2023-2025

Yolo County Community Health Assessment

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Acknowledgements

The Yolo County Community Health Assessment (CHA) combines demographic and survey data and viewpoints from Yolo County's leaders, non-profit agencies, healthcare agencies, community partners, and residents.

Yolo County Health and Human Services Agency's (HHSA) Public Health Branch is grateful for the collaboration with our healthcare entities, Woodland Memorial Hospital, Sutter Davis Hospital, Winters Healthcare, and CommuniCare Health Centers to develop the Community Health Needs Assessment (CHNA) with consulting group Community Health Insights (www.communityhealthinsights.com).

The complete CHNA, which is the foundation for this CHA, can be accessed through the URL listed as Appendix I.

Finally, we deeply appreciate the input and time of community residents and local community leaders, and our HHSA Public Health Branch collaborators, in helping us gain an understanding of our community's assets and health needs. We hope the information shared here can help build an equitable path to health for all who work, live, and play in Yolo County.

Land Acknowledgement

We would like to take a moment to acknowledge the land on which we live, work, and play in Yolo County. Since time immemorial, this land has been the home of Patwin people. Today, there are three federally-recognized Patwin tribes: Cachil Dehe Band of Wintun Indians of the Colusa Indian Community, Kletsel Dehe Band of Wintun Indians and Yocha Dehe Wintun Nation. The Patwin people have remained committed to the stewardship of this land over many centuries. It has been cherished and protected, as elders have instructed the young through generations. We are honored and grateful to be here today on their traditional lands.[1]

Dedication

At the time of writing the CHA, the world is just emerging from the COVID-19 pandemic. Beginning in late 2019, the COVID-19 virus swept through the world, causing widespread economic and community shut-downs, fundamental changes in the way we operate businesses, education institutions, and how we come together as a community. It also resulted in illness and, unfortunately, death for some. We would like to dedicate this CHA to the 335 Yolo County residents who lost their lives to the COVID-19 pandemic.[2] Our hearts go out to those families who lost loved ones and all who were significantly impacted by the virus.

Executive Summary

The Community Health Assessment (CHA) was developed by the Yolo County Health and Human Services Agency's Public Health Branch (HHSA). A CHA is a report that uses data analysis as well as community and leadership input to determine a county's Significant Health Needs (SHNs).

A SHN is a health-related issue seen widely across the community, and/or is a major issue for certain groups of people or a certain region of the county. A SHN can have a major impact on a person's overall health or quality of life.

The Yolo County 2023-2025 CHA has 11 SHNs. The 11 SHNs were identified through a data analysis process in 2021 during development of the Community Health Needs Assessment (CHNA), led by Community Health Insights in partnership with Woodland Memorial Hospital, Sutter Davis Hospital, Winters Healthcare, CommuniCare Health Centers and HHSA. The CHNA included the most up-to-date available data at time of analysis.

The CHA also identifies the county's priority communities: families living in poverty, rural communities, and communities of color, particularly in West Sacramento and Woodland.

Significant Health Needs (SHNs)

Listed by priority

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Injury and Disease Prevention and Management
4. Active Living and Healthy Eating
5. Access to Quality Primary Care Health Services
6. System Navigation
7. Access to Specialty and Extended Care
8. Increased Community Connections
9. Safe and Violence-Free Environment
10. Access to Functional Needs
11. Access to Dental Care and Preventive Services

Finally, it calls out some of the foundational issues that impact the health of our community: systemic racism, classism, and inequitable access to opportunity.

The CHA is a tool for action. The next step is to take the information in the CHA and develop a Community Health Improvement Plan (CHIP). A CHIP is the roadmap for addressing SHNs. CHIP development began in October 2022 and will go through the Summer of 2023. A CHIP workgroup made up of community-based organizations (CBOs), healthcare agencies, residents, and HHSA, is leading the effort. The workgroup will choose 1-3 priority areas to focus on over the next 3-years, and will then create a plan to address those priorities by choosing specific strategies, priority communities, partners, and meaningful ways to measure impact.

HHSA would like to thank the community, its healthcare and CBO partners, and all who have contributed to the development of this CHA, and the CHIP that will be finalized in the Summer of 2023.

To learn more about the CHA and the CHIP, as well as the CHNA, please visit www.healthyyolo.org.

List of Frequently Used Acronyms Used in the CHA

Acronyms

CBO	Community Based Organization
CHA	Community Health Assessment
CHI	Community Health Insights (CHNA Consultant)
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CHSS	Community Health Status Survey
HDI	Human Development Index
HHSA	Yolo County Health and Human Services Agency
SDOH	Social Determinants of Health
SHN	Significant Health Need(s)

CHA Partner/Participant List

Development of the CHA was a collaborative effort that included many partners.

To distinguish between development of the Community Health Needs Assessment (CHNA), and the Community Health Assessment (CHA) and the Community Health Improvement Plan (CHIP), partners are divided into two groups: **CHNA Partners** and ***Healthy Yolo* Partners** (see next page).

CHNA partners are those who worked directly on the CHNA, led by the Consulting Group Community Health Insights (CHI).[3]

CHNA PARTNERS

Process led by Community Health Insights

Workgroup Agencies

Woodland Memorial Hospital | Sutter Davis Hospital | CommuniCare Health Centers | Yolo County Health and Human Services Agency (HHSA) | Winters Healthcare

Interview Participants

Staff and leadership from Woodland Memorial Hospital; Sutter Davis Hospital; Yolo County HHSA, Winters Healthcare, CommuniCare; Yolo Food Bank; Fourth and Hope; Woodland Joint Unified School District; Rural Innovations in Social Economics (RISE) Inc.; and the Yolo County Children's Alliance.

An additional three *Focus Groups* were hosted with 18 participants by Woodland Area Educators (Woodland), RISE, Inc. (Esparto), and CommuniCare (West Sacramento)

***Healthy Yolo* is the group of partners who have provided input and collaborated with HHSA by:**

- Providing input on the Community Health Status Survey (CHSS) that informed the CHNA/CHA, and helped distribute the CHSS
- Providing feedback on the CHA draft and helped distribute the CHA
- Participating in the CHIP workgroup

Healthy Yolo

CHSS/CHA/CHIP process led by Yolo County HHSA

City of Davis
CommuniCare Health Centers
Community Advisors
Dignity Health
Downtown Streets Team
Empower Yolo
First 5 Yolo
Health Council
Health Education Council
Homeless and Poverty Action Coalition
Meals on Wheels Yolo County
National Alliance on Mental Illness (NAMI)
Northern Valley Indian Health
Partnership HealthPlan of California
PRO Youth and Families
Progress Ranch Treatment Services for Children
RISE, Inc.
Sutter Davis Hospital
UniteUs
VCSS West Sacramento
Western Center for Agricultural Health and Safety (UCD)
Western Regional Agricultural Stress Assistance Program (WRASAP)
California AgrAbility Program (UCD)
Winters Healthcare
Woodland Memorial Hospital
Yolo County Children's Alliance
Yolo County Housing Authority
Yolo County Office of Education
Yolo Farm to Fork
Yolo Food Bank
Yolo Healthy Aging Alliance

SECTION ONE

Purpose of a CHA

The purpose of the CHA is to identify SHNs of the Yolo County (Yolo) community, factors leading to poor ***health outcomes*** and ***health disparities***[4], and community assets that can be used to improve health. The CHA was developed for a diverse audience, including residents, community-based organizations, city leaders and programs, and other interested groups.

Using both quantitative and qualitative data from a variety of sources, the CHA is a big picture view of the overall health status of the community. The CHA also identifies health disparities seen among different communities, such as communities of color, class, and geographic location, showing that underlying inequities continue to impact health and quality of life across different populations in the county. Finally, the CHA is an opportunity to elevate community assets and strengths, as identified by residents and focus groups, that will become important factors in addressing Yolo's SHNs through the upcoming CHIP development process. More about the CHIP development process is found in the *Next Steps* section of this document.

HEALTH OUTCOMES

Health outcomes are **changes in health that result from measures or specific healthcare investments or interventions** such as preventing death after a heart attack through in-hospital care, and or **improvements in a patient's quality of life** following surgery for a specific health issue.

HEALTH DISPARITIES

Health disparities are **preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health** that are experienced by socially disadvantaged populations.

The benefits to completing a CHA for the community, County programs, and partners include:

- Improved collaboration among partners, residents, healthcare, and government
- A shared understanding of the most significant needs and disparities impacting our communities
- Developing a common language to discuss health needs, health outcomes, and solutions
- Synergizing efforts to address SHNs in meaningful ways
- Having a tool to communicate with the community about SHNs, priority communities, and efforts to address health disparities

In addition to being a best practice for identifying community needs, the CHA is also a requirement of the Public Health Accreditation Board (PHAB) for public health departments seeking reaccreditation.[5] Yolo County was first accredited in 2017 and is seeking reaccreditation in 2023.

Finally, the CHA reminds us that the systems and policies creating health disparities and inequities are repairable and amenable to change. It is possible to create the conditions within our communities for all residents to achieve optimal health and wellbeing.

SECTION TWO

CHA Development Process

Completion of the CHA began first with development of the CHNA in 2021, in partnership with local healthcare agencies and led by a consultant group, Community Health Insights. Once the CHNA was finalized, HHSA developed the CHA, which included data from the CHNA, and data sources to explore the SHNs identified in the CHNA from an equity perspective. Figure 1 shows the steps and timeline of the CHA development.

Spring 2021 – June 2022

Community Health Needs Assessment

The CHNA was developed by Community Health Insights (CHI)on behalf of the CHNA workgroup partners. The 11 prioritized SHNs in the CHNA were identified through analysis of quantitative data and qualitative data collected by input from 47 community leaders and providers (Appendix I). The CHNA was released publicly by the healthcare partners in July 2022.

June – August 2021

Community Health Status Survey

Community input on health concerns is an important part of the CHNA/CHA. The CHSS is a 49-question survey that 1,574 residents completed county-wide Summer of 2021. The CHSS was reviewed by 4 community partners to enhance diversity, equity, and inclusion in the survey questions. The survey was distributed in English, Spanish, and Russian. The survey can be found in Appendix II of this report.

June – December 2022

Community Health Assessment

The 2023-25 CHA was developed by Yolo County Public Health and integrates data from the CHNA along with data from the CHSS, the Human Development Index (HDI) data and other sources to integrate an equity perspective on the 11 SHNs identified in the CHNA. The CHA is finalized in December 2022 after a public review and CHIP workgroup review period in November 2022.

Oct 2022 – Summer 2023

Community Health Improvement Plan

The CHIP is a 3-year plan that identifies strategies and outcome measures to address 1-3 selected priorities from the CHA. The county-wide CHIP group started meeting on October 18, 2022 to identify the CHIP priorities and strategies. The workgroup will meet through the Summer of 2023 to finalize the CHIP.

SECTION THREE

County Overview and Demographic Profile

Yolo County is northwest of Sacramento, nestled between the Counties of Colusa, Solano, Sutter, Sacramento, Napa, and Lake. It encompasses a land mass of 1,024 square miles, and the population is approximately 225,000 in 2022.[6]

It is home to the University of California, Davis which has over 41,000 students, many of whom come from out of the county to attend school.[7] The student population of UC Davis is relatively large compared to the overall population, which can create challenges when interpreting certain data, such as data for which groups experience the highest rate of poverty and income levels in certain neighborhoods.

While most Yolo County residents identify as White or Hispanic/Latino, the population is diversifying, with growing Asian American and Pacific Islander (AAPI), and mixed-race population.

38.5% of Yolo County residents speak a language other than **English**[8]

Yolo County is home to a diverse population of both residents whose families have lived in the county for generations and those who have immigrated for work, education, family, or other reasons.

Over 15% of the UC Davis students are international.[9],Yolo County's robust agricultural industry also brings workers from Mexico and other Latin American countries to work, some of whom settle permanently in the County. As a result, residents from 6 continents make Yolo County their home. With that comes a diversity in cultures and languages spoken. Threshold languages include English, Spanish, and Russian[10] but there are large communities of people who speak Pashto, Urdu, Farsi, Mandarin, Cantonese, Korean, and Punjabi as well.[11]

Most Yolo residents (87%) live within the four cities of Davis, Winters, West Sacramento, and Woodland. Each of the cities is geographically separated from the other, either by farmland or the floodway bypass (also known as the "causeway"). The rural communities of Knights Landing, Esparto, Madison, and Dunnigan are home to many migrant agricultural workers and farmers.

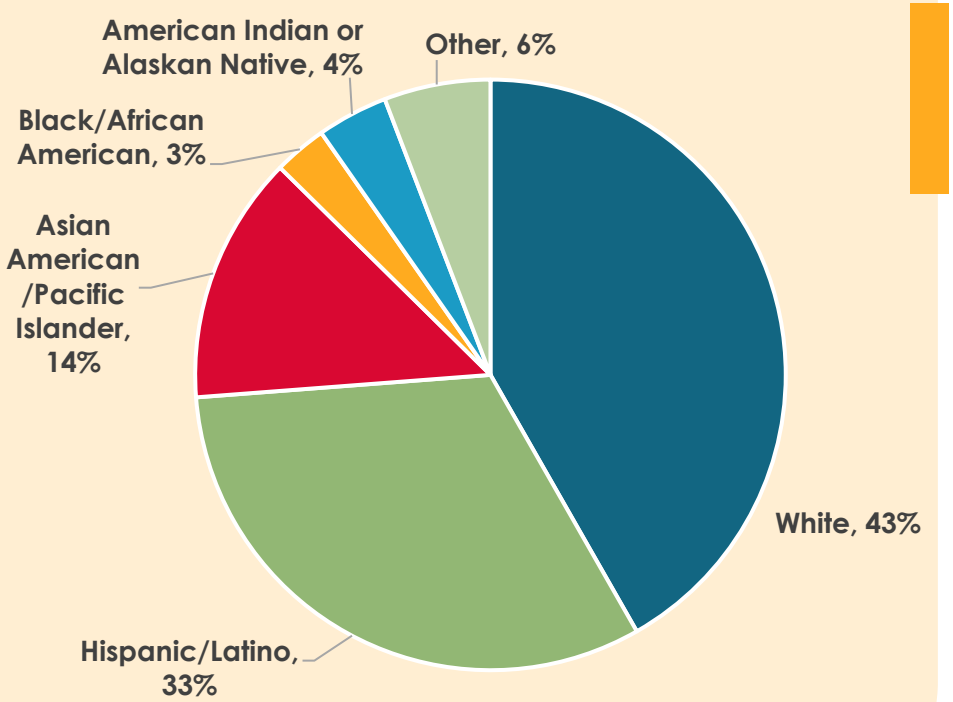


Fig. 2: Population by Race/Ethnicity, 2021 Data[12]

Consideration must be taken on how to ensure fair access to services, resources and information as the population continues to diversify.

Access to basic services like food outlets, health and dental care, behavioral health services, and even education, are limited in the rural regions. Rural residents often must travel 30-minutes or more for full-service grocery stores, jobs, and healthcare services. In contrast, the City of West Sacramento is relatively more urbanized, like its neighbor city Sacramento. West Sacramento is quite diverse, with the highest proportion of African American and Russian-speaking residents. Residents of West Sacramento have access to many of the amenities and services of a large, capital city. They may choose to shop, play, work, and use services in Sacramento due to convenience and a variety of options available. The diversity and distinction of each Yolo County city or community means that interventions to address barriers to health and prosperity cannot be 'one size fits all' and must take into consideration the unique make-up of the community itself.

Yolo County's Overall Health Status

From the big-picture perspective, Yolo County residents are relatively healthy compared to the rest of California. According to the Robert Wood Johnson's County Health Ranking, Yolo ranks in the top quarter (12th out of 58 California counties) for health factors, such as overall physical health and mental health, as well as health outcomes, such as average life expectancy and premature births.[13] The health ranking includes data on physical and mental health, and social and economic factors such as unemployment, education, and violent crime rates.

An additional way to measure the overall health of a community is the Human Development Index (HDI). The HDI gives a score to a community between 1 to 10, based on data from three domains: life expectancy, educational attainment, and overall standard of living. Yolo County's overall score is 5.89 and California's is 5.54, meaning that, for these metrics, Yolo County does better than the state. HDI data provides predictions for life expectancy.

Yolo County overall shows an average life expectancy of 81.4 years, slightly higher than the state average of 80.9 years and the United States average of 78.8 years. However, this does not tell the whole story. We see significant differences we look more closely at life expectancy in different neighborhoods.

To identify specific populations or regions where residents experience the highest levels of health disparities, it is important **to look closely at differences in measures like income and education** among communities or population groups, and **to look to the root causes of these differences while designing strategies to address the top health priorities**.

More information about this can be found in section 5: *Foundational Issues and Priority Communities*.

Additionally, certain health behaviors provide insight on the overall risks of a community for certain conditions, such as chronic diseases or lower life expectancies. For example, West Sacramento residents and Woodland residents have higher rates of smoking and physical inactivity than Davis residents.[14] These behaviors, while at the individual level, are in part a reflection of broader social determinants of health. These and other factors that contribute to health outcomes will be explored in Section 8, *Foundational Issues and Priority Communities*.

Fig. 3: Health Behaviors: Physical Inactivity and Smoking

PLACES Project, CDC (Years of Collection: 2019, 1 Year Model Estimate)

ADULTS REPORTED BEING PHYSICALLY INACTIVE

24.7% - West Sacramento

24.6% - Woodland

19.1% -Davis

ADULTS REPORTED SMOKING

15.2% -West Sacramento

13.6% -Woodland

10.5% -Davis

Furthermore, Yolo's HDI scores are higher than state and national averages for health and education domains, but not income. The presence of a large university, as well as two community colleges, likely contributes to higher than state averages for education. This may due the fact that resident students attending graduate or professional schools influence the numbers, as well as University of California, Davis (UC Davis) being the largest employer in the county. Many professional jobs at UC Davis require at least some college for employment.

The median household income in Yolo County was $73,736 in 2020, which is 6.6% lower than the state average.[15] The median income is a useful measure, but it does not indicate how income is distributed among residents. Yolo County has the second highest County income inequality ratio, which is the ratio of individuals in the 80th percentile (highest income) versus the 20th percentile (lowest income) in the state. Yolo's score is 21.4, which is 34% higher than neighboring Sacramento County. That means there are larger gaps between high wage earners and low wage earners in Yolo compared to Sacramento County, and the rest of the region in general.[16]

Homelessness

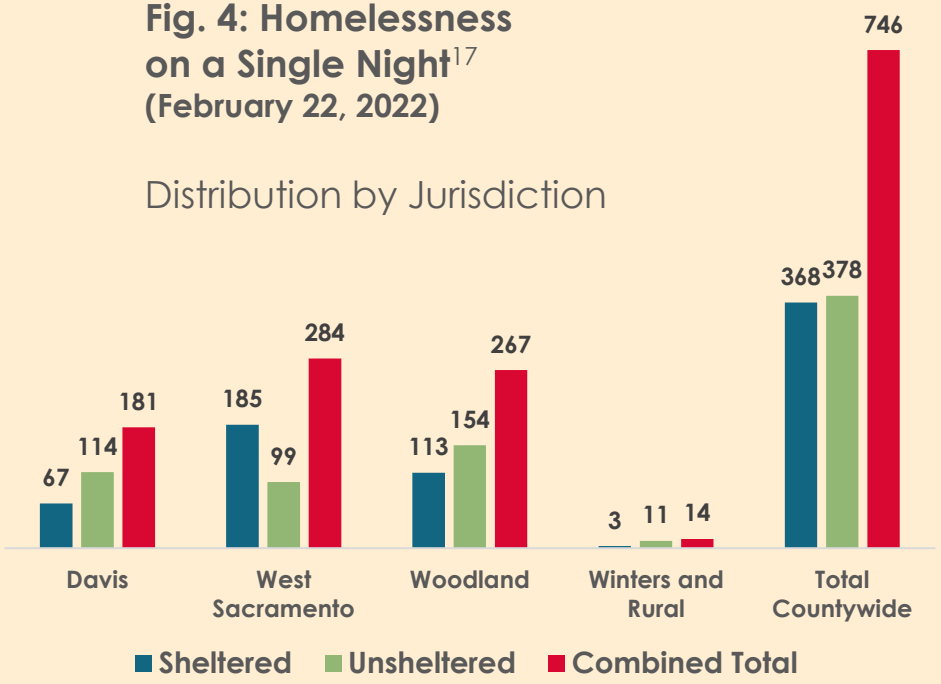
Homelessness is a growing concern in Yolo County as it is across California. As of the 2022 Point in Time Homeless Count, approximately 746 sheltered or unsheltered individuals were experiencing homelessness, the majority located in West Sacramento and Woodland.[17] This is a 13.9% increase since 2019, and a 51.9% increase since 2009.[18]

Poverty, as well as mental illness, are risk factors for homelessness. Additionally, as cost of living rises faster than wages, the story around homelessness becomes more complex. Increasingly, individuals and families are becoming homeless despite being employed, or even having a college education.

Programs such as the County's Yolo Basic Income Program aim to address the gap between wages and cost of living for families with young children experiencing homelessness by providing a monthly income to bring participating families up to the California Poverty Level -- $35,600/year for a family of four, on average.[19] However, until issues like access to affordable housing, access to education and job training opportunities, and higher wages are addressed, homelessness will persist and continue to impact our most vulnerable populations the most.

Fig. 4: Homelessness on a Single Night[17]
(February 22, 2022)

Distribution by Jurisdiction



Homelessness has increased

by **13.9%** since 2019

by **51.9%** since 2009

SECTION FOUR

Advancing Health Equity and the Social Determinants of Health

To better understand how the SHNs impact each of our communities differently, it is important to understand the role that ***Health Equity***[20] and the ***Social Determinants of Health (SDOH)***[21] play in creating poor health outcomes and health disparities for certain groups of people in certain environments.

Every resident of Yolo County should have the opportunity to have a long, healthy life. This includes having an income that allows them a reasonable standard of living as well as access to education and healthcare, regardless of race, gender, sexual orientation, ability status, ethnicity, birthplace, age, or geography.

The SDOH are grouped into five domains: Economic Stability; Education; Social and Community Context; Health and Healthcare; and Neighborhood/Built Environment. Examples of SDOH can be seen in Figure 4.[22]

HEALTH EQUITY

Means **everyone has a fair and just opportunity to be healthier**. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare.

SOCIAL DETERMINANTS OF HEALTH

Conditions where **people are born, live, work, worship, and play** that impact their long-term quality of life, health outcomes, and risk.

Fig. 5: Examples of Social Determinants of Health[21]

ECONOMIC STABILITY

Employment

Food Insecurity

Housing Instability

Poverty

SOCIAL AND COMMUNITY CONTEXT

Civic Participation

Discrimination

Incarceration

Social Cohesion

NEIGHBORHOOD AND BUILT ENVIRONMENT

Access to Foods that Support Healthy Living Patterns

Crime and Violence

Environmental Conditions

Quality of Housing

EDUCATION

Early Childhood Education and Development

Enrollment in Higher Education

High School Graduation

Language and Literacy

HEALTH AND HEALTHCARE

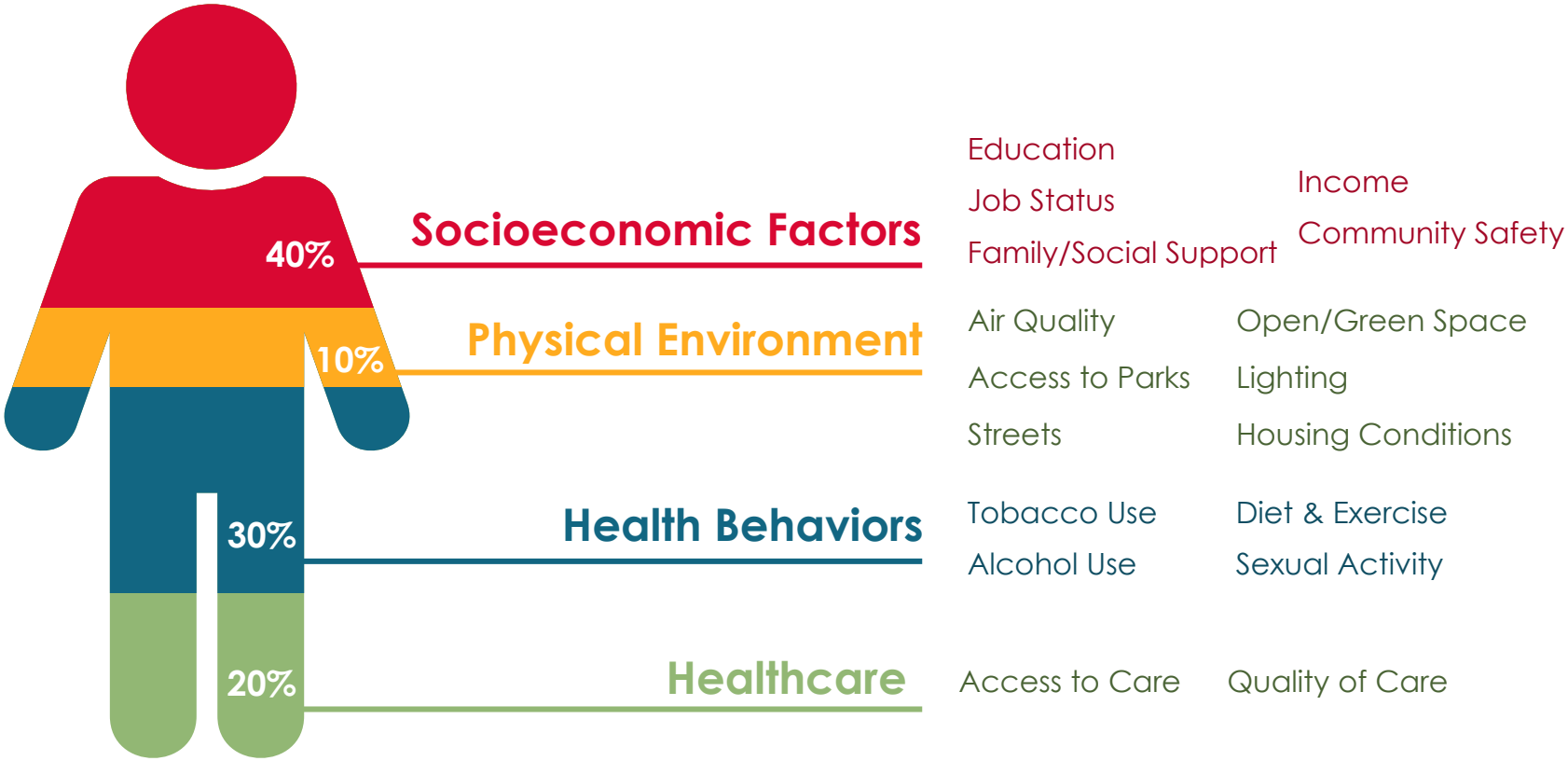
Access to Healthcare and Mental Health

Access to Primary Care

Health Literacy

Quality Healthcare

These examples can help guide planning for interventions to address health disparities within the community. Traditional thinking used to presume that access to and use of quality healthcare services were the major influencers of health. However, over the past several decades, an understanding of the SDOH show that healthcare is only a small part of the influence, and factors such as the SDOH, the environment, and health behaviors are much more predictive of overall health and life expectancy than healthcare.



20% of a person's health and well-being is related to access to care and quality of services.

The physical environment, social determinants, and behavioral factors drive 80% of health outcomes.

SECTION FIVE

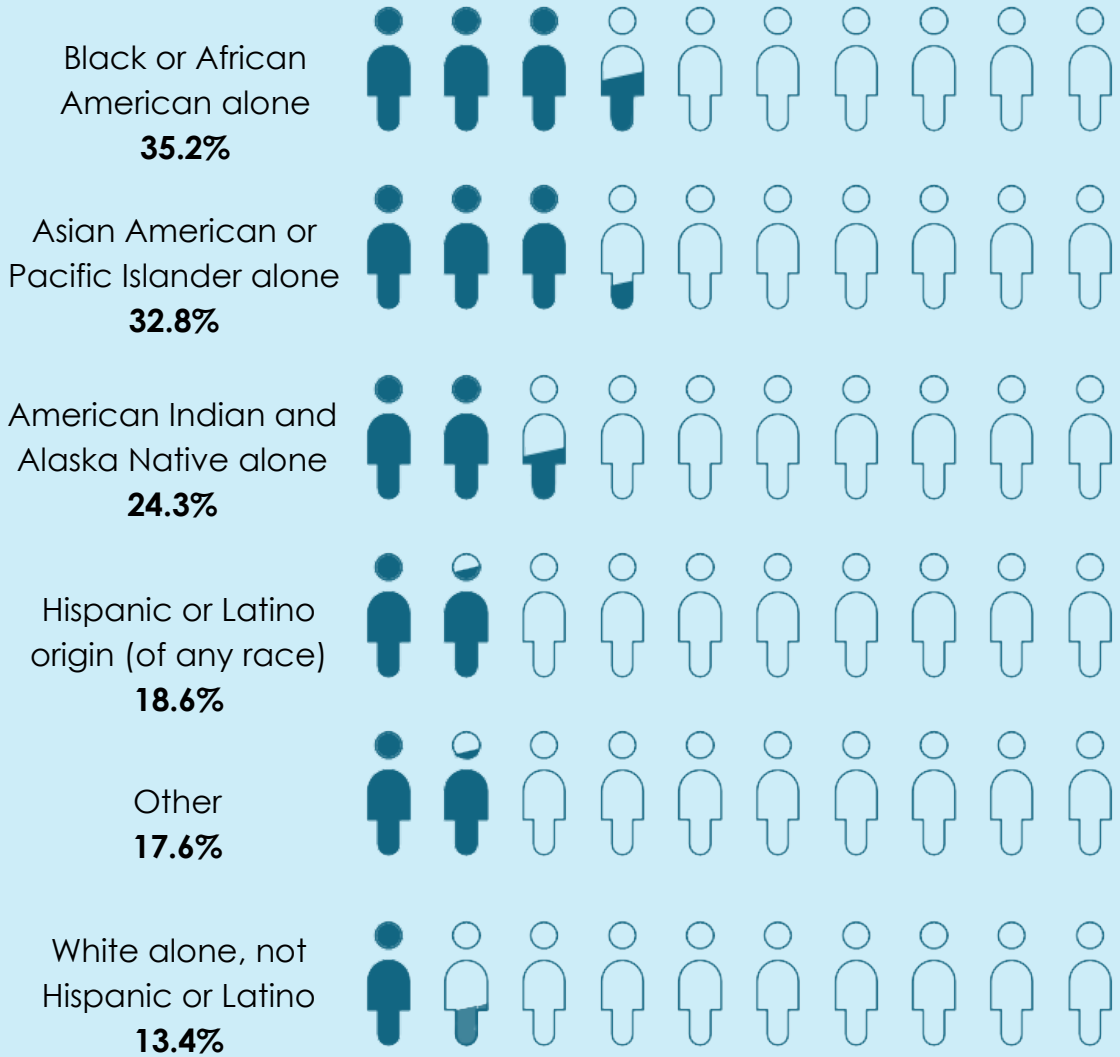
Foundational Issues and Priority Communities

Before exploring the SHNs in detail, it is important to address some of the foundational issues that impact certain groups, such as communities of color and some rural communities, more than other groups/communities. Foundational issues such as poverty, classism, and systemic racism influence the SDOH, and therefore impact health outcomes and overall quality of life. These issues and the communities they impact the most are at the root of many health disparities and need to be examined to identify who is experiencing the SHNs the most. Foundational issues and the SDOH need to be at the forefront of discussions regarding solutions; otherwise, they will continue to perpetuate themselves and lasting change will not be possible.

Poverty

Poverty is a serious concern in Yolo County and is a foundational issue certain race/ethnicity groups experience more than others. It is also a contributor to poor health outcomes. Poverty itself creates mental and physical stress and may be correlated with a lack of access to quality healthcare, including mental and oral healthcare. This can further add the possibility of poor health outcomes for those in poverty. California Poverty Measure Data show that 20.9% of residents live in poverty, much higher than the national average of 12.3%.[23] Further, 28.4% of residents are at or below 150% of the Federal Poverty Level, giving Yolo County one of the highest poverty rates in California.[24]

Fig. 7: Share of Population Living in Poverty, 2020[21]



However, this data may be skewed by the large UC Davis student body and does not tell the poverty story with complete accuracy. UC Davis students may be receiving financial supports from family or other means that are not reflected in reported income levels. This means that more individuals are classified as living below the poverty level more than there may be actually experiencing the struggles and impacts of poverty. Looking at data by race/ethnicity or geography gives a clearer picture of poverty in Yolo County. As Figure 6 shows, African American, Asian, and American Indian populations have the highest rates of poverty.

Income is a major indicator of poverty. The median personal income in Yolo County is $34,626.[25] However, similar to poverty rates, the influence of the UC Davis student population must be taken into consideration when evaluating this number. In addition to looking at poverty measures by race/ethnicity, we can also examine them by location in the County. As seen in Figure 7, median personal incomes vary among our different communities. Davis has both the neighborhoods with the highest and lowest personal incomes. The lowest income neighborhood is likely due to the high UC Davis student population residing in Davis.

However, there are also non-student groups living in Davis who experience poverty but are often overlooked because of overall high- income levels in Davis.

The cities of Woodland and West Sacramento have communities with the lower-than- County average personal income levels as well. Income levels in rural areas are higher than the County average, but what is not reflected is the difference between the incomes of migrant and farmworker communities, which are typically lower than other residents. Farmworkers and migrant workers also experience variability in their incomes based upon the agricultural seasonal cycles, with winter (December through February) being a time of significant wage losses for these residents.

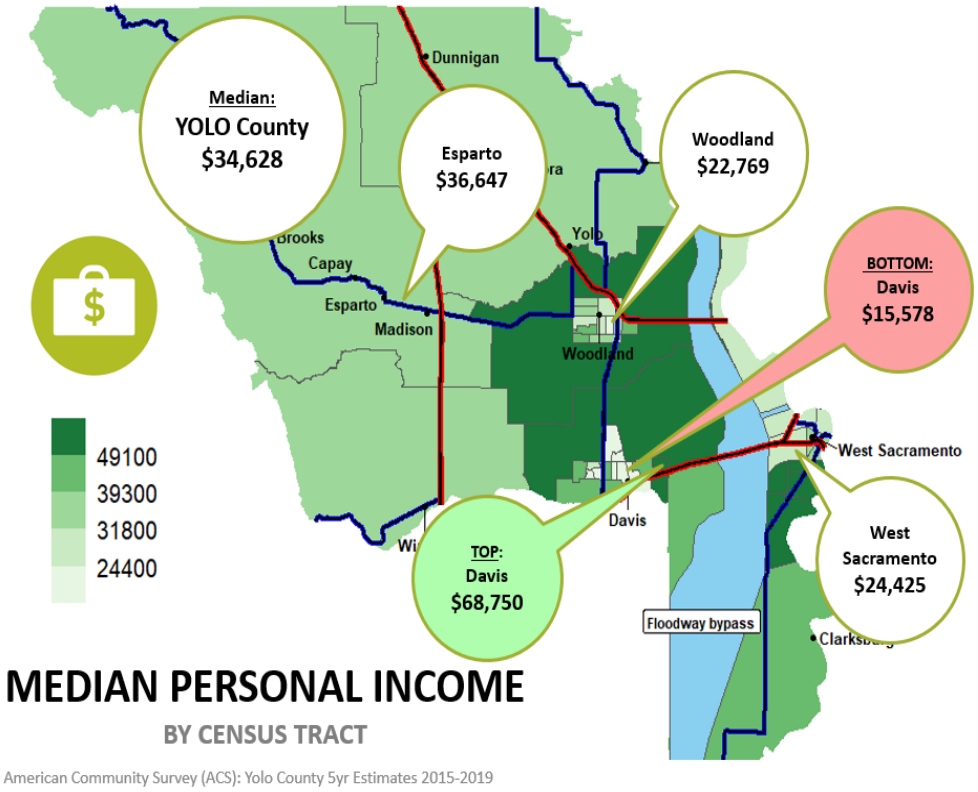


Fig. 8: Median Personal Income, by Census Tract

Housing Cost Burden

The cost of housing is also a major factor that contributes to and is impacted by poverty. The cost of housing is extremely high in Yolo County, with an average home price in August 2022 of $620K.[26]

Apartment costs are also high in Yolo County, with only 3% of apartment monthly rents being less than $1000, and only about 1 in three apartments renting for $1500/month or less in October 2022.[27] (Fig. 9)

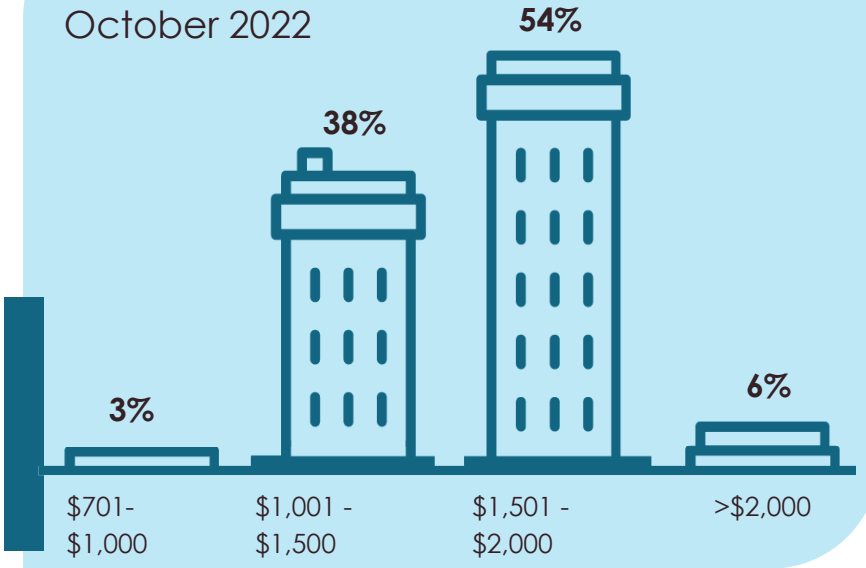
Picture taken from website of Mercy Housing California's 1801 West Capitol housing community

1 in 5 households spend more than 50% of their income on housing each month.

American Community Survey, 5-year estimate

Fig. 9: Apartment Rental Costs in Yolo County

October 2022



Education

Disparities in educational opportunities and educational attainment (highest level of education achieved) are also foundational factors that influence health and quality of life.

High school graduation rates are higher overall than state averages but are significantly lower for Latino residents than all other races. Bachelor's Degree attainment rates are higher overall compared with state averages (possibly due to the presence of UC Davis), but are significantly lower for Hispanic/Latino and Black communities compared with Whites and Asians.

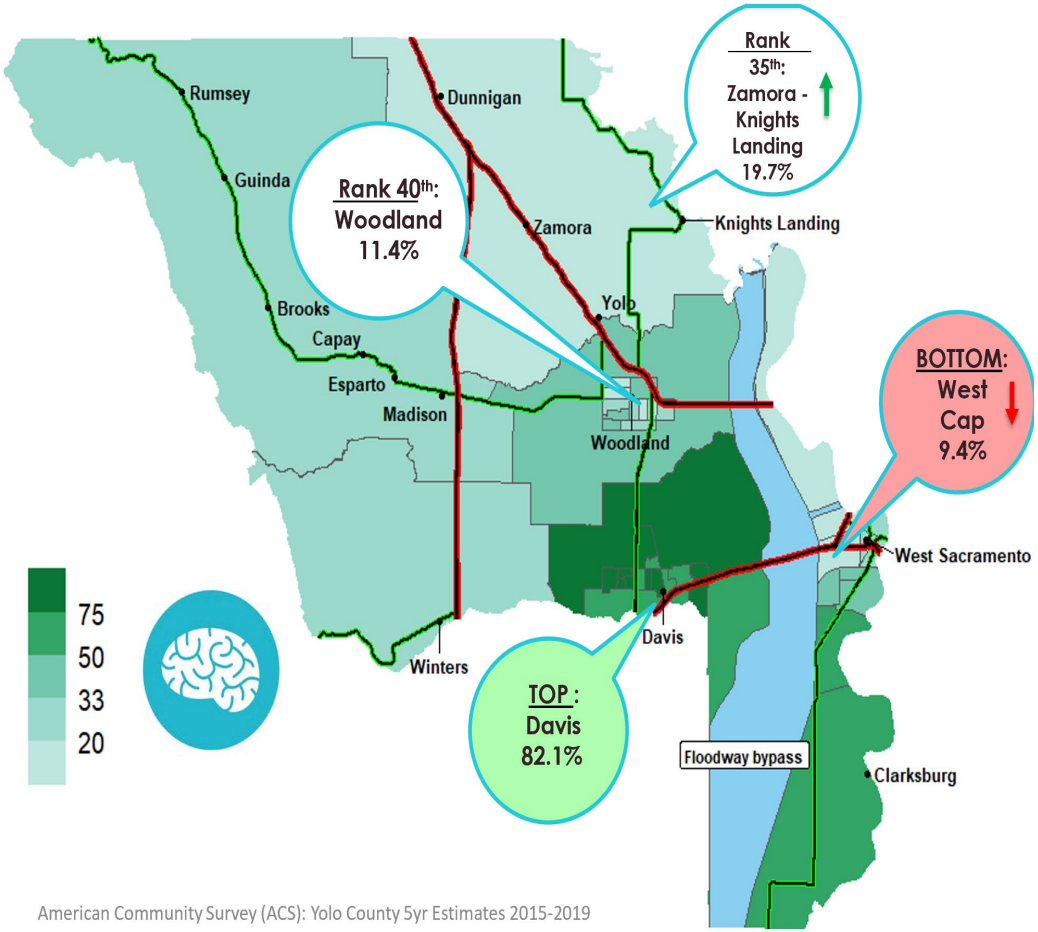


Fig. 10: Educational Attainment by Race, Yolo County[28]

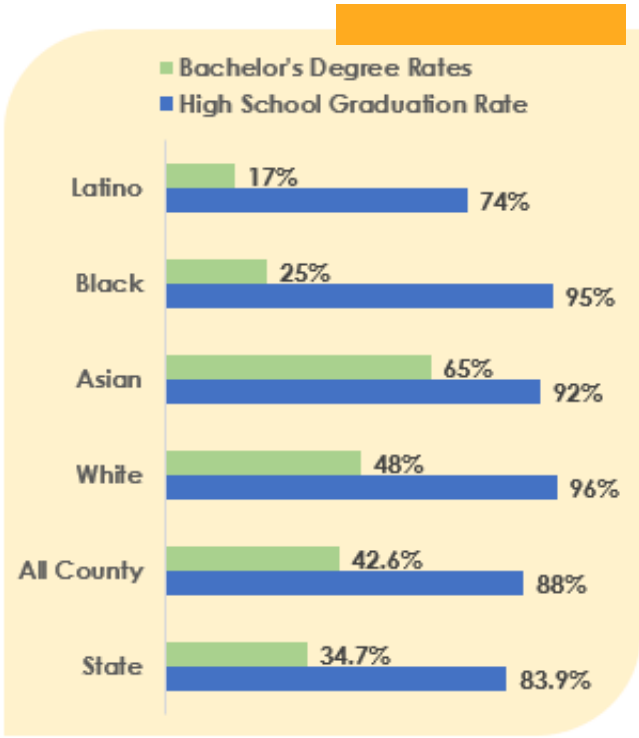


Fig. 11: Percentage of Adults with Bachelor-Degrees, by Census Tract

Priority Populations

During the CHNA development, interview participants and focus group participants were asked questions about what specific groups experience health issues the most, and what areas of the county also experience the most health issues. A list of key informants and focus group participants can be found in the CHNA (Appendix 1). Based on how frequently the groups or regions were mentioned, the list was analyzed and categorized by priority populations. The priority populations mentioned most frequently included those **living in poverty, those living in rural areas, migrant farmworkers and aging residents**.

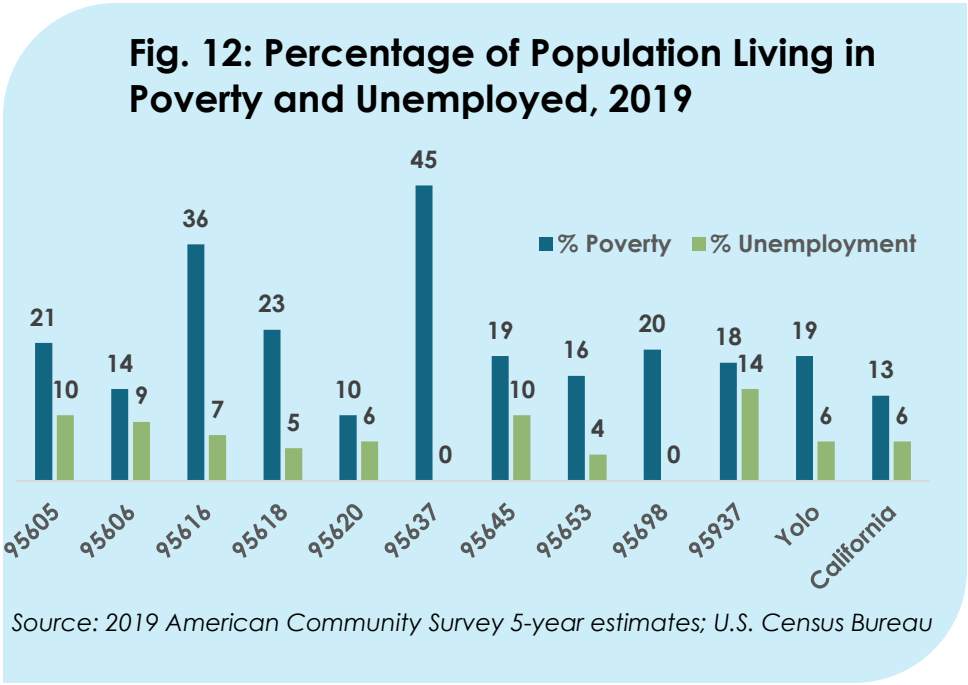
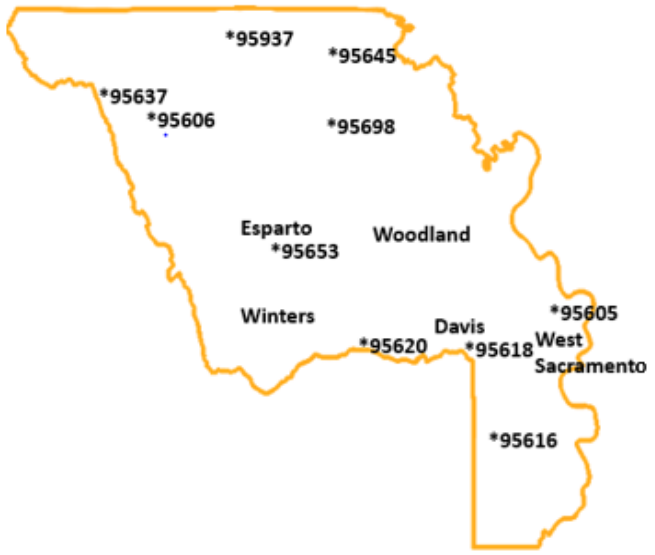


Fig. 12: Percentage of Population Living in Poverty and Unemployed, 2019

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau

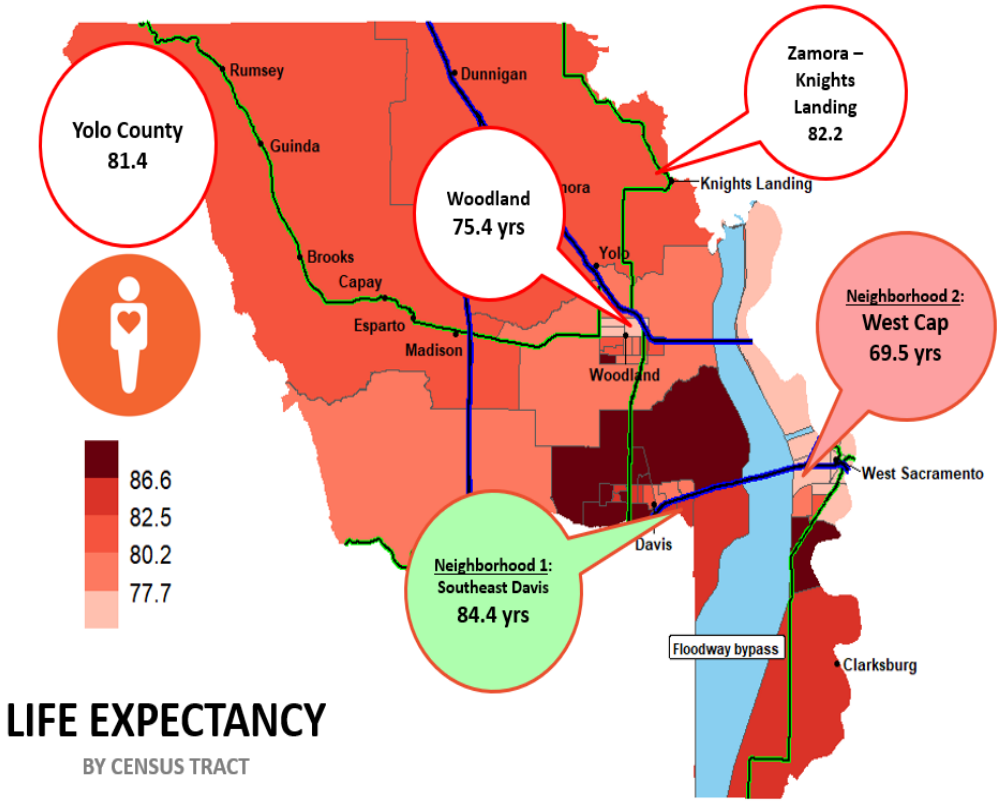


These communities may be considered the most vulnerable and susceptible to poorer health outcomes and more impacted by the SHNs.(Appendix 1). Additionally, several zip codes were identified as priority communities, based on poverty rates that exceeded the state average of 13.1%. Figure 11 indicates the locations of these zip codes, and their respective poverty and unemployment rates. While poverty and unemployment rates do not always tell the complete story, they can be important benchmarks for determining which communities experience higher rates of health, economic and other disparities.

Life Expectancy

Comparing life expectancies across the County provides a snapshot of the long-term impact of health disparities. As a whole, life expectancy for the County is relatively high. However, looking at different communities reveals a different story. Most dramatically, there is a stark and significant difference in life expectancy in the West Capitol area of West Sacramento in comparison to the whole county, but particularly to Davis. These two communities are separated only by the Yolo Causeway, yet clearly show that availability of and access to the SDOH are not the same for these two neighborhoods. Figure 12 shows the average life expectancy for different cities and communities across the County.[29]

Figure 13 illustrates how differences in the SDOH and other foundational issues influence life expectancy between two Yolo County neighborhoods that are only 10 miles apart.



Source: National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates File for Yolo County, 2010-2015

Fig. 13: Average life expectancy in Yolo County

Fig.14: A Tale of Two Neighborhoods[27]

SOUTHEAST DAVIS (Neighborhood 1)
Life Expectancy: 84.4 years

9% living in poverty

Extensive parks and green space

77% at least bachelor's degree

$63,750 median personal income

74% management occupations

64% housing occupied by owner

5% of population is African American

17% of population is foreign-born

WEST CAP – WEST SACRAMENTO (Neighborhood 2)
Life Expectancy: 69.2 years

41% living in poverty

Limited parks and green space

10% at least bachelor's degree

$24,425 median personal income

27% management occupations

24% housing occupied by owner

12% of population is African American

27% of population is foreign-born

SECTION SIX

Overview of the Significant Health Needs

The following eleven Significant Health Needs were originally identified in development of the CHNA. The process for identifying and prioritizing the SHNs can be found in the CHNA (Appendix 1).

1. Access to Basic Needs Such as Housing, Jobs, and Food

Access to affordable and clean housing, stable employment, quality education, and adequate food is vital for survival. These Social Determinants of Health influence individual health as much as individual health behaviors and access to clinical care.

2. Access to Mental/Behavioral Health and Substance Use Services

Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is essential for a healthy community.

3. Injury and Disease Prevention and Management

Prevention efforts that reduce cases of injury and infectious disease, and intensive strategies in the management of chronic diseases, are important for community health. Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is essential for a healthy community.

4. Active Living and Healthy Eating

Physical activity and a healthy diet are important for overall health and well-being. Communities experiencing poor health outcomes often face challenges with food insecurity, easy access to unhealthy foods, and limited safe places to recreate.

5. Access to Quality Primary Care Health Services

Primary care services and primary care resources are often the front line in the prevention and treatment of common diseases and injuries in a community.

6. System Navigation

System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems to receive the necessary benefits and supports to improve health outcomes.

7. Access to Specialty and Extended Care

Specialty and extended care services include care provided in a particular branch of medicine and focused on the treatment of a particular disease. Without access to specialists, such as cardiologists and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. Extended care also refers to skilled-nursing facilities, hospice care, and in-home healthcare.

8. Increased Community Connections

A crucial part of living a healthy life is community connections. Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community.

9. Safe and Violence-Free Environment

Feeling safe in one's home and community is fundamental to overall health. Individuals exposed to violence in their homes and community are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.

10. Access to Functional Needs

Functional needs include adequate transportation access and access to basic life needs for all populations, including individuals with physical disabilities. Without transportation, individuals struggle to meet basic needs.

11. Access to Dental Care and Preventive Services

Lack of oral health can lead to preventable chronic diseases, like tooth decay, and contribute to increased risk of other chronic diseases. Poor oral health also impacts school attendance for students.

The following provides an in-depth look at a few key data metrics, both qualitative and quantitative, that support each of the identified top health needs. The complete list of data is available in Appendix I. Where possible, data on health disparities are included. Community Health Status Survey (CHSS), interview participants, and healthcare provider survey quotes are also included to lift community voices.

ONE

Access to Basic Needs such as Housing, Jobs, and Food

Access to affordable and clean housing, stable employment, quality education, and adequate food is vital for survival. These Social Determinants of Health influence individual health as much as individual health behaviors and access to clinical care.

More than half of CHSS respondents (64%) said that **the high cost of living was a major social or economic condition impacting health** in the county[30]

11,895 low-income renter households in Yolo County do not have access to an affordable home (2019)[31]

Average home sale price: **$624,421** (August 2022)[32]

Median household income in 2020: **$73,746**[33]

Annual Inflation Rate, August 2022[34]
Overall inflation rate: **8.3**;
Food inflation rate: **11.4**;
Energy inflation rate: **23.4**

53.8% of Yolo County Children (15,986 kids) eligible for Free and Reduced Price Meals in 2021-22[35]

1 in 3 CHSS survey respondents worried that they would run out of food before they got money to buy more.

> **"My doctor has me on a special diet for my health and I can't buy the food. My rent is more than half my income.**
>
> *CHNA survey response* (Appendix 1)

TWO

Access to Mental/Behavioral Health and Substance Use Services

Individual health and well-being are inseparable from mental and emotional outlook. Coping with daily stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is essential for a healthy community.

More than half **(56%)** of CHSS survey respondents said that mental health was a top health issue impacting the Yolo community (Appendix 2)

Hospitalizations for Mental Health for persons ages 15-24 are **30% higher** in Yolo County than California overall (Appendix 1)

More than half **(51%)** of CHSS survey respondents said that life stress or a lack of coping skills was one of the top three most impactful influences on health issues (Appendix 2)

There are **368.7** mental health providers per 100,000 people in Yolo (Compared to 373.4 statewide)[36]

20.2% of adults reported binge or heavy drinking (age-adjusted)[37]

> **There are various blocks to receiving mental health services, especially for kids. We need to remove barriers by increasing providers, eliminating stigma, making it affordable, etc.**
>
> *CHNA provider survey response* (Appendix 1).

THREE

Injury and Disease Prevention and Management

Prevention efforts that reduce cases of injury and infectious disease, and intensive strategies in the management of chronic diseases, are important for community health.

9.6% of Yolo County Residents have a disability[38]

Number of deaths due to hypertension: Yolo County is **24%** higher than California[39]

13.8% of adults in Yolo County smoke compared to 11.3% across California[40]

Emergency Department visit due to falls for people over 65 and older are **7.6%** higher than the state average[41]

> **I have a respiratory disease, which is asthma. In my daily life, I look like everyone else, but when I get sick, it is very painful, and as long as I take the medicine in time, I can recover immediately, so I have to keep the medicine with me at all times.**
>
> *CHNA key informant response* (Appendix 1).

FOUR

Active Living and Healthy Eating

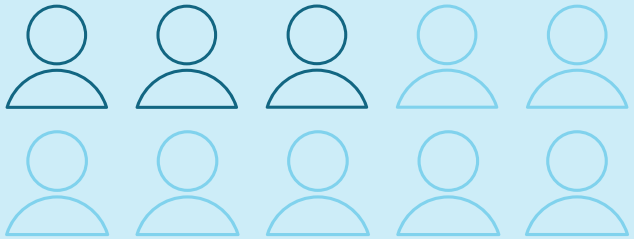
Physical activity and a healthy diet are important for overall health and well-being. Communities experiencing poor health outcomes often face challenges with food insecurity, easy access to unhealthy foods, and limited safe places to recreate.

26,300 food insecure people in Yolo County (12.1% of total pop)[42]

4 out of 5 children ages 5 to 12 were NOT physically active at least an hour every day[44]

7.8% of adults age 20 or older are diagnosed with diabetes (CA: 8.8%)[45]; **11.3%** of CHSS respondents indicated they have been told they have diabetes (Appendix 2).

3 in 10 adults over the age of 18 are obese[46]



Yolo county is **16th of 58** in CA for parks per capita[43]

Yolo Food bank will distribute **12M pounds of food** in 2022, which is twice what they distributed in 2019 (pre-COVID)[47]

CalFresh utilization FY21-22: **20,911 individuals**, up 5% from FY20-21 (Peak Pandemic Year)[48]

> **Some streets are poorly lit, which makes it challenging to feel like I can walk safely with my baby when it is dark.**
>
> *CHNA key informant response* (Appendix 1).

FIVE

Access to Quality Primary Care Health Services

Primary care services and primary care resources are often the front line in the prevention and treatment of common diseases and injuries in a community.

6.8% of residents under age 64 without health insurance; **8.2%** of Hispanic/Latino and **11.9%** American Indian/Alaskan Native[49]

26% of CHSS respondents indicated traveling 20 minutes or longer to get to their regular doctor.

88% of Yolo County Key Informants indicated Access to Quality Primary Care Health Services as a significant health need (Appendix 1).

When asked if they had ever been treated differently by their health provider, including mental health and dentistry, **9.8%** of CHSS survey respondents felt they had been treated differently due to the color of their skin, and **13.2%** felt they had been treated differently due to their gender.

> **"Patients have difficulty obtaining appointments outside of regular business hours.**
>
> *CHNA Provider Survey (Appendix 1)*

20% of CHSS respondents indicated going to the emergency department (ED) because they could not get an appointment with their doctor.

SIX

System Navigation

System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems to receive the necessary benefits and supports to improve health outcomes.

Relations between law enforcement, healthcare systems, and the community need to be better coordinated.

-CHNA Provide survey (Appendix 1)

78% of Health Service Provider Survey respondents indicate that System Navigation is the most significant health need.

-CHNA Provider Survey (Appendix 1)

13.1% of CHSS respondents indicate they were unsatisfied with how quickly they could get a doctor appointment.

> **The area needs more navigators to help get people connected to services.**
>
> *CHNA Provider Survey* (Appendix 1)

SEVEN

Access to Specialty and Extended Care

Specialty and extended care services include care provided in a particular branch of medicine and focused on the treatment of a particular disease. Without access to specialists, such as cardiologists and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. Extended care also refers to skilled-nursing facilities, hospice care, and in-home healthcare.

Alzheimer disease mortality is **10% higher** in Yolo than the State[50]

Breast cancer is **9% more prevalent** in Yolo County than in CA

Lung Cancer is **13% more prevalent** in Yolo County than in CA (Appendix 1).

Yolo County is considered a Medically Underserved County[51]

> **The area needs more extended care options for the aging population (e.g., skilled nursing homes, in home care).**
>
> CHNA Key Informant response (Appendix 1).

> **Wait times for specialist appointments are excessively long.**
>
> CHNA Key Informant response (Appendix 1).

EIGHT

Increased Community Connections

A crucial part of living a healthy life is community connections. Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community.

The average Yolo County Household spends **27%** of its income on Childcare (for 2 children).[52]

74.2 % self-response rate in 2020 Census (CA was 69.9%)

83.1% turnout among registered voters in 2020 General Election (CA was 80.7%), **65.6%** voter turnout among eligible voters (CA was 70.9%)[53]

People in the community lack representation of BIPOC (Black and Indigenous People of Color) communities in local service providers.

Relations between law enforcement, healthcare systems, and the community need to be better coordinated.

CHNA key informant responses (Appendix 1)

NINE

Safe and Violence Free Environments

Feeling safe in one's home and community is fundamental to overall health. Individuals exposed to violence in their homes and community are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.

Incidence of child entry into CWS is **8-10x higher** in AA communities than all others[54]. Structural, cultural, and institutional racism are factors that contribute to the racial disproportionality among CWS cases.[55]

FIREARM FATALITIES RATE

Number of deaths due to firearms per 100,000 population: **5.3**.

There were **61 firearm fatalities** in Yolo County from 2016-20 a **15% increase** since 2011-15[56]

VIOLENT CRIME RATE

Number of reported violent crime offenses per 100,000 population: **331.9**[57]

JUVENILE ARREST RATE

Felony juvenile arrests per 1,000 juveniles: **2.6** (Yolo County)/**2.1** (State)[58]

> **There are not enough resources to address domestic violence and sexual assault in the county.**
>
> CHNA focus group (Appendix 1)

TEN

Access to Functional Needs

Functional needs include adequate transportation access and access to basic life needs for all populations, including individuals with physical disabilities. Without transportation, individuals struggle to meet basic needs.

Out of all the workers who commute in their car alone, **31.9%** commute more than 30 minutes (CA:42.2%)[59]

8.0% of occupied housing units have no vehicles available (CA: 7.1%)[60]

> **The geography of the area makes it difficult for those without reliable transportation to get around.**
>
> *CHNA Focus Group* (Appendix 1).

13.4% households don't have reliable internet at home (CA:13.1%)[61]

ELEVEN

Access to Dental Care and Preventative Services

Lack of oral health can lead to preventable chronic diseases, like tooth decay, and contribute to increased risk of other chronic diseases. Poor oral health also impacts school attendance for students.

- Average wait times at Community Clinics for dental appointments have increased from **30** days in 2016 to **60** days in 2022[62]
- **19%** of Yolo County Dentists accept MediCal Dental, but only **6%** are accepting new patients [63,64]
- Emergency visits for persons aged 18 and older with dental problems as primary diagnosis per 100,000 population: 433 (CA: 277)[65]

2019-20 school screening decay rates: average of **37%** for kindergarteners screened; **28%** 3rd graders[63]

There has been a real shortage of Registered Dental Assistants (RDAs) and Registered Dental Hygienists (RDHs)

..... the need for dental care is still there, but we are not able to provide enough access because of a RDA and provider shortage.
2022 Yolo County Oral Health Needs Assessment

> **There aren't enough providers in the area who accept Denti-Cal**
>
> *CHNA Provider Survey* (Appendix 1).

SECTION SEVEN

Community Assets

Despite the health issues and disparities that exist in Yolo County, many assets and strengths are present to help improve access and availability of the resources a community needs to thrive. The community itself is an asset, as seen in the demonstrated resiliency and strength during the 2020 COVID-19 pandemic. Yolo County experienced some of the highest vaccination rates in the region, including vaccination of over 80% of farmworkers, largely due to strong community connections among trusted leaders, partners, and residents. This resiliency and the community pride often felt within each of the distinct cities and communities can be put into play as interventions are identified. Several approaches were taken during the data collection phases of the CHNA and CHA to help name and quantify some of the community assets and strengths.

During CHNA development, CHI identified 367 resources to support the community's mental and physical health needs. These resources were shared by the 112 individuals and organizations that contributed information to the CHNA. A summary of the assets, categorized by the SHN they relate to, are listed in Table 1. Some assets might be included in the number for more than one SHN. A full list of identified resources can be found on page 44 of the CHNA report (Appendix 1).

CHSS also included questions about community assets and resources. When asked about their top trusted leaders and institutions, survey respondents chose the following. (Appendix II)

Making connections with trusted leaders and institutions will be essential to success when CHIP priorities are selected, and decisions are made about who is included in discussions about intervention strategies.

Fig: 15: Top Trusted Leaders, based on response frequency in 2021 CHSS

Fig: 16: Top Trusted Institutions, based on response frequency in 2021 CHSS

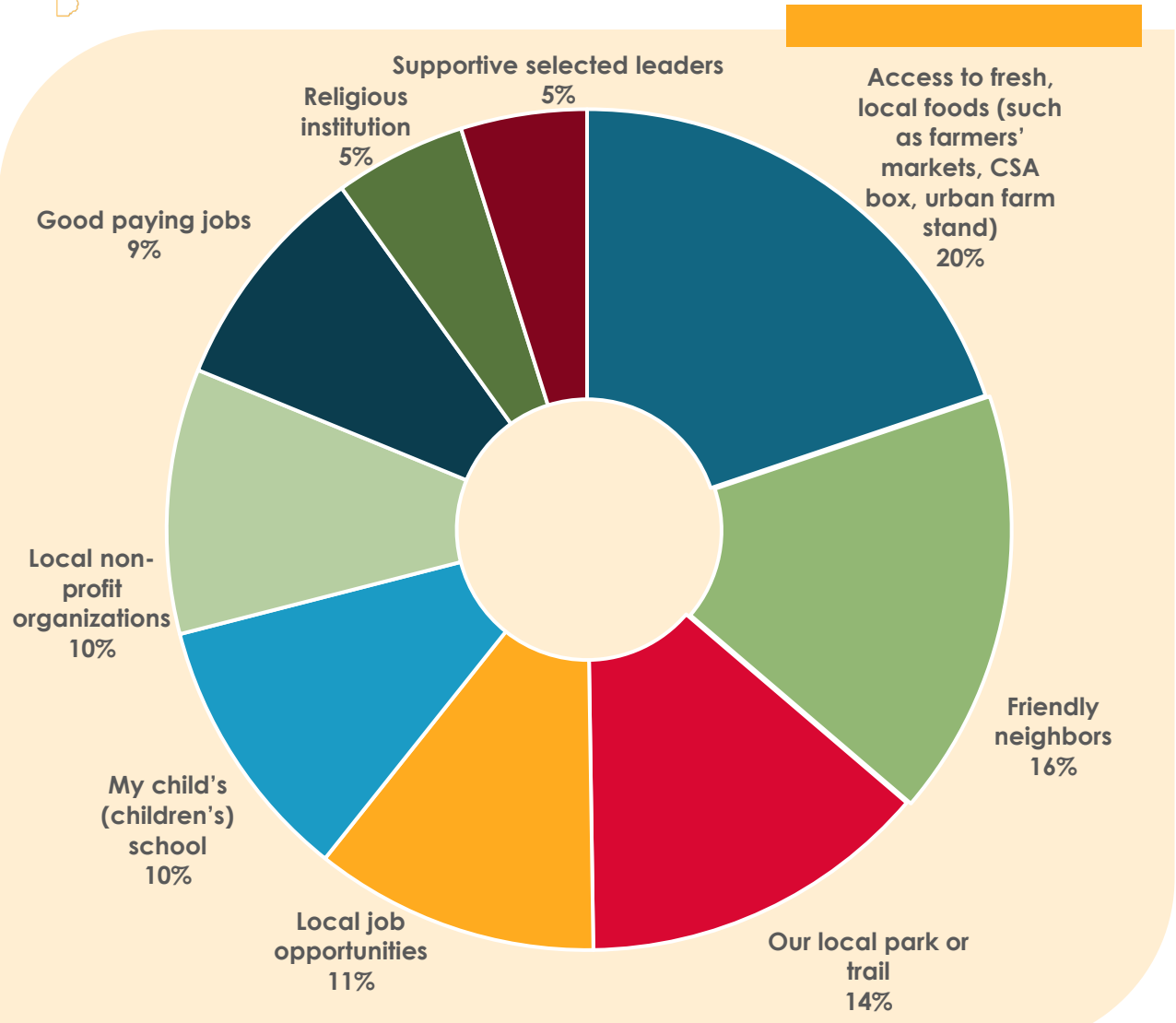


Fig. 17: Community's Top Strengths, based on response frequency in 2021 CHSS

Finally, CHSS respondents named their community's top strengths in supporting physical and mental wellbeing. Response themes focused on local farmers markets, neighbors, trails, and more. See Figure 15 for responses.

The CHSS provides unique resident insight into the way that our community members view the strengths and assets in Yolo County. Collectively, all the resources and assets identified can help address the top health needs of the Yolo community. Developing a plan to use the existing resources and assets with clear goals is a primary objective of the CHIP.

SECTION EIGHT

Next Steps – Developing the Community Health Improvement Plan (CHIP)

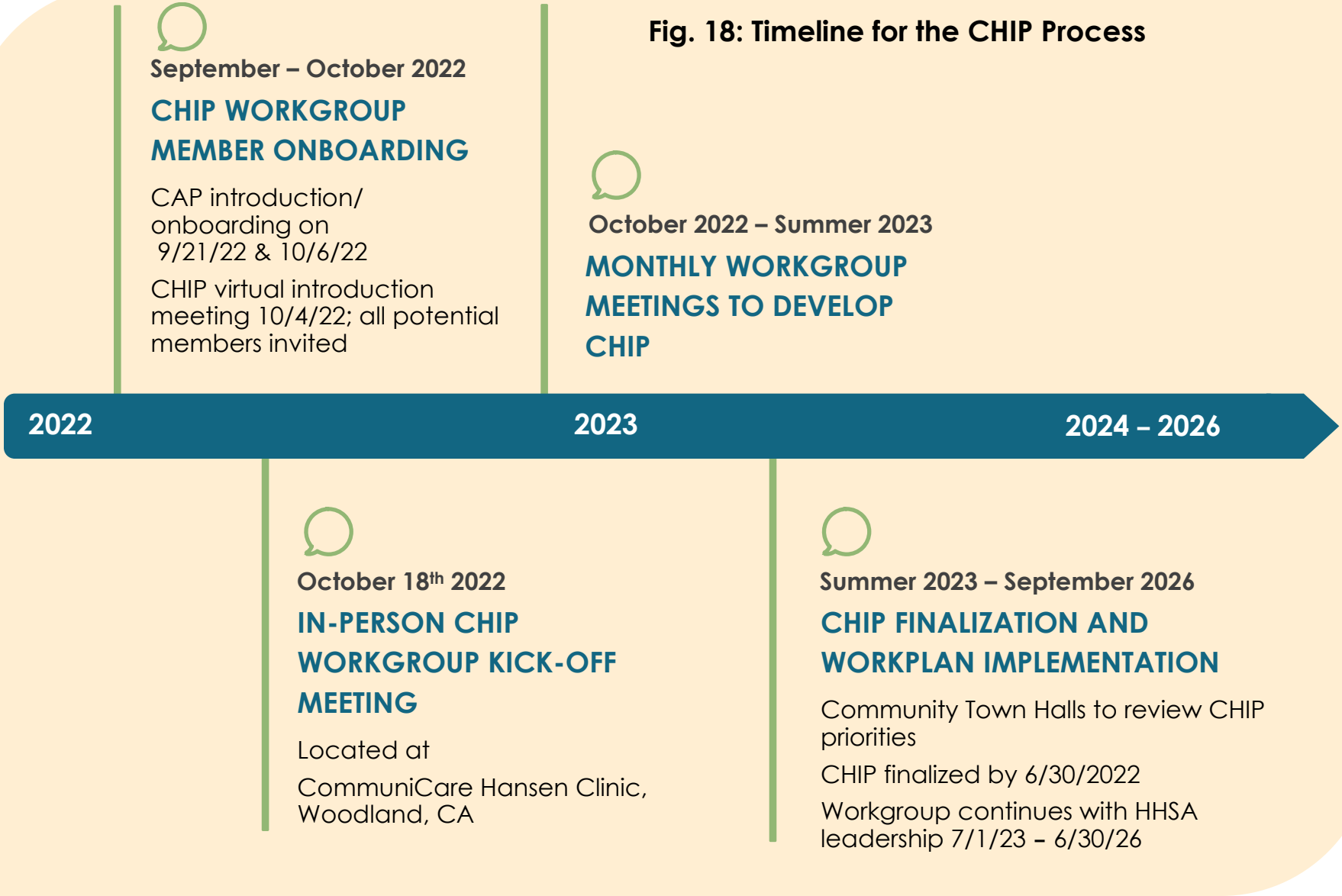
The CHIP development process is a pathway for the community to collectively design interventions and strategies to help reduce disparities or barriers to health and wellbeing, particularly for those groups that experience disparities the most. Development of the CHIP began in October 2022. HHSA, in partnership with RDA consulting, is facilitating the CHIP workgroup that includes residents, County program staff, and community-based partners. The CHIP development process includes these phases:

1. **A Review of the CHA to select up to three priority areas for the CHIP for the next three years**
2. **Development of an action plan and timeline to address each of the priority areas chosen**
3. **Identification of assets, resources, funding, and partners who can support this work**
4. **Creation of evaluation measures to demonstrate progress and impact in the CHIP priorities**
5. **Communication with the community about CHIP priorities as the CHIP is being finalized**

Community voice is an important part of the CHIP. To support community involvement in the CHIP development, HHSA is piloting the Community Advisory Program (CAP). The CAP includes up to 10 residents from throughout the County to participate in the CHIP workgroups as compensated members. The CAP also includes two trainings for residents prior to the first CHIP workgroup meeting to provide members with public health background about the CHIP and information on what to expect in CHIP meetings. This is part of HHSA's commitment to more impactful and equitable community engagement. CAP members will receive compensation in the form of a stipend for participating in CHIP meetings and doing meeting preparation work, such as reviewing documents being discussed at the CHIP meetings.

Below is an overall timeline for the CHIP process. New partners and residents may be added, based upon the identified priorities and intervention strategies.

Fig. 18: Timeline for the CHIP Process



Communication of the CHA and CHIP

The power of the CHA and the CHIP lives in how they are communicated and put into use to bring about positive changes in how programs, services, and policies influence health. The CHA and the CHIP are public-facing documents, meaning that residents and community partners will have access to these documents. HHSA will be intentional in the approach to sharing the CHA and CHIP with the community. The CHA and the CHIP will be located on the HHSA Healthy Yolo Webpage: www.healthyolo.org. Executive summaries of each will be made available in English, Spanish, and Russian as well.

The following are additional strategies HHSA will adopt to share the CHA and CHIP with the community.

This communication plan may change as the CHIP workgroup priorities are identified and a specific communication approach is needed.

- Holding a 21-day public review process before the draft CHA is finalized
- Hosting a public learning session where HHSA staff will present the CHA to the community
- Sharing the CHA with the CHIP workgroup members and encouraging them to share with their respective clients and community partners
- Providing an executive summary of the CHA in Spanish and Russian, the threshold languages in Yolo County
- Using infographics to share important data points on the Healthy Yolo webpage
- Posting updates about CHIP workgroup meetings (agendas/notes) on the Healthy Yolo website
- Press Release: SHNs press release was sent out on 7/1/22; an additional press release will be sent out when the CHIP is complete
- Inviting HHSA programs and leaders to read the CHA and share it with their partners and clients
- Social media update on Facebook and the County's Twitter page to release each document
- Asking CHIP workgroup members for feedback on additional ways to share the CHA and CHIP
- Highlighting CHIP implementation successes through various media outlets

Fig. 19: Communication strategies for the CHA and the CHIP

SECTION NINE

Impact of COVID on the CHA findings

The COVID-19 pandemic has put a spotlight on existing health inequities in Yolo County as we observe the disproportionate impact of COVID-19 on communities of color with rates of illness that exceed their representation in the population throughout the Country. As of October 10, 2022, Yolo County has confirmed 47,644 cases of COVID-19.[66]

Between March 2020 – March 2022 **Communities of Color were more at risk for COVID-19 infection** statewide and in Yolo County

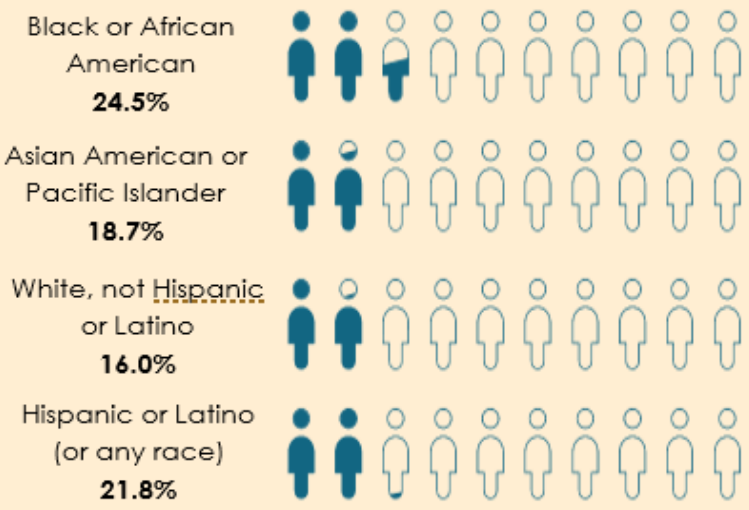


Fig. 20: COVID-19 Infection Rates in Yolo County Residents, by Race/Ethnicity March 2020 - 2022 on Communities of Color[72]

However, COVID-19 did not impact all Yolo County communities in the same way. Since the start of the pandemic in 2020, 24.5% of all African American (AA) residents experienced COVID-19 infection.[67]

Similarly, 18.7% of the Asian community experienced COVID-19 infection.[68]

Approximately one in five (28.2%) Hispanic/Latino residents experienced COVID-19 infection, and this group represents 40.6% of all COVID cases between March 2020-March 2022.[69] Between March 2020 – March 2022, Communities of Color were more at risk for COVID-19 infection statewide and in Yolo County, but did not experience more disease severity or death.[70] Asian communities experienced the highest COVID-19 infection incidence rates in Yolo County.[71]

Geographically, the distribution of COVID-19 also varied, with Woodland having the highest number of cases and Davis the lowest overall, though the case distribution changed throughout the pandemic.[72]

These disparities and trends echo other health disparities and their underlying causes previously discussed in this document. Additionally, the COVID-19 pandemic had a profound impact on the way of life and business for the entire world, outside of the impact of the disease itself.

Thus, health data captured during the peak of COVID-19 shut-downs and restrictions may not accurately reflect true rates of physical or mental health needs. Some medical/dental/mental health services were limited during shutdowns, and many individuals chose to delay care to minimize disease exposure risk.

Further, as unemployment increased, individuals may have lost healthcare benefits as a result, which may have impacted their ability to address any physical or mental health needs.

COVID-19 vaccination rates for Yolo County residents also reveal disparities among race/ethnicity groups. Overall, COVID vaccination rates for the primary series (either a single dose, or two doses, depending upon vaccine maker) show that Yolo County is slightly below the state average (71.0% for Yolo overall, and 72.4% for CA overall). However, rates for all race/ethnicity groups except White and Asian were lower than the state/county average overall (Figure 21).

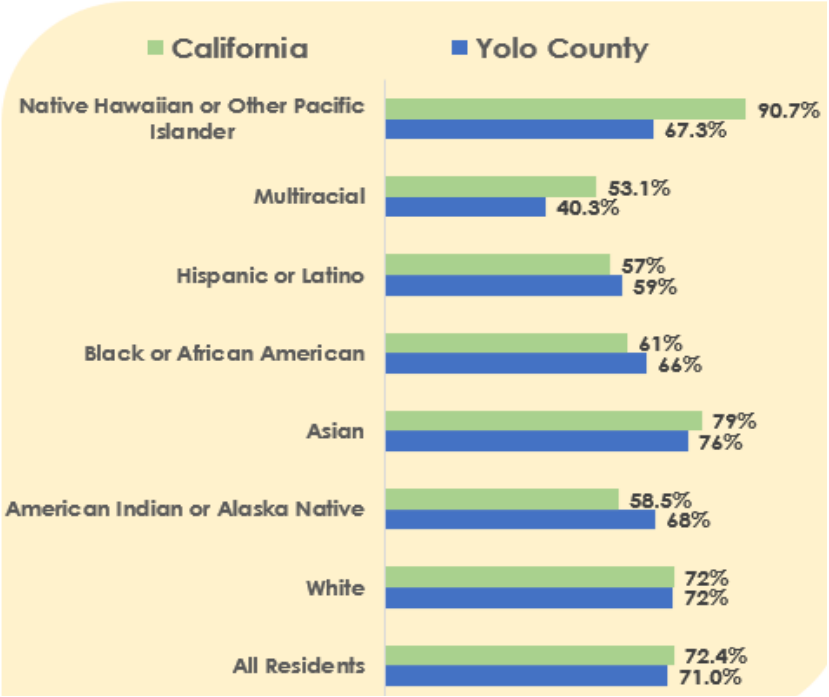


Fig 21: Vaccination Rates by Race/Ethnicity Yolo County vs California Average[72-73]

Given that communities of color are also impacted by other health, education and economic disparities, these data reinforce the need to address gaps in social determinants of health for priority populations.

In 2021 Yolo County received a grant to partner with and fund community-based organizations on promotion of COVID-19 vaccine uptake, particularly among underserved, rural, and minority communities. Efforts were made to share vaccine facts and information about how to get vaccinated.

Vaccine access was increased through offering COVID-19 vaccines at migrant centers, at residents' homes, at faith-based centers, and other venues, such as food distribution sites and community events, to help remove time and travel barriers for residents.

Partners worked with resident champions and trusted leaders within various communities to build trust and share accurate information. Phone lines were created to provide vaccine information in English/Spanish/Russian, and materials were also shared in these three languages as well as other languages when available.

During the 6-month grant period, various barriers to vaccine uptake and vaccine hesitation were identified. Barriers identified included general distrust of government and vaccinations, religious beliefs, lack of information or understanding of the purpose and benefits of vaccination, lack of time, and even concerns about having to take time away from work to recover from vaccine side-effects.

These barriers were not consistent across all groups, and variability in vaccine uptake rates could be due to the concerns mentioned, as well as differences in social norms among groups for accepting vaccines, and language barriers to information about vaccines. Rates for Hispanic, African American, and American Indian/Alaskan Native Yolo residents are higher than rates for these groups state-wide, suggesting that the concerted efforts to reach all residents with COVID-19 vaccines in Yolo County did improve uptake for these groups compared with the state overall.

Finally, the impact of school shutdowns on children's academic progress is something that is yet to be fully seen.

COVID-19 impacts on unemployment meant that more individuals were also applying for benefits such as Medi-Cal and CalFresh and had to learn how to navigate those processes and services. Based on Yolo County CalFresh program data, between July 2019 and June 2022 there was 19% increase in the number of families utilizing CalFresh, and that jump began in April 2020 shortly after pandemic shutdowns. This is one metric to demonstrate the dramatic shift in life circumstances that many individuals experienced.

The ripple effect of the COVID-19 pandemic on health and quality of life outcomes will not be fully known for years to come. It's important to review the information presented here with that perspective, and to apply what is already known about the structural inequities that existed before COVID and were elevated during COVID when looking ahead at long-term solutions to support a high quality of life and positive health outcomes for all residents.

Appendices

Appendix I

COMMUNITY HEALTH NEEDS ASSESSMENT

https://www.yolocounty.org/home/showpublisheddocument/74781/637998705177229989

Appendix II

COMMUNITY HEALTH STATUS SRUVEY DATA TABLES AND SURVEY INSTRUMENT

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