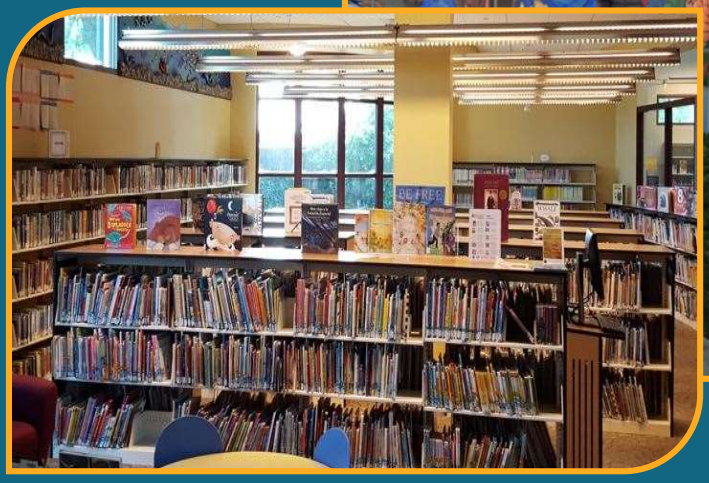

Yolo County 2023
Community Health Improvement Plan

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Founded 1850

Yolo County 2023
Community Health Improvement Plan

This report was developed by RDA Consulting under contract with Yolo County Health and Human Services Agency.
RDA Consulting, 2023

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Table of Contents

Acronyms

Acronyms that are used frequently throughout this Community Health Improvement Plan:

- **CAP** Community Advisory Program
- **CBO** Community Based Organization
- **CHA** Community Health Assessment
- **CHNA** Community Health Needs Assessment
- **CHIP** Community Health Improvement Plan
- **CHSS** Community Health Status Survey
- **HDI** Human Development Index
- **HHSA** Yolo County Health & Human Services Agency
- **PHAB** Public Health Accreditation Board
- **SDoH** Social Determinants of Health
- **SHNs** Significant Health Needs

Additional definitions of commonly used words and terms used throughout the CHIP are included in Appendix A.

Executive Summary

A community health improvement plan (CHIP) is a long-term, systematic effort to address public health problems based on the results of Community Health Assessment. The 2023 CHIP was developed collaboratively by the Yolo County Health and Human Services Agency (HHSA) Public Health Branch, cross-sector partners, organizations, and community members. The CHIP provides a community-level plan of action in response to the 11 Significant Health Needs (SHNs) identified in the 2023-2025 **Community Health Assessment (CHA)**.

Significant Health Needs (SHNs)

- **Access to Basic Needs Such as Housing, Jobs, and Food**
- **Access to Mental/Behavioral Health and Substance Use**
- **Injury and Disease Prevention and Management**
- **Active Living and Healthy Eating**
- **Access to Quality Primary Care Health Services**
- **System Navigation**
- **Access to Specialty and Extended Care**
- **Increased Community Connections**
- **Safe and Violence-free Environment**
- **Access to Functional Needs**
- **Access to Dental Care and Preventative Services**

Following CHA completion, HHSA convened a CHIP planning and development workgroup. The workgroup included approximately 50 people representing cross-sector partners, healthcare providers, community-based organizations, and community members. The workgroup identified two Health Priorities with corresponding Goals. It also identified Objective Themes, Strategies, and Measures of interest to improve health equity, support community wellness, and improve health outcomes across these Priority Areas. This concluded Phase I of the CHIP process.

HEALTH PRIORITY AREA

Service Environment

GOAL

All community members can easily access quality behavioral health, physical health, and wellness services.

HEALTH PRIORITY AREA

Risk Behaviors

GOAL

All children and youth will thrive and develop their healthiest behaviors.

The CHIP is based on the following guiding principles set by HHSA:

- **Social Determinants of Health (SDoH).** Working to address upstream community needs (e.g., access to education, jobs, and safe living conditions).[1]
- **Health Equity.** Ensuring that every community member has a fair and just opportunity to achieve their highest level of health.[2]
- **Collective Impact**. A framework to support aligned, collaborative, and measurable efforts.[3]

Furthermore, the workgroup created a Vision and a set of Values that communicate the desired impact of the CHIP and provide direction in all CHIP work. The Vision and Values, as well as the guiding principles, will continue to support CHIP implementation, annual action planning, and evaluation efforts.

CHIP implementation, Phase II, will begin with a relaunch of Healthy Yolo in early 2024. Healthy Yolo is a collective impact partnership coordinated by the Public Health Branch. It was formed to address the SHNs identified the County's first CHA in 2015.

Following a period of pause due to the COVID-19 pandemic, Healthy Yolo will relaunch and renew its focus on leading, convening, and supporting cross-sector partners to positively impact the health and wellbeing of those living in Yolo County.

The CHIP is a living document that is responsive to community and partner needs. As such, Healthy Yolo will continue to develop the ideas and priorities identified by the CHIP workgroup in late 2022-23. Formal adoption of SMART Objectives and timelines for Strategies will be established by HHSA and Healthy Yolo to support a clear implementation plan and evaluation of the impact of CHIP strategies on improving the health and wellbeing of people in Yolo County. As such, the current CHIP is the first of two phases. Phase 1 had a focus on planning and prioritization and Phase 2 will focus on implementation and evaluation.

Message from the Public Health Department

Dear Yolo County Community,

We are honored to present our 2023 Yolo County Community Health Improvement Plan (CHIP).

The Yolo County CHIP is not just a document; it is a promise. It is a promise to work together to ensure that every resident, regardless of their age, race, gender, or socioeconomic status, has an equal opportunity to lead a healthy and fulfilling life. It recognizes that good health is not only the absence of disease, but also the presence of physical, mental, and social well-being.

The CHIP offers a guide to priorities and strategies for addressing the most significant health challenges facing our community. This plan is the result of a collaborative effort between Yolo County Health and Human Services Agency Public Health Branch (HHSA), a multi-sectoral partner group of 25 agencies, and a group of community advisors.

CHIP development and implementation has two phases. Phase I began with a review of the 11 Significant Health Needs (SHNs) identified in the 2022 Community Health Assessment (CHA), populations most impacted by them, and common underlying causes of these SHNs. Health equity and the social determinants of health (SDOH) were at the forefront of discussions and decisions surrounding the proposed health priority areas, objectives, strategies, and metrics for implementation. Two priority areas emerged in Phase I:

1. Improving the Service Environment
2. Decreasing Engagement in Risk Behaviors

Implementation of the CHIP, Phase II, will commence with a relaunch of Healthy Yolo – a multi-sector collaborative strategically aligning its work to carry out specific CHIP strategies over the next several years. CHIP implementation will link up with initiatives in the County that are addressing similar priorities to maximize impact and best support the health and wellbeing of our community members.

Finally, Phase II efforts will reflect the vision and values developed in Phase I:

CHIP Vision: Yolo County is a Place Where Everyone Can Thrive
CHIP Values: Equity, Innovation, Collaboration, Community Engagement

We are excited for the work ahead, and more importantly for the changes that will be seen, from policy to programs, as we collaborate to make Yolo County a place where everyone thrives.

Sincerely,
Brian Vaughn – Yolo County Public Health Director
Dr. Aimee Sisson – Yolo County Public Health Officer

Introduction

Overview

The Community Health Improvement Plan (CHIP) is a long-term, community-focused roadmap that guides the work of public health agencies and community partners to ensure community members can achieve their highest quality of life and optimal health. The CHIP provides a Vision for health in Yolo County and a community-wide strategy to respond to and address the Significant Health Needs (SHNs) that were identified in the Community Health Assessment (CHA).

HHSA is invested in the CHIP to improve health and wellbeing in a sustainable way. The CHIP strengthens community partnerships and works to improve coordination, collaboration, and accountability among organizations and the community. Additionally, alongside the CHA, it serves to increase community knowledge about public health and how public health activities and actions can improve health outcomes for all community members across Yolo County.

The engagement of community partners and community members in the development of the 2023 CHIP exemplifies public health best practices for community and partner collaboration in addressing local health needs.

Community Health Assessment Findings

This CHIP was developed in response to the 11 SHNs and health inequities and health disparities that were identified in the **CHA**.

CHIP implementation will focus on Strategies that address **priority communities** and the identified **foundational issues** that impact health in Yolo County.

Priority Communities: Families living in poverty, rural communities, and communities of color, particularly in West Sacramento and Woodland.

Foundational Issues: Systemic racism, classism, and inequitable access to opportunity.

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

CHIP Vision & Values

The Vision and Values set a common agenda and collective direction among partners involved in CHIP implementation.

VISION

Yolo County is a place where EVERYONE can THRIVE.

VALUES

Equity: We are committed to initiatives, policies, and strategies that address root causes of inequity.

Innovation: We balance use of evidence-based practices with a willingness to be bold and try new approaches.

Community Engagement: We integrate community engagement across all phases of our work, and we use community input to help inform our decisions.

Collaboration: We align efforts to address complex issues for greater impact and sustainability.

CHIP implementation will be guided by a Community Action Plan (Action Plan). Phase I of the Action Plan development, which includes the identified priorities and suggested Objective, Strategy and Measurements, is outlined on pages 13-22. The Action Plan will continue to be refined and aligned with a timeline for action as work moves into the implementation period with Healthy Yolo.

The suggested community-wide Strategies will be reviewed, refined, and prioritized in the implementation phase (Phase II) through the relaunch of Healthy Yolo in early 2024. Healthy Yolo is a collaborative of government and local agency leaders, community members, and community-based organizations (CBOs). Healthy Yolo will review the Objective Themes, Suggested Strategies, and Measures for Consideration in the CHIP to inform their approach to implementation. Additionally, the Healthy Yolo partners will align CHIP implementation strategies with existing efforts that have a similar focus to enhance impact and minimize duplication of efforts.

Structure of the CHIP Community Action Plan

HEALTH PRIORITY AREA
Broad health-related areas, usually identified through a prioritization process of CHA data.

GOAL
A broad & aspirational statement about what it is the community wants to achieve in the noted priority area.

OBJECTIVES OF INTEREST
A statement about what specific work efforts and actions are intended to achieve for the community.

COMMUNITY STRATEGIES
Evidence-based or data-informed actions, decisions, and efforts that will be carried out to meet Goals & Objectives.

MEASURES FOR CONSIDERATION
The data we collect and document to determine the impact of our efforts.

County Overview

Yolo County is located northwest of Sacramento in the agricultural region of California's Central Valley.[4] The county has four incorporated cities (Davis, West Sacramento, Winters, and Woodland) and a population of approximately 222,000 as of 2022 estimates – a 2.6% increase since 2020 and a 10% increase since 2010.[5]

As the population has grown, the county has diversified. While most Yolo County community members identify as White (50%), Yolo County has growing Asian American and Pacific Islander (AAPI) (15%) and mixed-race populations (18%). In addition, more than a third (33%) of community members identify as Hispanic/Latinx (reported separately from race by the United States Census Bureau).[6] Furthermore, almost 40% of community members speak a language other than English, including Spanish.[7,8]

Yolo County is home to the University of California, Davis. As a result, the county has a relatively young population with a median age of 32.7 years and 20% of the total population falling within the 18-to-24-year age group.[9]

A further detailed demographic profile of the county is available in the **2023-2025 Yolo County CHA**.[10]

Health Disparities and Health Inequities

There are existing ***health disparities***,[11] or differences in health outcomes, across Yolo County communities. For example, based on 2020 estimates, community members residing in Southeast Davis (Mace Ranch area) have an average life expectancy of 84.4 years. In comparison, those in Zamora/Knights Landing, Northern Woodland, and the West Capitol area of West Sacramento have lower life expectancies of 82.2, 73.4 and 69.5 years, respectively.[13] ***Health inequities***, such as structural racism, language barriers, and the lack of access to the same care contribute to these disparities.

Community partners must work together to address health disparities and focus work across the ***social determinants of health (SDoH)***.[14] The SDoH are community conditions that impact health, such as racism, classism, and inequitable access to basic needs, education, and good jobs. These community conditions contribute to differences in health outcomes and negatively impact the health of certain groups more than others.

HEALTH DISPARITIES and HEALTH INEQUTIES[12]

Differences in health among population groups are called health disparities. Health disparities that are deemed unfair or stemming from some form of injustices are called health inequities

SOCIAL DETERMINANTS OF HEALTH

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

CHIP Planning & Development Process

CHIP development occurred in two Phases. Phase I began in October 2022 with assembling a multi-sector workgroup that included government, community-based partners, residents, and health care partners. The workgroup met monthly to develop the CHIP between October 2022 and May 2023.

CHIP Development Timeline

SEPTEMBER 2022
HHSA Public Health hosts community-wide webinar setting foundation for CHIP & launches Community Advisory Program

OCTOBER 2022
First CHIP Workgroup Convening & Vision Setting

NOVEMBER – DECEMBER 2022
Identify Health Priority Areas through root cause analysis across the SHNs

JANUARY 2023
Subgroups formed for each Health Priority Area

JANUARY – MAY 2023
Development of Goals, Objectives, Strategies, and Measures

MAY – JUNE 2023
Strategy sharing for community prioritization and feedback & HHSA hosted a community Town Hall to share a CHIP preview

DECEMBER 2023
CHIP finalization and community sharing

JANUARY – MARCH 2024
Healthy Yolo relaunch and CHIP implementation begins

Rather than solidifying specific strategies and measures now, the workgroup decided to build in flexibility for partners to identify the best path forward during implementation.

The approach taken was identifying a menu of possible Objectives/Strategies/Measures that would reduce barriers to health and wellbeing, with a focus on those that would positively impact community members and groups experiencing the greatest disparities.

To begin CHIP development, the workgroup reviewed the 11 prioritized SHNs and applied a root cause analysis to each. This approach was taken after the workgroup came to consensus that identifying and addressing common root causes to individual SHNs in the CHIP would have more impact than focusing on an individual SHN.

Through this process, the workgroup selected two Health Priority Areas – **Service Environment** and **Risk Behaviors** – to focus on over the next three years.

The SHNs that are addressed by each of the two priority areas are listed in the Community Action Plan section below.

Following the identification of these Health Priorities, the workgroup then set Goals, identified Objective Themes of interest, and suggested Strategies for implementation and outcome Measures to be considered during the implementation phase.

CHIP Workgroup members gathered for the mid-CHIP planning celebration in May 2023.

Convening Partners:

Two steps were taken to prepare for convening the workgroup to develop the CHIP. First, HHSA hosted a community-wide webinar in September 2022. The focus of the webinar was to increase community awareness about the SHNs and the CHA/CHIP work, and to create a common language around public health concepts, such as the SDoH, health equity, and collective impact and discuss how each would serve as a guiding principle for the CHIP.

The second step was a CHIP kick-off meeting specifically for the workgroup members. During this meeting, attendees were introduced to the CHA, including its health findings and SHNs. The meeting also included an overview of the CHIP development process.

CHIP Workgroup members during the planning kick-off meeting in the fall of 2022.

In September 2022, HHSA developed and launched the **Community Advisory Program** (CAP) to create more opportunities for community members to participate in CHIP development. The CAP recruited community members, ages 14 and older, to participate in CHIP development and share their lived experience as community members. The eight participating Community Advisors represented the communities of Davis, Esparto, Guinda, West Sacramento, Woodland, and Zamora. The CAP offered additional onboarding sessions as well as a stipend of $25/hour for the community expertise CAP participants was provided.

CHIP workgroup membership and CAP representatives are included in the **Acknowledgements**.

CHIP Guiding Principles for Development

- **Social Determinants of Health (SDoH).** Working to address upstream community needs (e.g., access to education, jobs, and safe living conditions)
- **Health Equity.** Making sure that every community member has a fair and just opportunity to achieve their highest level of health.
- **Collective Impact.** A framework to support aligned, collaborative, and measurable efforts.

CHIP Development:

Between October 2022 and May 2023, the CHIP workgroup convened eight times to develop the CHIP Health Priority Areas and Goals, as well as a menu of Objective themes, suggested Strategies and Measures for consideration during implementation. The first meeting was held in-person in Woodland, CA, and the following meetings were virtual. The CHIP workgroup discussions and decisions focused on equity and the SDoH as foundational to improving lives and health in Yolo County.

CHIP Milestones: Creating a Vision and Values

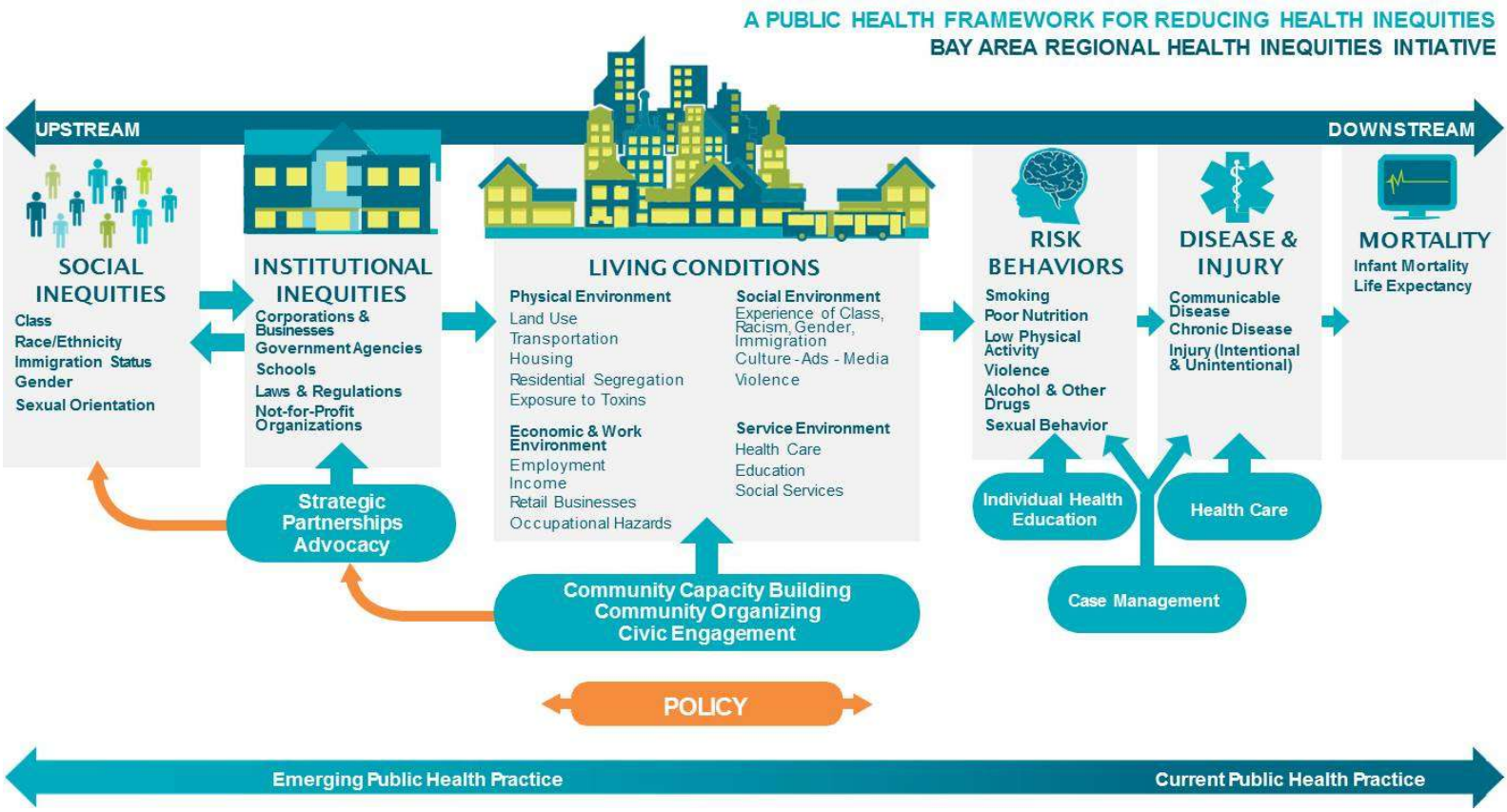
In October 2022, the workgroup completed a visioning exercise to answer the question, "What will this CHIP accomplish if we do our very best?" During the spring of 2023, the workgroup revisited the visioning work to address the question, "What would your community at its healthiest look like, be like, and feel like?" These activities led to the development of a unified Vision for the CHIP as well as Values for guiding the work and convening new partners during implementation.

CHIP Milestones: Defining Health Priority Areas

Identifying underlying health inequities and disparities was critical to addressing the root causes of the 11 SHNs.

To complement the root cause analysis exercise, the workgroup reviewed *The Public Health Framework for Reducing Health Inequities*, developed by the Bay Area Regional Health Inequities Initiative (BARHII) [**see Figure 1**]. This increased group understanding of the social and systemic factors affecting health outcomes and led to discussion of upstream approaches for collective action. This also helped to inform the two Health Priority Areas for the CHIP: After the Health Priority Areas were selected by the workgroup, subgroups were then formed to focus on identifying Goals, Objectives, and Strategies.

Figure 1. The Public Health Framework for Reducing Health Inequities[15]



CHIP Milestones: Identifying Priorities, Goals, Objectives, Strategies & Measures

From January through May 2023, the workgroup and the newly formed Health Priority Area subgroups convened monthly to continue building the Community Action Plan. The workgroup and subgroups identified a Goal under each Health Priority Area as well as Objectives Themes, suggested Strategies, and Measures for consideration. The Action Plan framework can be found on page 28. Workgroup members also identified potential partners who could bring specific leadership, expertise, or advocacy to the implementation phase of the CHIP process.

CHIP Milestones: Community Sharing & Feedback

In May 2023, a virtual community town hall was held to provide an overview of the CHIP planning and development process as well as a preview of the Community Action Plan. The two Health Priority Areas and their associated Goals and Strategies were shared, and participants had the opportunity to ask questions and provide input on the Strategies.

Additionally, throughout May 2023, HHSA staff attended ten community events such as farmers' markets, food bank distributions, a bike rodeo, farmworker resource events, and others to share a preview of the Community Action Plan and collect community feedback.

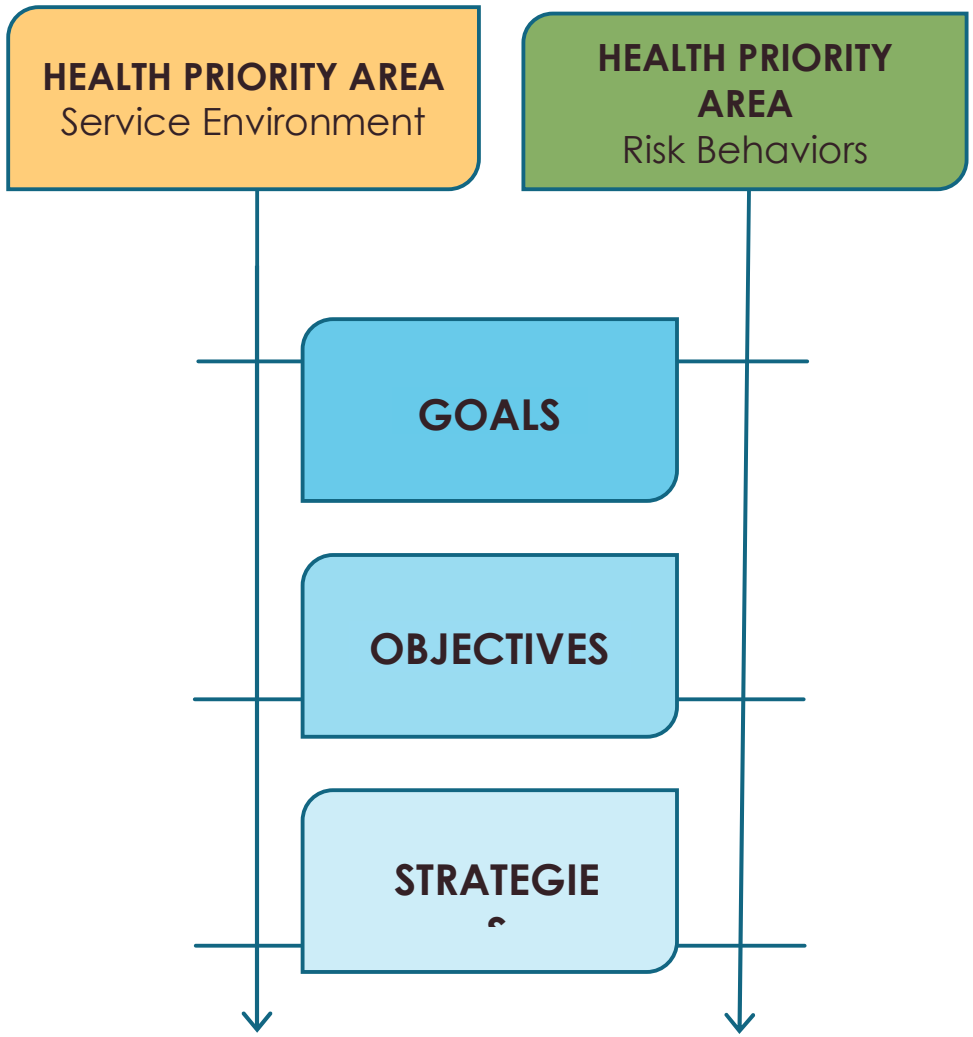
Community members were asked to help prioritize the proposed Strategies. A digital survey was made available for online feedback as well during this time.

Nearly 300 community members provided input during the CHIP planning and development process through workgroup participation, town hall attendance, and community outreach events.

Phase 1: Identifying Priorities for Community Action Plan

The Community Action Plan outlines the Health Priority Areas, Goals, Objective themes, Strategies, and Measures for consideration which HHSA, Healthy Yolo, community members, and partners will use as a menu for health improvement activities over the next three years. As work shifts from CHIP planning and development (Phase 1) to CHIP implementation (Phase 2) in early 2024, the Objective themes, Strategies, and Measures proposed here will continue to be refined. Some Objective themes will be further developed to become "SMART" (**s**pecific, **m**easurable, **a**chievable, **r**elevant, and **t**ime-bound) Objectives and timelines will be set for Strategy implementation. Other Objectives will not be pursued. These refinements and updates to the Community Action Plan will be shared through annual plan updates during the CHIP implementation period.

Community Action Plan Structure



Health Priority: **Service Environment**

Goal: Community members can easily access quality behavioral health, physical health, and wellness services.

The focus of this Health Priority is to **improve the service environment and ensure equitable access to resources community members need to be their healthiest.**

There are barriers and a lack of access to resources and services, such as early intervention and prevention services. This leads to poor health outcomes for community members, particularly those from marginalized communities, rural communities, and communities of color. In addition, there is insufficient coordination in Yolo County across service systems, such as healthcare, behavioral health, social services, housing, public safety, etc.

The community impact from lack of access and coordination in service delivery results into long waits for needed services, as well as frustrations with not being able to find or connect to services at all. These lack of connections most frequently were attributed to the lack of providers (across primary, specialty, behavioral health, and dental care needs), the lack of trauma-informed and/or culturally responsive services, and the lack of proximity to needed services resulting in transportation challenges.

9.8% of survey respondents felt they had been **treated differently by a healthcare provider due to the color of their skin.**
Source: CHSS

4 out of 5 children ages 5-12 were **not physically active** at least an hour every day.
Source: California Health Interview Survey

13.1% of CHSS respondents reported they were **unsatisfied with how quickly they could get a doctor appointment.**
Source: CHSS

Figure 2. Community Data Snapshot, Service Environment

"One thing that struck me was [the] lack of coordination across systems" (CHIP Workgroup Member)

"I love that Yolo County has so many people committed to addressing issues but [it is] difficult because we're not as coordinated as we could be." (CHIP Workgroup Member)

Health Priority: **Service Environment**

Goal: Community members can easily access quality behavioral health, physical health, and wellness services.

Significant Health Needs

Addressed by the Service Environment Health Priority Area

- Access to basic needs
- Access to specialty & extended care
- System Navigation
- Access to Dental care & preventative services
- Injury disease prevention & management
- Access to functional needs
- Access to quality primary care

Health Priority: **Service Environment**

Goal: Community members can easily access quality behavioral health, physical health, and wellness services.

Category: Service Access and Utilization

Objective Themes of Interest	Measures for Consideration	Suggested Strategies
• Improved referral-making processes and timely referral follow-up by community and providers • Reduced barriers to accessing and utilizing healthcare and community services for Black, Indigenous, People of Color (BIPOC) and marginalized community members	• Percent of adults who report that their physical or mental health is not good *(CDC Places)* • Proportion of community members who report their overall health status to be very good, or excellent, over time *(Let's Get Healthy California)* • Number of community health workers (CHW) or similar positions within community- and government-based organizations *(Baseline to be set in implementation)* • Proportion of adolescents who had a preventive health care visit in the past year *(Healthy People 2030)* • Ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it *(Healthy People 2030)* • Percentage of patients who report having access to culturally and linguistically appropriate services *(Let's Get Healthy California)* • Number of preventable hospital stays *(County Health Rankings (RWJ))*	*Resource Navigation to Connect People to Services:* • Convene partners to support development of a county-wide process/platform for the comprehensive coordination of service identification and referral • Encourage policy makers and cross-sector leaders to support increased funding and recruitment incentives for navigation support positions such as CHWs and *promotores* • Coordinate community-wide service awareness & program overview training opportunities *Coordinated Care Among Community Agencies:* • Communicate with community leaders and policy makers about supporting actions that retain and recruit more behavioral health, physical health, and wellness service providers • Advocate for transparency and partnership in funding decisions across healthcare and community-based organizations *Transportation to Services:* • Advocate for actions that improve public transportation and mobility for underserved and rural communities

Health Priority: **Service Environment**

Goal: Community members can easily access quality behavioral health, physical health, and wellness services.

Category: Improved Trust and Relationships

Objective Themes of Interest	Measures for Consideration	Suggested Strategies
• Increased community engagement among community institutions and agencies • Increased participatior in the CAP • Increased community member participation in Healthy Yolo	• Community member engagement and participation in Healthy Yolo (*Baseline to be set in implementation)* • Reach and coordination of communication between community partners and providers (*Baseline to be set in implementation)* • Number of cross-sector partner convenings hosted (*Baseline to be set in implementation)* • Number of new partnerships and collaborations initiated to support community service and advocacy needs (*Baseline to be set in implementation)*	*Community Engagement and Awareness of Resources Available:* • Develop unified messaging and information sharing across organizations and providers and incorporate non-traditional community communication partners to increase reach within underserved and rural communities • Expand public/private partnerships for increased alignment across community workforce and infrastructure planning and development initiatives

Category: Improved Health Outcomes

Objective Themes of Interest	Measures for Consideration	Suggested Strategies
• Improved mental health among community members • Lower prevalence of chronic diseases (e.g., cancer, heart disease, stroke, diabetes, etc.)	• Percentage of parents who report their child(ren) (ages 6-17) are calm and in control when facing a challenge *(Kids Data)* • Percentage of parents who report their child(ren) (ages 0-17) experienced at least one adverse childhood experience *(Kids Data)* • Proportion of children and adolescents with symptoms of trauma who get treatment *(Healthy People 2030)* • Number of premature deaths in the County *(Health Indicators, Yolo County)* • Percentage of Yolo County population with adequate access to locations for physical activity *(County Health Rankings, RWJ)* Average number of physically & mentally unhealthy days reported in the past 30 days *(County Health Rankings, RWJ)*	*Youth Resiliency:* • Partner with family resource centers to advocate for policies and practices that support child & youth health • Provide and advocate for more programs that equip children, youth, and families with healthy coping skills *Trauma-Informed Training for Providers:* • Establish a process for sharing trainings, lessons learned, and best practices for supporting trauma-informed care *Physical Activity:* • Provide awareness and advocacy to local government leaders and policy makers to support actions that increase access to parks and green space in underserved areas of Yolo County

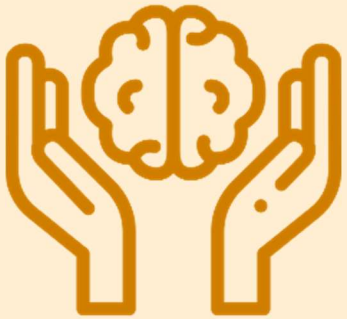
Health Priority: **Risk Behaviors**

Goal: All children and youth will thrive and develop their healthiest behaviors.

The focus of this Health Priority is to **increase protective factors, social connection, and belonging for community members to lead to a decrease in risk behaviors.**

Yolo County communities have continued to report a rise in youth anxiety, depression, stress, and suicidal ideation, as well as negative impacts from substance use disorders (SUD) among both youth and adults. This increase is attributable to many community and societal factors including, but not limited to, COVID-19 pandemic isolation and life disruptions, a lack of SUD services focused specifically on youth prevention, intervention and treatment needs, lack of opportunity and spaces for engagement in healthier behaviors such as physical fitness activities and sports, as well as limited services and resources that are culturally informed or appropriately supported for community members with limited English proficiency.

35% of all CHSS respondents said there was a time in the past 12 months when they felt the **need to see a professional** because of problems with **mental/emotional health or use of alcohol or drugs.**
Source: CHSS



Hospitalizations for **mental health** for persons ages 15-24 are **30% higher** in the county than California overall.
Source: Office of Statewide Health Planning and Development

Approximately **11%** of Community members are **food insecure** in the county.
Source: Feeding America, 2019

Figure 3. Community Data Snapshot, Risk Behaviors

> *"Prevention is easier than a cure - if we can help [the] younger population have a healthy foundation, parents can benefit too."*
> (CHIP Subgroup Member)

Significant Health Needs Addressed by the Risk Behavior Priority Area

- Access to mental/behavioral health & SUD services
- Active living and healthy eating
- Safe & violence-free environment
- Injury disease prevention & management
- Increased community connections

Health Priority: **Risk Behaviors**

Goal: All children and youth will thrive and develop their healthiest behaviors.

Category: Basic Needs

Objective Themes of Interest	Measures for Consideration	Suggested Strategies
• Increased access to basic needs • Increased food and nutrition security • Decreased number of individuals experiencing homelessness	• Percentage of eligible community members who enroll in CalFresh *(CDSS CalFresh Dashboard)* • Proportion of children (ages 0-17) who are food insecure *(Feeding America)* • Proportion of families that spend more than 30 percent of their income on housing *(Healthy People 2030)* • Number of preventable hospital stays *(County Health Rankings, RWJ)* • The number of families impacted by severe housing cost burden *(County Health Rankings, RWJ)* • Number of community members experiencing homelessness *(Health Indicators, Yolo County)*	*School & Community Nutrition:* • Develop greater community awareness of eligibility for food programs such as CalFresh and WIC and build more organizational partnerships to increase access to enrollment opportunities for food programs • Build partnerships with educational system partners, community leaders, and policy makers to prioritize programs, policy, zoning, and designation of funding that increase equitable access to nutritious and nutrient-rich foods in community, school, and childcare settings (e.g., school & community gardens, healthy corner store initiatives, etc.) *Housing and Homelessness:* • Advocate for local government leaders and policy makers to support funding and infrastructure improvements that provide more safe, stable, and affordable housing for community members of all ages • Support increased integration of case managers, social workers, and CHWs in healthcare and social service settings to support community members in accessing and coordinating needed services and resources

Health Priority: **Risk Behaviors**

Goal: All children and youth will thrive and develop their healthiest behaviors.

Category: Adolescent Health

Objective Themes of Interest	Measures for Consideration	Suggested Strategies
• Reduced risk factors for chronic and communicable diseases (e.g., smoking, substance use, physical inactivity, etc.) • Reduced teen pregnancy rate • Improved mental health outcomes in youth • Decreased percentage of 7th graders experiencing depression	• Percentage of 11th grade public school students who report using alcohol or drugs (excluding tobacco) in the previous 30 days *(Kids Data)* • Number of youth ages 10-19 with reported cases of chlamydia and/or gonorrhea *(Kids Data)* • Marijuana, e-cigarette, and smoking use rates for youth *(Health Indicators, Yolo County)* • Percentage of Yolo County public school students (7th, 9th, 11th grade) who reported feeling sad or hopeless almost every day for two weeks or more *(Kids Data)* • Percentage of public-school students who identify as gay/lesbian/bisexual in grades 9, 11, and non-traditional programs who report seriously considering attempting suicide in the previous year *(Kids Data)* • Proportion of adolescents who get formal sex education before age 18 *(Healthy People 2030)* • Proportion of public schools with at least one full-time or part-time counselor, social worker, or psychologist to provide mental health services to students	*Adolescent Risk Behaviors:* • Support increased use and incorporation of evidence-based health education programs addressing sexually transmitted infections (STI) and substance use disorder (SUD) prevention in school-based settings • Convene a youth coalition to inform public health messaging and actions to reduce initiation of risk behaviors (substance use, bullying, social media, etc.) in Yolo's children, youth, and young adults • Advocate for community leaders and policy makers to support policy and funding efforts to increase availability of after-school programs and school-based behavioral health services and resources • Conduct a community-wide assessment to deepen understanding, knowledge, and awareness of suicide prevention services, resources, and needs for youth and young-adults

Health Priority: **Risk Behaviors**

Goal: All children and youth will thrive and develop their healthiest behaviors.

Category: School Readiness

Objective Themes of Interest	Measures for Consideration	Suggested Strategies
• Increased literacy rates among school-aged children • Increased number of children enrolled in kindergarten readiness programs, such as preschool or transitional kindergarten (TK)	• Proportion of children who are developmentally on track and ready for school *(Healthy People 2030)* • Proportion of children who participate in high-quality early childhood education programs *(Healthy People 2030)* • Percentage of third grade students at reading level *(Health Indicators, Yolo County)* • Chronic absenteeism rate *(Health Indicators, Yolo County)* • Percentage of children enrolled in preschool *(Health Indicators, Yolo County)* • Percentage of families engaging in home-visiting and home-based services *(Baseline to be set in implementation)* • Proportion of children who receive developmental screening *(Healthy People 2030)* • Proportion of children with developmental delays who get intervention services by age four *(Healthy People 2030)* • Number of childcare spaces in licensed facilities *(Kids Data)* • Number of parent and baby-friendly worksites *(Baseline to be set in implementation)*	*Early Childhood (0 -5) Universal Health Screenings:* • Develop partnerships to support the integration of behavioral and physical health prevention, screening, and early intervention services into more community-familiar settings (e.g., community resource centers, libraries, etc.) and home-based care services • Expand access to culturally appropriate home visiting programs throughout Yolo County *Early Childhood Education & Supports:* • Advocate for community leaders and policy makers to expand childcare subsidies and to support actions that will increase the number of quality and affordable childcare and preschool options for families • Expand reading and literacy programs to more community-based settings and organizations • Provide technical assistance to community employers to develop and implement policies that support and increase the number of parent and baby-friendly worksites

Community Alignment

There are complementary community initiatives happening in Yolo County. HHSA and Healthy Yolo will prioritize efforts to align CHIP implementation plans with community initiatives already in existence to prevent duplication of efforts and leverage available resources and capacity. The following are examples of aligned initiatives or areas of work currently being supported within Yolo County. Each bolded title also provides a hyperlink to the initiative's website.

- **Mental Health Services Act (MHSA) Three-Year Plan Implementation:** Yolo County conducts a continuous public planning process for implementation of the Mental Health Services Act (MHSA), which involves the development of Three-Year Program and Expenditure Plans and Annual Updates. The Three-Year Program and Expenditure Plans engage community members in naming funding priorities and proposing solutions to community needs as it relates to behavioral health and wellness.[16]

- **Roadmap to the Future:** Roadmap to the Future is a project facilitated by the Yolo County Office of Education. The Roadmap to the Future is a long-term plan to help effectively coordinate the services, supports and opportunities that children, youth, and families in Yolo County need to thrive, as well as establish a shared framework to ensure their healthy development. The roadmap will include a community engagement process, a needs assessment, and asset mapping. As a part of this process, Yolo County leaders have developed a set of principles and shared priorities. These activities and the priorities will inform how the Board of Supervisors will allocate American Rescue Plan funding to support children, youth, and families in Yolo County.[17]

- **Yolo County Strategic Plan:** The 2020-2025 Yolo County Strategic Plan is a guiding document for Yolo County government to align goals and actions, prioritize funding, and set policies over a five-year period. The development of the Strategic Plan includes a community engagement process that gathers input on potential priority topics. The work of the CHIP largely falls within the Strategic Goal of "Thriving Communities."[18]

- **West Sacramento California Accountable Communities for Health Initiative (CACHI):** CACHI is a multi-sector alliance working to promote the health and well-being of community members. CACHI actively convenes stakeholders, increases investments to support health and wellbeing, mobilizes current available resources, and supports various programs and policies that are aimed to improve health equity and health outcomes.[19]

- **Resilient Yolo:** Resilient Yolo is a community-based collaborative that works to strengthen the resilience of Yolo County by providing education on Adverse Childhood Experiences (ACEs) and building strong relationships with local organizations focused on trauma-informed awareness. As part of Resilient Yolo, the ACEs Aware Yolo County Trauma Informed Network of Care (TINOC) is a group of county organizations and leaders convening around common goals, such as increasing awareness of trauma-informed care, increase ACEs screenings, increasing knowledge of ACEs, adopting a shared referral platform, and many others.[20]

CHIP Phase 2: Implementation & Next Steps

The next step for CHIP implementation begins with the relaunch of Healthy Yolo early 2024. Healthy Yolo will be facilitated by HHSA staff. As a first step HHSA will convene CHIP partners, as well as additional agency leaders, community partners, residents, and others. Healthy Yolo will approach CHIP implementation through both short term and long-term timeframes. Short-term, actionable interventions will lead to immediate change, while systems change requires a longer time horizon but may have a greater impact. Together these approaches will ensure impactful, long-lasting change. Figure 4 provides an overview of the CHIP implementation process and relaunch of Healthy Yolo described below.

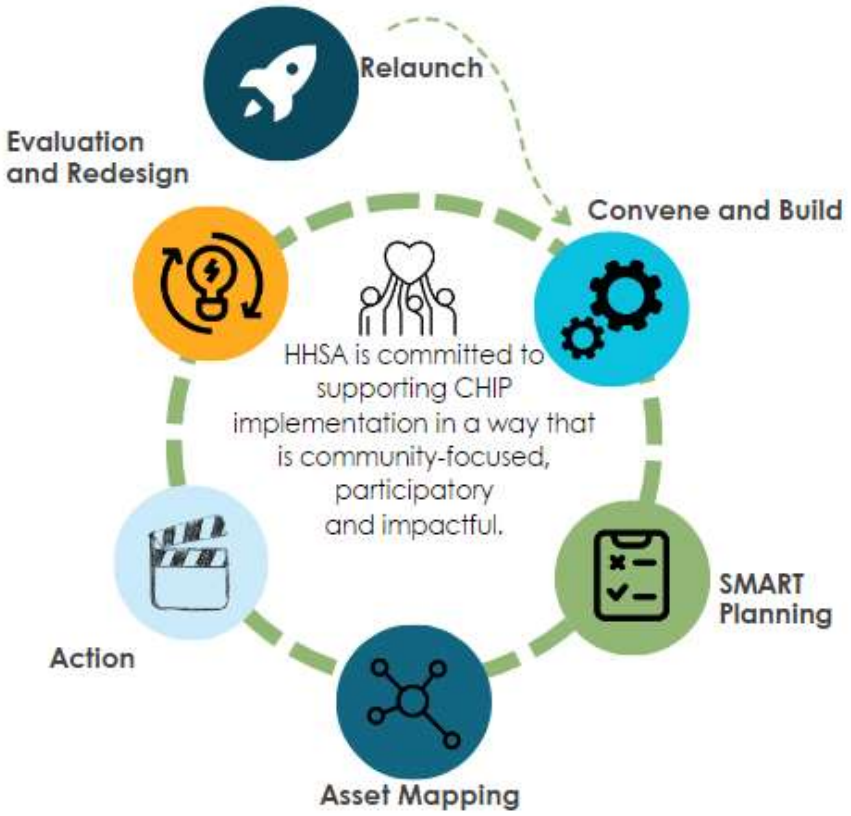


Figure 4: Overview of CHIP implementation and Healthy Yolo Relaunch.

The initial task of Healthy Yolo will be to establish standards and criteria to evaluate the feasibility and impact of the CHIP's Objective Themes to determine which Objectives, Strategies, and Measures are best suited to address the community needs in each Priority Area. This will include reviewing other initiatives working to address similar issues, as discussed in the Community Alignment Section, and determining where CHIP efforts can complement or align with current initiatives. From there, Healthy Yolo will use the established criteria to review CHIP Objective Themes, Measures for Consideration and Suggested Strategies to develop SMART objectives, specific and targeted strategies, and outcome measures to track progress and impact of implementation strategies.

Objectives, measures, and strategies will be based on a 3-year timeframe and will include a plan for annual updates on each Priority Area and Objective. However, the intention of Healthy Yolo is to be forward looking, and CHIP efforts may be part of larger, long-term efforts to address the SDoH's and health inequities.

Community Assets

Healthy Yolo alone cannot successfully reverse long-standing health disparities or inequities. Success requires trust building among partners, community members, and institutions in all sectors of the community. Shared trust among partners and residents is a community asset itself, and one that will underpin the approaches taken to implement CHIP Strategies. Healthy Yolo must also be asset-focused when developing new initiatives and will focus on lifting up and building upon strengths and assets that already exist in the community.

Asset mapping will be a part of developing SMART Objectives and specific Strategies chosen for CHIP implementation. These community assets may be institutions, such as a trusted community-based organization in a neighborhood where an intervention is going to take place. Or they may be something more intangible, such as a strong neighborhood bond or comradery that will help advance and sustain positive change at the community level. Community will be included in the discussions about asset mapping and development of specific CHIP strategies.

An important piece to CHIP implementation and Healthy Yolo will be action. Healthy Yolo will bring the CHIP action plan to life through implementing strategies that create change at a policy, system, or community level. The effectiveness and impact of implemented strategies will be evaluated regularly to course correct or build on successes, whichever is needed to bring about the desired outcome.

Healthy Yolo will have a commitment to transparency and consistent communication with partners and residents. Annual CHIP progress updates will be shared publicly. These updates will include key activities, success stories, or resident/neighborhood stories. To make Healthy Yolo and CHIP updates accessible as possible, HHSA will take the following approaches for communication:

- Healthy Yolo Website- Healthy Yolo meeting information, annual reports, the CHA and CHIP are housed on the website (HealthyYolo.org) and updated regularly
- Executive summary of CHA and CHIP and Annual Reports will be available in English and Spanish
- Press releases and social media will be used to announce new reports such as the CHA or CHIP and to promote community input or engagement opportunities. They will also be used to showcase success stories

- Reports will be widely circulated among partners to ensure they are widely available among all key partners, including those who are not directly involved with CHIP implementation
- HHSA staff commit to attending community and collaborative meetings to present the work of Healthy Yolo and directly engage with partners when invited to do so

Finally, HHSA is committed to supporting CHIP implementation in a way that is community-focused, participatory, and impactful. To support work to achieve the Goals set by the CHIP, and to further its commitment to collective impact, HHSA has designated funds to support involvement of residents and community members in the implementation phase. These funds can be used in the form of stipends for time spent participating in CHIP development and CHIP implementation. Efforts will be made to ensure community representation for those groups most impacted by selected CHIP strategies.

Nonetheless, the guiding principles that led CHIP planning and development will continue to be the guiding principles of CHIP implementation.

Community members may stay connected with Healthy Yolo and CHIP implementation updates by emailing **healthyyolo@yolocounty.org** and/or visiting its website at **www.healthyyolo.org**.

Acknowledgements

CHIP Workgroup Members

The CHIP was developed in collaboration with many partners representing community members, organizations, and agencies throughout Yolo County. Partner organizations include:

Children's Therapy Center
City of Davis
CommuniCare Health Centers
Dignity Health
Empower Yolo
First 5 Yolo
Health Council
Health Education Council
Homeless and Poverty Action Coalition
NAMI
Northern Valley Indian Health
Partnership HealthPlan of California
Progress Ranch Treatment Services for Children
Rise, Inc.
Sutter Health
UniteUs
Western Center for Agricultural Health and Safety (UCD)
Winters Health
Yolo County Children's Alliance
Yolo County HHSA
Yolo County Housing Authority
Yolo County Office of Education
Yolo Farm to Fork
Yolo Food Bank
Yolo Healthy Aging Alliance
Western Regional Agricultural Stress Assistance Program (WRASAP), California AgrAbility Program (UCD)

Community Advisory Program (CAP)

The following community members served as Community Advisors within the CHIP workgroup through the Community Advisory Program. Their participation was invaluable to the development of the CHIP, and we extend our gratitude for their time, insight, and passion for supporting their community.

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Appendices

Appendix A: CHIP Associated Definitions

Setting Common Language & Definitions
Overarching words, concepts, principles of CHIP planning and development

Key Term	Definition	Alternate Terms to Use
CHIP	A long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process.	Community Health Improvement Plan, Community Roadmap, Plan for Action
Equity	When all residents have the rights and opportunities they need to live, grow, and achieve their healthiest and fullest potential.	"All residents, children, youth" *Health Equity* means everyone has a fair and just opportunity to attain their highest level of health
Health Disparity	The preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.	Preventable differences among populations in health and health outcomes
Risk Behaviors	Individual or group actions that increase exposure to potential or experienced harm that impact health and health outcomes / actions or activities that can increase risk of injury and harm to health.	Violence, substance use, self-harm, poor nutrition, lack of physical exercise, unmanaged mental health conditions, unmanaged stress, etc.
Service Environment	All aspects of physical facilities that provide resources and services to residents including locations, communications, and overall accessibility to community members.	Service coordination, service access healthcare, social services, education
Social Determinants of Health	The conditions where people are born, live, learn, work, worship, play, and grow that impact their long-term quality of life, health outcomes, and risk.	Conditions that affect health and wellbeing: housing, employment, environment, education, structural racism, systemic bias

Appendix B: Components of CHIP Community Action Plan

	Priority Area	Goals	Objectives	Strategies	Activities	Measures
Definition	Broad health-related areas, usually identified through a prioritization process of community health assessment (CHA) data	A broad & aspirational statement about what it is you want to achieve in the noted priority area	A statement about what specific work efforts and actions are intended to achieve for the community **S**pecific - **M**easurable - **A**chievable - **R**elevant - **T**ime-Bound –	Evidence based or data informed actions, decisions, efforts that will be carried out to meet Goals & Objectives	Action steps that individuals and organizations will take to plan for and implement Strategies.	The data we collect and document to determine the impact of our efforts Outcome Measures & Process Measures
Plan, Size, & Measurement	Broad, Overarching Difficult to measure (usually intangible/not measurable)	Broad in scope Difficult to measure (usually intangible/not measurable)	Narrow in scope Small chunks, parts of the whole Measurable steps	Specific & Narrow in Scope Identifiable actions and measurable steps	Specific and well-defined steps that lead to achievement of strategic work	Specific and well defined Data available to evaluate
Timeframe	Long-term	Long-term	Medium-Short Term	Medium - Short Term	Short Term	Long- Medium - Short Term
Example	Increase prevention to improve health	Increase access to care	By 2026, 80% of all medical care systems provide information on services in the most common languages spoken in Yolo County	Medical care systems evaluate gaps in languages used for virtual and print materials Assessment completed on 5 most common languages spoken in each city	Healthcare agencies establish internal language gap evaluation teams FQHCs translate all care brochures into top 5 languages	Outcome: 75% of residents whose primary language is not English report having healthcare resources in their primary language Process: number of materials updated
Alternate Words to Use	Priority Theme / CHIP area of focus			Actions, initiatives, efforts		Metrics, data used to evaluate progress

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