury related hospitalizations in youth
- Suicide rate
- Mental health or alcohol/drug related hospital admissions
- Hospitalizations for mental health issues in youth

STRATEGY A: INCREASE AVAILABILITY OF MENTAL HEALTH SERVICE SLOTS

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE FULL SERVICE PARTNERSHIP* (FSP) SLOTS FOR CHILDREN (AGED 0-15)	# of FSP slots for children	2015: 4	2016..... 2017..... 2018..... 2019..... 2020..... 25	Mental Health Services Act (MHSA) Program	HHSA – Samantha Fusselman	Annually
SUSTAIN FSP SLOTS FOR TRANSITIONAL AGE YOUTH (16-25)	# of FSP slots for TAY	2014: 20	2016..... 20 2017..... 2018..... 2019..... 2020..... 20	Mental Health Services Act (MHSA) Program	HHSA - Samantha Fusselman	Annually
INCREASE FSP SLOTS FOR ADULTS	# of FSP slots for adults	2015: 45	2016..... 50 2017..... 55 2018..... 60 2019..... 65 2020..... 70	Mental Health Services Act (MHSA) Program	HHSA - Samantha Fusselman	Annually
SUSTAIN FSP SLOTS FOR OLDER ADULTS	# of FSP slots for older adults	2015: 20	2016..... 20 2017..... 20 2018..... 20 2019..... 20 2020..... 20	Mental Health Services Act (MHSA) Program	HHSA - Samantha Fusselman	Annually
INCREASE LATINO/HISPANIC PENETRATION RATE	# and % of Hispanic Medi-Cal beneficiaries served	2014: Number Served = 460 Hispanic Penetration Rate Yolo MHP– 2.41%	2016..... 2.5% 2017..... 2.6% 2018..... 2.7% 2019..... 2.8% 2020..... 2.9%	External Quality Review Organization (EQRO) - Annual breakdown of medical beneficiary claims	HHSA – Samantha Fusselman	Annually

*Full Service Partnership (FSP) is an intensive and comprehensive clinic or field-based mental health service for individuals experiencing significant serious mental illness (SMI). Individuals referred for FSP services are those individuals with severe and persistent mental health conditions, substance use disorders, chronic homelessness and/or forensic/behavioral health involvement. In addition, the individuals require wrap-around supportive engagement in services, which may include practical supports of food and shelter, in order to decrease utilization of high-end services and programs such as hospitals. <http://www.yolocounty.org/health-human-services/adult-aging/full-service-partnership-fsp-services>

STRATEGY B: DECREASE WAIT TIME FOR MENTAL HEALTH SERVICES

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE TIMELINESS OF FOLLOW UP APPOINTMENTS POST HOSPITAL DISCHARGE	# and % of follow up appointments within 7 days	TBD	2016.....(Establish baseline) 2017..... 2018..... 2019..... 2020.....(20% increase)	Avatar (EHR) data EQRO- Annual Approved Medi- Cal Claims data	HHSA – Samantha Fusselman	Quarterly
	# and % of follow up appointments within 30 days	TBD	2016.....(Establish baseline) 2017..... 2018..... 2019..... 2020.....(20% increase)	Avatar (EHR) data EQRO- Annual Approved Medi- Cal Claims data	HHSA – Samantha Fusselman	Quarterly
	ACTIVITIES: • Establish baseline					
REDUCE TIME FOR FIRST CLINICAL ASSESSMENT	# of days for first clinical assessment	2015: 18 days	2016..... 17 days 2017..... 2018..... 16 days 2019..... 2020..... 14 days	Avatar (EHR) data	HHSA – Samantha Fusselman	Quarterly

STRATEGY C: INCREASE INFORMATIONAL ACCESS

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE NUMBER OF HITS ON 2-1-1 SITE/DATABASE FOR MENTAL HEALTH SERVICES	# of hits on 2-1-1 site/database for mental health services	To be shared at January meeting	2016.....(Establish baseline) 2017..... 2018..... 2019..... 2020.....(10% increase)	2-1-1 Yolo program data	2-1-1 Yolo – Victoria Lewis	Quarterly

PRIORITY HEALTH ISSUE: CHRONIC DISEASE MANAGEMENT

SITUATIONAL ANALYSIS: WHY IS THIS A CONCERN?

Chronic diseases are responsible nationwide for 7 of every 10 deaths each year. The cost of treating people with chronic diseases accounts for 86% of all health care costs nationwide.⁹

Chronic disease was not only identified as a top issue by Yolo County residents in every age group, but it also contributes to and impacts the leading causes of death as noted by the following table. With 45% of Yolo County residents reporting at least one chronic disease, and the increased medical costs for those managing chronic disease, it is imperative to work to make the healthy choice the easy choice.

Chronic disease is also a major cause of disability which can lead to economic insecurity and additional emotional and economic stress for not only the one with the chronic disease, but the entire family. With people living longer than ever, management of chronic disease is crucial to help individuals age in a healthy way.

The drivers of chronic disease are largely lifestyle-based so by working to increase fruit and vegetable consumption, physical activity, utilization of preventive services and decreasing tobacco use and sugar-sweetened beverage consumption, the burden of chronic diseases can be lessened.

Leading Causes of Death by Age Group, Yolo County: 2000 - 2010								
Rank	Ages 1 - 14	Ages 15 - 24	Ages 25 - 34	Ages 35 - 44	Ages 45 - 54	Ages 55 - 64	Ages 65 - 74	Ages 75 and over
1	Accidents other than Motor Vehicle	Motor Vehicle Accident	Motor Vehicle Accident	Cancer	Cancer	Cancer	Cancer	Ischaemic Heart Diseases
2	Motor Vehicle Accident	Suicide	Suicide	Accidents other than Motor Vehicle	Ischaemic Heart Diseases	Ischaemic Heart Diseases	Ischaemic Heart Diseases	Cancer
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	Ischaemic Heart Diseases	Motor Vehicle Accident	Cerebro-vascular Diseases	Other forms of heart disease	Influenza and Pneumonia

⁹ Centers for Disease Control and Prevention. *Chronic Disease Prevention and Health Promotion*. Retrieved from <http://www.cdc.gov/chronicdisease/>

GOAL 1: STRENGTHEN THE SUPPORT NETWORK FOR CHRONIC DISEASE PREVENTION AND MANAGEMENT

HEALTH INDICATORS

Semiannual California Health Interview Survey (CHIS)

- Obesity rate
- Blood pressure management

Annual Office of Statewide Health Planning and Development (OSHPD)

- Preventable hospitalizations for diabetes

Annual County Health Rankings, Centers for Medicare and Medicaid Services

- Diabetes management a1c test in past year (% of Medicare enrollees)

STRATEGY A: INCREASE COLLABORATION AND COLLECTIVE IMPACT

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE CHIP WORK GROUP PARTICIPATION	# of participants in CHIP work group	2015: Average of 9 participants per meeting	2016 9 2017 2018 11 2019 2020 12	Healthy Yolo Internal tracking	HHSA – Emily Vaden	Annually
	% of participants who found meetings to be of quality	TBD	2016 (Establish baseline) 2017 2018 2019 2020(30% increase)	Healthy Yolo Survey of participants	HHSA – Emily Vaden	Annually
	ACTIVITIES: <ul style="list-style-type: none"> • Develop survey for 2016 quarterly meetings. 					

STRATEGY B: INCREASE ACCESS TO CHRONIC DISEASE PREVENTION AND MANAGEMENT

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE AVAILABILITY OF ADULT DAY SERVICES IN YOLO COUNTY*	# of slots available for adult day services	2015: 59	2016 59 2017 2018 80 2019 2020100	Yolo Adult Day Health Data	Yolo Adult Day Health Center - Dawn Myers Purkey	Quarterly
	# on waiting list	2015: 64	2016 60 2017 2018 30 2019 2020 0	Yolo Adult Day Health Data	Yolo Adult Day Health Center - Dawn Myers Purkey	Quarterly

* This count does not include the Golden Days Adult Day Health Center in West Sacramento which almost exclusively serves the Russian-speaking population

GOAL 2: INCREASE CONSUMPTION OF FRUITS AND VEGETABLES

HEALTH INDICATORS

Semiannual California Health Interview Survey (CHIS)

- Adults eating 5 or more servings of fruits or vegetables per day
- Obesity rate
- Diabetes diagnosis
- Adults with high blood pressure
- Adults with heart disease

STRATEGY A: INCREASE EXPOSURE TO HARVEST OF THE MONTH (HOTM) CAMPAIGN*

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE PERCENTAGE OF WIC CLIENTS WHO RECOGNIZE HARVEST OF THE MONTH (HOTM) CAMPAIGN	% of WIC clients who recognize HotM campaign	June 2015: 18% of WIC clients recognized HotM (n = 165)	2016..... 19% 2017..... 20% 2018..... 21% 2019..... 2020..... 22%	Nutrition Education and Obesity Prevention (NEOP) Program data	HHSA – Rebecca Tryon	Semiannually
SUSTAIN NUMBER OF SCHOOLS WHERE HOTM IS PROMOTED	# of schools where HotM is promoted	FFY15: 4 schools (One in each city: W. Sacramento, Winters, Woodland, and Esparto)	2016.....4 2017..... 2018..... 2019..... 2020.....4	Nutrition Education and Obesity Prevention Program (NEOP) Data - Activity Tracking Form (ATF)	HHSA – Rebecca Tryon	Annually
SUSTAIN NUMBER OF KIDS WHO RECEIVE HOTM TASTE TESTS	# of kids who receive HotM tastes tests	FFY15: TBD October 15	2016..... 2017..... 2018..... 2019..... 2020.....Sustain	Nutrition Education and Obesity Prevention Program (NEOP) Data - Activity Tracking Form (ATF)	HHSA – Rebecca Tryon	Annually
INCREASE NUMBER OF PROGRAMS WHO UTILIZE HOTM WITH THEIR CLIENTS	# of County Nutrition Action Partnership (CNAP) partners who utilize HotM with their clients	2015: 7 partners	2016.....8 2017.....8 2018.....9 2019.....9 2020.....10	County Nutrition Action Partnership (CNAP) Data	HHSA – Rebecca Tryon	Annually
	# of HHSA programs that utilize HotM	2015: 2 programs	2016.....2 2017..... 2018.....3 2019..... 2020.....4	HHSA Internal Tracking	HHSA – Rebecca Tryon	Annually
ACTIVITIES:						
<ul style="list-style-type: none"> • Develop survey 						

* Harvest of the Month is a California Department of Public Health campaign aimed at increasing the consumption of seasonally available produce among children. <http://harvestofthemonth.cdph.ca.gov/Pages/Program-Overview.aspx>

STRATEGY B: INCREASE IMPACT OF COMMUNITY GARDEN(S)

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE NUMBER OF PEOPLE WHO RECEIVE PRODUCE FROM THE HANNA & HERBERT BAUER MEMORIAL COMMUNITY GARDEN	# of pounds of produce produced and distributed	FY2015: 570 pounds	2016.....575 lbs 2017..... 2018.....585lbs 2019..... 2020.....600 lbs	Nutrition Education and Obesity Prevention (NEOP) program data	HHSA – Rebecca Tryon	Annually
	# of bags distributed	FY2015: 320 bags	2016.....323bags 2017..... 2018.....330 bags 2019..... 2020.....336 bags	Nutrition Education and Obesity Prevention (NEOP) program data	HHSA – Rebecca Tryon	Annually
SUSTAIN NUMBER OF GARDEN CLASS PARTICIPANTS AND YOUTH PROGRAM PARTICIPANTS	# of people who attended garden classes	FFY15: 75 adults attended classes and 208 youth participated in programs	2016..... 2017..... 2018..... 2019..... 2020.....75 adults, 208 youth	Nutrition Education and Obesity Prevention (NEOP) program data	HHSA – Rebecca Tryon	Annually

GOAL 3: DECREASE CONSUMPTION OF SUGAR SWEETENED BEVERAGES

HEALTH INDICATORS

Semiannual California Health Interview Survey (CHIS)

- Obesity rate
- Diabetes diagnosis

Annual California Healthy Kids Survey

- Water consumption/ sugar sweetened beverages for school aged children

STRATEGY: INCREASE AWARENESS OF HEALTH RISKS ASSOCIATED WITH SUGAR SWEETENED BEVERAGE CONSUMPTION

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE NUMBER OF PROGRAMS WHO UTILIZE A SUGAR SWEETENED BEVERAGE CONSUMPTION REDUCTION PROGRAM (SSBCRP)	# of County Nutrition Action Partnership (CNAP) partners who utilize SSBCRP	TBD	2016..... 2017..... 2018..... 2019..... 2020..... (10% increase)	County Nutrition Action Partnership (CNAP) Data	HSA – Rebecca Tryon	Annually
SUSTAIN NUMBER OF NEOP ACTIVITIES USING RETHINK YOUR DRINK MESSAGING	# of NEOP activities that include Rethink Your Drink Messaging	2015: 6 activities	2016..... 2017..... 2018..... 2019..... 2020..... 6	Nutrition Education and Obesity Prevention Program (NEOP) Data - Activity Tracking Form (ATF)	HSA -- Rebecca Tryon	Annually

GOAL 4: INCREASE THE PERCENTAGE OF THE POPULATION ADHERING TO RECOMMENDED PHYSICAL ACTIVITY STANDARDS

HEALTH INDICATORS

Semiannual California Health Interview Survey

- No exercise in the past month among children

Annual California Department of Education

- Fitness-gram

STRATEGY: INCREASE NUMBER OF CHILDREN ACTIVELY TRANSPORTING TO SCHOOL

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE PERCENT OF KIDS WALKING AND BIKING TO SCHOOL IN WOODLAND ELEMENTARY AND MIDDLE SCHOOLS	% of kids walking or biking to school	October 2015: Total - 22.9% Walk – 20% Bike – 2.9%	201623% 2017 201824% 2019 2020 25%	Active Transportation Program (ATP) data Transportation Mode Survey	HHSa – Ana Enriquez	Every 2 years
	# of schools with parent-led walking or biking groups	2015: 0	20161 20172 20183 20194 20205	Active Transportation Program (ATP) Internal Tracking	HHSa – Ana Enriquez	Annually
SUSTAIN NUMBER OF KIDS WALKING AND BIKING TO SCHOOL IN DAVIS ELEMENTARY SCHOOLS	# of kids walking and biking to school	November 2015: Total - 37% Walk - 12% Bike - 25%	2016 2017 2018 2019 2020Sustain	City of Davis Active For Me Program	HHSa – Rebecca Tryon	Annually

GOAL 5: INCREASE ACCESS TO PREVENTIVE SERVICES

HEALTH INDICATORS:

No county wide data source exists

STRATEGY: INCREASE ACCESS TO FLOURIDATED WATER

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE PERCENTAGE OF HEALTH SYSTEM ADVOCATES THAT ACTIVELY SUPPORT COMMUNITY WATER FLUORIDATION	% of health system advocates that actively support community water fluoridation	2015: 0	2016..... 10% 2017..... 15% 2018..... 20% 2019..... 25% 2020..... 30%	Community Health Branch Data	HHSA – Jan Babb	Quarterly
INCREASE NUMBER OF COMMUNITIES WITH WATER FLUORIDATION	# of cities with community water fluoridation	2015: 1	2016..... 1 2017..... 2018..... 2 2019..... 2020..... 3	Community Health Branch Data	HHSA – Jan Babb	Annually

GOAL 6: DECREASE YOUTH ACCESS TO TOBACCO PRODUCTS

HEALTH INDICATORS

Semiannual California Health Interview Survey (CHIS)

- Adult smoking rate

Annual California Healthy Kids Survey

- Youth smoking rate

Annual California Cancer Registry

- Lung cancer

STRATEGY: ENCOURAGE LOCAL CITY COUNCILS TO ADOPT TOBACCO RETAIL LICENSING POLICIES

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE NUMBER OF CITIES WITH TOBACCO RETAIL LICENSING (TRL) POLICIES	# of cities with TRL policies	2015: 3 cities	2016..... 2017..... 2018..... update West Sac Policy 2019..... 2020.....4	Tobacco Prevention Program data	HHSA – Steven Jensen	Semiannually
	Activity: <ul style="list-style-type: none"> • Update the West Sacramento TRL Policy to be comparable to the other policies. 					

PRIORITY HEALTH ISSUE: HEALTHY AGING

SITUATIONAL ANALYSIS: WHY IS THIS A CONCERN?

From 2000 to 2010, Yolo County experienced a 74% increase in the number of 55-65 year old adults. As of 2010, more than 10% of Yolo County residents were over 65 years of age. This large increase in number of older adults, coupled with a recessed economy and benefit programs not growing to meet that need, has created a dismal situation for older adults.¹⁰

In response to the unaddressed needs of seniors, the Yolo Healthy Aging Alliance was created in July of 2013 with a startup grant from The SCAN Foundation. As a part of their work to “promote the wellbeing of older adults through Education, Collaboration and Advocacy”, a Healthy Aging Summit was held in October of 2014.¹¹ More than 100 individuals including seniors, caregivers, and providers of senior care, elected officials and interested citizens participated. The key findings of the summit included large gaps in regards to housing, mental health, healthy aging, caregiving and transportation.¹²

It is important to note, that when the Healthy Yolo Community Health Assessment was done in 2013, many of these same issues were identified. Specifically in the table below, you can see that for adults older than 65, health problems associated with aging and mental health were the top two concerns. When convening the Healthy Aging CHIP work group, it was important that we not duplicate other community efforts and had strong representation from the Yolo Healthy Aging Alliance Board of Directors. This led to the CHIP referencing and reinforcing the previously developed Yolo Healthy Aging Alliance strategic plan, which leads to greater collective impact.

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)

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¹⁰ Bellamy, A. T. (2014) Yolo County Grapples with Silver Tsunami. *The Davis Enterprise*. pp. A1

¹¹ Yolo Healthy Aging Alliance. (2015). *Mission statement*. Retrieved from http://yhaa.nfshost.com/?page_id=14

¹² Yolo Healthy Aging Alliance. (2014). *2014 Healthy aging summit report and finding*. Woodland, CA: Allen, S.

¹³ Yolo County Health Department (2014) *Healthy Yolo: Community Health Assessment*. Retrieved from <http://www.yolocounty.org/home/showdocument?id=27029>

GOAL 1: INCREASE ACCESS TO SAFE AND AFFORDABLE HOUSING FOR ALL OLDER ADULTS

HEALTH INDICATORS

Annual Office of Statewide Health Planning and Development (OSHPD)

- Hospitalizations due to falls in older adults
- Emergency room visits due to falls in older adults
- Mental health or alcohol/drug related hospital admissions
- Asthma hospitalizations and emergency department visits, preventable hospitalizations

Semiannual California Health Interview Survey (CHIS)

- Adults with high blood pressure
- Asthma prevalence

STRATEGY A: PROVIDE INFORMATION REGARDING HOME SAFETY/FALL PREVENTION

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
HEALTHY LIVING WORKSHOP PARTICIPANTS REPORT PLANNING TO APPLY FALL PREVENTION STRATEGIES	% of participants who reported planning to apply fall prevention strategies	Dec 2015- 96%	2016 75% 2017 75% 2018 75% 2019 75% 2020 75%	Healthy Living Program Data	HSA – Lisa Musser	Quarterly

STRATEGY B: ASSESS AND INCREASE HOUSING FOR OLDER ADULTS

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE NUMBER OF JURISDICTIONS WITH UNIVERSAL DESIGN IN THEIR HOUSING CODE	# of jurisdictions with universal design in their housing code	To be shared at January meeting	2016..... 2017..... 2018.....1 additional jurisdiction 2019..... 2020..... 2 additional jurisdictions	Healthy Aging Alliance program data	Healthy Aging Alliance – Sheila Allen	Annually
	ACTIVITIES: <ul style="list-style-type: none"> Assess current number of jurisdictions with universal design in their housing code 					
INCREASE NUMBER OF JURISDICTIONS WITH AFFORDABLE HOUSING POLICIES	# of jurisdictions with affordable housing policies	To be shared at January meeting	2016..... 2017..... 2018.....1 additional jurisdiction 2019..... 2020..... 2 additional jurisdictions	Healthy Aging Alliance program data	Healthy Aging Alliance – Sheila Allen	Annually
	ACTIVITIES: <ul style="list-style-type: none"> Assess current number of jurisdictions with affordable housing policies 					

GOAL ACTIVITIES

- Increase number of affordable housing units in the County
 - Assess current number of affordable house units in the County
 - Add question to Health Care Access Survey about percentage of income used for housing
- Increase number of affordable residential care facilities for older adults
 - Access current number of affordable residential care facilities for older adults

GOAL 2: IMPROVE THE INFORMATION SYSTEM FOR OLDER ADULTS

HEALTH INDICATORS

Every two years Health Care Access Survey

- Older adults reporting “good” to “excellent” health status
- Older adults who had seen a medical provider in the past 12 months

STRATEGY: ASSESS AND IMPROVE CURRENT SYSTEM

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
INCREASE NUMBER OF HITS ON 2-1-1 SITE/DATABASE FOR OLDER ADULT SERVICES	# of hits on 2-1-1 site/database for older adult services	TBD	2016(<i>Establish baseline</i>) 2017 2018 2019 2020 (<i>10% increase</i>)	2-1-1 Yolo program data	2-1-1 Yolo – Victoria Lewis	Quarterly

GOAL 3: IMPROVE ACCESS TO SAFE, AFFORDABLE TRANSPORTATION FOR OLDER ADULTS

HEALTH INDICATORS

Every 2 years Health Care Access Survey

- Avoiding obtaining healthcare services due to lack of transportation

STRATEGY: ASSESS CURRENT GAPS IN TRANSPORTATION SERVICES

OBJECTIVE	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
ASSESS # OF VOUCHERS DISTRIBUTED BY ADULT DAY HEALTH FOR YOLOBUS SPECIAL	# of one way rides redeemed by voucher	To be shared at January meeting	Not applicable	Area 4 Agency on Aging	Lori Howton	Quarterly

Note: Further strategies and objectives will be developed after initial assessment.

POTENTIAL PARTNERS

- Unitrans
- YoloBus

GOAL 4: IMPROVE ACCESS TO PREVENTIVE SERVICES, EARLY DIAGNOSIS AND TREATMENT FOR OLDER ADULTS

HEALTH INDICATORS

Semiannual California Health Interview Survey (CHIS)

- Adults with high blood pressure
- Adults with heart disease

Annual Office of Statewide Health Planning and Development (OSHPD)

- Colon cancer hospitalizations

STRATEGY: IMPROVE CONFIDENCE IN SELF-MANAGEMENT OF CHRONIC CONDITIONS

OBJECTIVE(S)	PERFORMANCE MEASURES	BASELINE	TARGET	DATA SOURCE	RESPONSIBLE PERSON	FREQUENCY
HEALTHY LIVING WORKSHOP PARTICIPANTS REPORT PLANNING TO APPLY CHRONIC DISEASE MANAGEMENT SKILLS	% of participants who reported planning to apply chronic disease management skills	To be shared at January meeting	2016..... 75% 2017..... 75% 2018..... 75% 2019..... 75% 2020..... 75%	Healthy Living Program Data	HHS – Lisa Musser	Quarterly
HEALTHY LIVING HOME VISITATION CLIENTS REPORT PLANNING TO APPLY CHRONIC DISEASE MANAGEMENT SKILLS	% of participants who reported planning to apply chronic disease management skills	To be shared at January meeting	2016..... 75% 2017..... 75% 2018..... 75% 2019..... 75% 2020..... 75%	Healthy Living Program Data	HHS – Lisa Musser	Quarterly

MONITORING AND IMPLEMENTATION

Each of the 3 work groups will continue to meet quarterly beginning in January 2016. Each meeting there will be a review of available data to assess progress towards the CHIP objectives.

Each year starting in January 2017, there will be an annual report done to show overall progress and will be shared widely with the community in a high impact visual. Eventually the goals and performance measures will be captured in the Data Dashboard system that has recently been purchased by the Health and Human Services Agency.

Healthy Aging

Date	Time	Location
January 27, 2016	1:00 – 2:30	Bauer Building, Thomson Room
April 20, 2016*	9:00 – 10:30	Bauer Building, Thomson/Walker Rooms
July 27, 2016	2:00 – 3:30	Bauer Building, Thomson Room
October 27, 2016*	1:30 – 3:00	Bauer Building, Thomson/Walker Rooms

Mental Health

Date	Time	Location
January 28, 2016	2:00 – 3:30	Bauer Building, Thomson Room
April 20, 2016*	9:00 – 10:30	Bauer Building, Thomson/Walker Rooms
July 28, 2016	2:00 – 3:30	Bauer Building, Thomson Room
October 27, 2016*	1:30 – 3:00	Bauer Building, Thomson/Walker Rooms

Chronic Disease Prevention

Date	Time	Location
January 26, 2016	2:00 – 3:30	Bauer Building, Thomson Room
April 20, 2016*	9:00 – 10:30	Bauer Building, Thomson/Walker Rooms
July 26, 2016	2:00 – 3:30	Bauer Building, Thomson Room
October 27, 2016*	1:30 – 3:00	Bauer Building, Thomson/Walker Rooms

*joint meetings with all three workgroups.

APPENDIX A: DATA SOURCES

ANNUAL DATA SOURCES

California Cancer Registry

- Lung Cancer

California Department of Education

- Fitness-gram

California Health Kids Survey

- Water consumption/sugar sweetened beverages for school aged children
- Youth smoking rate

County Health Rankings

- Diabetes management A1C test in Past Year (% of Medicare enrollees)

Office of Statewide Health Planning and Development (OSHPD)

- Asthma hospitalizations and emergency department visits, preventable hospitalizations
- Colon cancer hospitalizations
- Emergency room visits due to falls in older adults
- Hospitalizations due to falls in older adults
- Hospitalizations for mental health issues in youth
- Mental health or alcohol/drug related hospital admissions
- Preventable hospitalizations for diabetes
- Self-inflicted injury related hospitalizations in youth
- Suicide rate

SEMIANNUAL DATA SOURCES

California Health Interview Survey (CHIS)

- Adult smoking rate
- Adults eating 5 or more servings of fruits or vegetables per day
- Adults with heart disease
- Adults with high blood pressure
- Asthma prevalence
- Blood pressure management
- Diabetes diagnosis
- Did not receive adequate social/emotional support
- No exercise in the past month among children
- Obesity rate
- Reason for seeking treatment

EVERY 2 YEARS DATA SOURCES

Health Care Access Survey

- Adults who received mental health treatment
- Avoiding obtaining healthcare services due to lack of transportation
- Older adults reporting “good” to “excellent” health status
- Older adults who had seen a medical provider in the past 12 months
- Reasons for not getting mental health treatment