SUTTER DAVIS HOSPITAL

2022 Community Health Needs Assessment

Mission
We enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellence in healthcare services.

Vision
Sutter Health leads the transformation of healthcare to achieve the highest levels of quality, access, and affordability.

Community Health Needs Assessment
The following report contains Sutter Davis Hospital's 2019 Community Health Needs Assessment (CHNA), which is used to identify and prioritize the significant health needs of the communities we serve. CHNAs are conducted once every three years, in collaboration with other healthcare providers, public health departments and a variety of community organizations. This CHNA report guides our strategic investments in community health programs and partnerships that extend Sutter Health's not-for-profit mission beyond the walls of our hospitals, improving health and quality of life in the areas we serve.

2022 Community Health Needs Assessment

Conducted on behalf of

Sutter Davis Hospital
2000 Sutter Place
Davis, CA 95616

Woodland Memorial Hospital
1325 Cottonwood Street
Woodland, CA 95695

Yolo County Health and Human Services Community Health Branch
137 N Cottonwood Street
Woodland, CA 95695

Conducted by

COMMUNITY HEALTH INSIGHTS

February 2022

Acknowledgments

We are deeply grateful to all those who contributed to the community health needs assessment conducted on behalf of Yolo County. Many dedicated community health experts and members of various social service organizations working with the most vulnerable members of the community gave their time and expertise as key informants and survey respondents to help guide and inform the findings of the assessment. Specific survey respondents that expressed a desire to be recognized in the report are listed in the technical section of the report in the Service Provider Survey section. Many community residents also contributed as interview and Community Health Status Survey (community survey) participants and shared the challenges they face working to achieve better health. We also appreciate the collaborative spirit of Kaiser Permanente and their willingness to share the information they gathered while conducting a similar health assessment in the Sacramento area. To everyone who supported this important work, we extend our heartfelt gratitude.

Community Health Insights (www.communityhealthinsights.com) conducted the assessment on behalf of Yolo County. Community Health Insights is a Sacramento-based, research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. This joint report was authored by:

- Heather Diaz, DrPH, MPH, Managing Partner of Community Health Insights and Professor of Public Health at California State University, Sacramento
- Mathew Schmidtlein, PhD, MS, Managing Partner of Community Health Insights and Professor of Geography at California State University, Sacramento
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- Traci Van, Senior Community Impact Specialist of Community Health Insights

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Report Summary

Purpose

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs of the Yolo County (Yolo) community. The priorities identified in this report help to guide health improvement efforts of Woodland Memorial Hospital, Sutter Davis Hospital, and Yolo County Health and Human Services, Community Health Branch.

This report meets requirements of the Patient Protection and Affordable Care Act (and, in California, Senate Bill 697) that not-for-profit hospitals conduct a CHNA at least once every three years, as well as the Public Health Accreditation Board (PHAB) CHA requirements. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com). Multiple other community partners participated in and collaborated to conduct the health assessment, including CommuniCare Health Centers and Winters Healthcare.

Community Definition

Yolo County was chosen as the geographical area for the CHNA because it is the primary service area of the two hospitals participating in the joint assessment and is the statutory service area of the public health department. Yolo County is located northwest of Sacramento along the Interstate 5 corridor and includes both urban and rural communities. The City of Woodland is the county seat of Yolo County.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[1] This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 29 community health experts, social service providers, and medical personnel. Additionally, 18 community residents or community service provider organizations participated in 3 focus groups across the county. Finally, 14 community service providers responded to a Service Provider Survey asking about health need identification and prioritization and 1,574 community residents participated in the Community Health Status Survey (community survey).

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity, as well as social and economic factors such as income, educational attainment, and employment. Furthermore, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

At the time that this assessment was conducted, the COVID-19 pandemic was still impacting communities across the United States, including Yolo County. The process for conducting the assessment remained fundamentally the same. However, adjustments were made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into

[1] County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

the quantitative data analysis and COVID-19 impact was captured during primary data collection as well. These findings are reported throughout various sections of the report.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 12 potential health needs (PHNs). These PHNs were identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in Yolo County. After these were identified, PHNs were labeled as significant health needs (SHNs) and were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 12 PHNs identified in previous CHNAs.

List of Prioritized Significant Health Needs

The following significant health needs identified for Yolo County are listed below in prioritized order.

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

Communities of Concern

Communities of Concern are geographic areas within the county that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Nine ZIP codes were identified as Communities of Concern for Yolo County and were separated into primary and secondary. The primary Communities of Concern included 95605 and 95691 (West Sacramento) and 95695 and 95776 (Woodland). Secondary Communities of Concern with low population size included 95612 (Clarksburg), 95627 (Esparto), 95645 (Knights Landing), 95653 (Madison), and 95937 (Dunnigan). According to 2019 American Community Survey 5-year estimates, the total population of the Communities of Concern was 127,497, which is 58.7% of Yolo County.

Resources Potentially Available to Meet the Significant Health Needs

In all, 367 resources were identified in the county that are potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2019 CHNA for Yolo County, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report.

Conclusion

This CHNA details the process and findings of a comprehensive health assessment to guide decision-making for the implementation of community health improvement efforts using a health equity lens. The CHNA includes an overall health and social examination of Yolo County and highlights the needs of community members living in parts of the county where more health disparities exist. This report also serves as a resource for community organizations in an effort to help improve the health and well-being of the communities they serve.

Introduction and Purpose

It is vital that health prevention efforts focus on the most critical health areas and are implemented in communities that are disproportionately affected. Nationwide, nonprofit hospitals and local public health departments conduct community health assessments to guide community prevention investments.

California state and federal laws require that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years. Nationally, state, local, and tribal health departments pursue public health accreditation from the national Public Health Accreditation Board (PHAB), and a community health assessment (CHA) is a required component. Though titled differently, CHNAs and CHAs both focus on important key components: using a systematic collection and analysis of data; reporting on the health status, health needs, and other key social determinants of health for the community; ensuring community engagement and input; fostering collective participation; and identifying community assets and resources.

The definition of a community health need is similar for the CHNA and the CHA. Federal regulations define *health needs* as follows: "Health needs include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities)."[2] Meanwhile, PHAB refers to health needs as "those demands required by a population or community to improve their health status."[3] Both CHNAs and CHAs guide the development of community health improvement efforts aimed at addressing the identified needs. Hospital CHNAs refer to these as implementation plans, while public health agencies call them community health improvement plans or CHIPs. Given the similarities between the CHNA and CHA processes, national experts are calling for nonprofit hospitals and public health departments to work together on local health assessments and community health improvement efforts.[4]

The collaborative work featured in this report will be referred to as CHNA though meeting the requirements for both federal requirements for hospitals and PHAB. This report documents the processes, methods, and findings of a collaborative CHNA conducted on behalf of a partnership between Sutter Davis Hospital (Sutter Health), Woodland Memorial Hospital and Yolo County Health and Human Services Community Health Branch. Additional partners involved in the CHNA included CommuniCare Health Centers and Winters Healthcare. The collaboration between the hospitals and the county emphasizes a team approach to addressing the key components of the CHNA. Each partner was committed to the process, engaged in regular meetings, provided timely feedback to analysis, and willingly shared expertise to support the successful completion of the report. The CHNA was conducted over a period of one year beginning in February 2021 and concluding in February 2022. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and in California of Senate Bill 697). In addition, this report meets the requirements set out by PHAB for conducting a CHA as a part of a local health department's needs assessment.

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[2] *Federal Register*, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

[3] Public Health Accreditation Board (2011, September). Acronyms and Glossary of Terms, Version 1.0.

[4] Burnett, K. (2012, February). Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A review of scientific methods, current practices, and future potential. Public Health Institute on behalf of Center for Disease Control and Prevention.

Community Health Insights (www.communityhealthinsights.com) conducted the CHNA on the behalf of the collaborative. Community Health Insights is a Sacramento-based, research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. Community Health Insights has conducted dozens of CHNAs and CHAs for multiple health systems and local health departments over the previous decade.

Findings

Prioritized Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the Yolo service area. In all, 11 significant health needs were identified. Primary data were then used to prioritize these significant health needs. Findings are presented first to highlight the outcome upfront in the report, followed by a methods overview. Detailed methods are found in the technical section of the report.

Prioritization was based on four measures of community input. The first two measures came from the key informant interview and focus group results. These included the percentage of sources that identified a health need as existing in the community, and the percentage of times the sources identified a health need as a top priority. The last two measures were based on survey data. These include the percentage of service provider survey respondents that identified a health need as a top priority, and the percentage of top priority themes from the community survey that were associated with a health need. Table 1 shows the values of these measures for each significant health need.

Table 1: Health need prioritization inputs for Yolo service area.

Prioritized Health Needs	Percentage of Key Informants and Focus Groups Identifying Health Need	Percentage of Times Key Informants and Focus Groups Identified Health Need as a Top Priority	Percentage of Provider Survey Respondents that Identified Health Need as a Top Priority	Percentage of Top Priority Themes from Community Survey Associated with the Health Need
Access to Basic Needs Such as Housing, Jobs, and Food	94%	39%	50%	37%
Access to Mental/Behavioral Health and Substance Use Services	88%	22%	50%	37%
Injury and Disease Prevention and Management	75%	3%	21%	37%
Active Living and Healthy Eating	62%	9%	21%	21%

Access to Quality Primary Care Health Services	88%	7%	21%	5%
System Navigation	81%	4%	29%	~
Access to Specialty and Extended Care	38%	3%	36%	5%
Increased Community Connections	69%	3%	21%	~
Safe and Violence-Free Environment	56%	3%	~	5%
Access to Functional Needs	56%	6%	~	~
Access to Dental Care and Preventive Services	19%	~	14%	~

~ Health need not mentioned

These measures were then combined to create a health need prioritization index. The highest priority was given to health needs that were more frequently mentioned and that were more frequently identified among the top priority needs.[5] The prioritization index values are shown in Figure *1*, where health needs are ordered from highest priority at the top to lowest priority at the bottom.

[5] Further details regarding the creation of the prioritization index can be found in the technical section of the report.

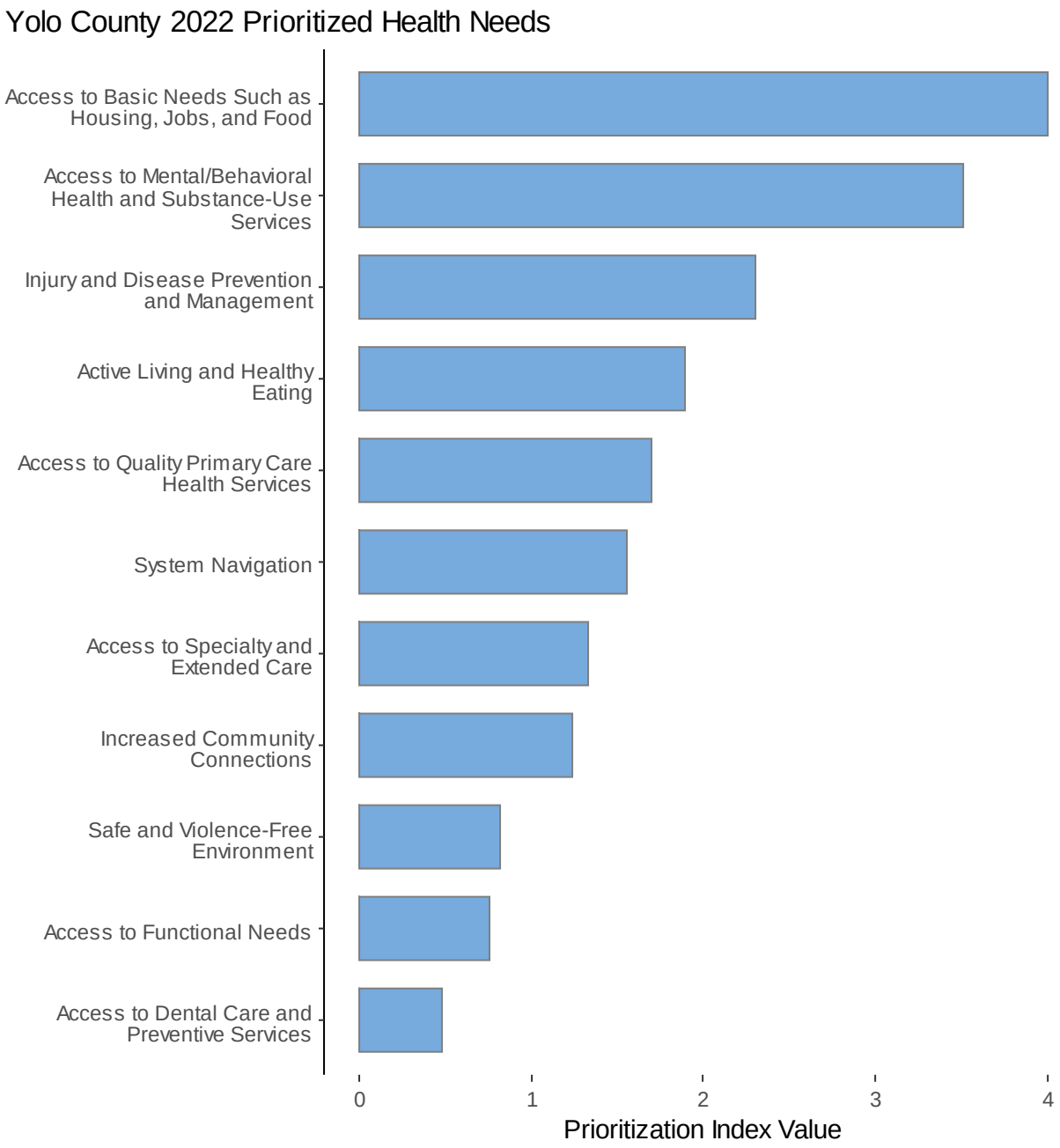

Figure 1: Prioritized, significant health needs for Yolo service area.

COVID-19 was top of mind for many participating in the primary data collection process, and feedback regarding the impact of COVID-19 confirmed that the pandemic exacerbated existing needs in the community.

The significant health needs are described below. Those secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health and ordered by their relationship to the conceptual model. Results from primary data analysis are also provided in the table. (A full listing of all quantitative indicators can be found in the technical section of

this report). Community Survey responses by question number ("Q") are also provided. For a full description of the question see the technical section's Table 17.

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

Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs[6] suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.

Primary Data Analysis			**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- Many residents struggle with food insecurity. - The area needs additional low-income housing options. - Lack of affordable housing is a significant issue in the area. - Poverty in the county is high. - Services for homeless residents in the area are insufficient. - Services are inaccessible for Spanish-speaking and immigrant residents. - It is difficult to find affordable childcare. - Many people in the area do not make a living wage. - Employment opportunities in the area are limited.	- It is difficult to find affordable childcare. - Lack of affordable housing is a significant issue in the area. - Many people in the area do not make a living wage. - The area needs additional low-income housing options. - Many residents struggle with food insecurity. - Poverty in the county is high. - Educational attainment in the area is low.	- Q10a: Told Lung Disease - Q21b: No Screening Unde Insured - Q21e: No Screening Lacking Trust - Q50: No Home Internet	- Hypertension Mortality - Emergency Department (ED) Visits for Dental Diagnosis Adult - ED Falls Ages 65+ - Hospitalizations for Falls Ages 65+ - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Adult Obesity - Food Environment Index - Medically Underserved Area - English Language Learners

[6] McLeod, S. 2014. Maslow's Hierarchy of Needs. Retrieved from: http://www.simplypsychology.org/maslow.html

- There is a need in the county for dependent living facilities. - Insurance coverage for mental health care in the county is very hard to obtain. - Digital divide is a big issue in the county, especially for rural residents. - Lack of technology/computer literacy directly limits access to many basic needs during the COVID-19 pandemic. - There is increased need for senior housing and spaces to recreate, socialize. - A functional local food system for the entire county is needed.	- Services for homeless residents in the area are insufficient. - Employment opportunities in the area are limited. - Services are inaccessible for Spanish-speaking and immigrant residents.		- Third Grade Math Level - Unemployment - Median Household Income - Income Inequality - Homeownership - Households with no Vehicle Available

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 an essential ingredient for a healthy community where residents can obtain additional support when needed.

Primary Data Analysis			**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- There aren't enough mental health providers or treatment centers in the area, e.g., psychiatric beds, therapists, support groups.	- There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds,	- Q10h: Told Mental Illness - Q11: Needed Mental	- Liver Cancer Mortality - Liver Disease Mortality - Hospitalizations for Mental Health Young Adults

- Additional services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in schools). - The area lacks the infrastructure to support acute mental health crises. - It's difficult for people to navigate mental/ behavioral healthcare. - The stigma around mental health treatment keeps people from seeking care. - The cost for mental/ behavioral health treatment is too high. - There are too few substance use treatment services in the area (e.g., detox centers, rehabilitation centers). - Substance use is an issue among area youth. - There aren't enough services here for those who are homeless and dealing with substance use issues. - Adverse Childhood Experiences (ACEs) are a contributor to alcohol and substance use in the county. - Mental health services are needed for dementia and Alzheimer patients and families. - There is increased need for workforce development to	therapists, support groups). - Substance use is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse). - There aren't enough services here for those who are homeless and dealing with substance use issues. - Additional services for those who are homeless and experiencing mental/behavioral health issues are needed. - It's difficult for people to navigate mental/behavioral healthcare. - There are too few substance use treatment services in the area (e.g., detox centers, rehabilitation centers). - Additional services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in schools). - Awareness of mental health issues among community members is low. - The area lacks the infrastructure to support acute mental health crises. - The stigma around mental health	Health Care	- Hospitalizations for Mental Health or Substance Use - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Excessive Drinking - Adult Smoking - Mental Health Care Shortage Area - Medically Underserved Area - Mental Health Providers - Juvenile Arrest Rate - Income Inequality

encourage young people to enter the mental health field in the future. - Supportive housing for communities experiencing mental illness is highly needed in the county. - Transportation to get to needed mental health care services is lacking. - Violence and injury in Yolo County have increased due to declining mental health.	treatment keeps people from seeking care. - Treatment options in the area for those with Medi-Cal are limited. - Substance use is an issue among youth in particular. - Substance use treatment options for those with Medi-Cal are limited. - Mental/behavioral health services are available in the area, but people do not know about them. - The cost for mental/behavioral health treatment is too high. - The use of nicotine delivery products such as e-cigarettes and tobacco are a problem in the community.		

3. Injury and Disease Prevention and Management

Knowledge is important for individual health and well-being, and efforts aimed at injury and disease prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focus on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection (STI) prevention and influenza shots), and intensive strategies in the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

<table>
<tr><th colspan="3">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="3">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.</td><td rowspan="2">The following indicators performed worse in the county when compared to state averages:</td></tr>
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</table>

- There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease). - Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, the elderly, LGBTQ individuals, immigrants). - There is increased homelessness in the region, especially West Sacramento and Woodland. - There isn't really a focus on prevention in Yolo County. - The community needs nutrition education opportunities. - Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision). - Many residents in the county lack the financial means and basic technology to access health information. - Vaping prevention in the county is needed.	- Health education in schools needs to be improved. - Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision). - The community needs nutrition education opportunities. - There isn't really a focus on prevention around here. - There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease).	- Q10a: Told Lung Disease - Q10b: Told Autoimmune Disease - Q10d: Told Diabetes - Q10h: Told Mental Illness	- Chronic Lower Respiratory Disease Mortality - Hypertension Mortality - Liver Cancer Mortality - Liver Disease Mortality - Alzheimer's Disease Mortality - Emergency Department (ED) Visits for Dental Diagnosis Adult - ED Falls Ages 65+ - Hospitalizations for Falls Ages 65+ - Hospitalizations for Mental Health Young Adults - Hospitalizations for Mental Health or Substance Use - Poor Mental Health Days - Frequent Mental Distress - Frequent Physical Distress - Excessive Drinking - Adult Obesity - Adult Smoking - Juvenile Arrest Rate - Motor Vehicle Crash Death - Third Grade Math Level - Income Inequality

4. Active Living and Healthy Eating

Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes often live in areas with fast food and other establishments where unhealthy food is sold. Under-resourced communities may be challenged with food insecurity, absent the means to consistently secure food for themselves or their families, relying on food pantries and school meals often lacking in sufficient nutrition for maintaining health.

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<tr><td>Key Informant and Focus Group Responses</td><td>Service Provider Survey Responses</td><td>Community Survey Responses</td></tr>
<tr><td>- Food insecurity is a concern in the county, especially for college students and those living in rural areas.
- The community needs nutrition education programs.
- Grocery store options in the area are limited especially in rural areas of the county.
- Fresh, unprocessed foods are unaffordable.
- The built environment doesn't support physical activity (e.g., neighborhoods aren't walkable, roads aren't bike-friendly, or parks are inaccessible).
- Improvements are needed in the food system to reduce targeting of highly processed foods to poor and disenfranchised community residents.
- Kids need healthier food options to avoid</td><td>- Homelessness in parks or other public spaces deters residents from their use.
- Recreational opportunities in the area are unaffordable (e.g., gym memberships, recreational activity programming).
- There aren't enough recreational opportunities in the area (e.g., organized activities, youth sports leagues).
- Food insecurity is an issue here.
- Fresh, unprocessed foods are unaffordable.
- Grocery store options in the area are limited.
- The built environment doesn't support physical activity (e.g., neighborhoods aren't walkable, roads aren't bike-friendly, or parks are inaccessible).</td><td>- Q10d: Told Diabetes</td><td>- Hypertension Mortality
- Liver Cancer Mortality
- Poor Mental Health Days
- Frequent Mental Distress
- Poor Physical Health Days
- Frequent Physical Distress
- Breast Cancer Prevalence
- Adult Obesity
- Food Environment Index
- Income Inequality</td></tr>
</table>

early onset chronic disease development. - Food distribution to residents that are isolated geographically or medically is lacking.	- The community needs nutrition education programs. - The food available in local homeless shelters and food banks is not nutritious.		

5. Access to Quality Primary Care Health Services

Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

Primary Data Analysis			**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- The quality of care is low (e.g., appointments are rushed, providers lack cultural competence). - There aren't enough primary care service providers in the area. - Transportation is a significant barrier to accessing primary care for many residents due to physical distance. - Increased access to healthcare via telehealth, mobile health, street health is needed in the county. - Specific services are unavailable here (e.g., 24-hour	- It is difficult to recruit and retain primary care providers in the region. - Out-of-pocket costs are too high. - Patients have difficulty obtaining appointments outside of regular business hours. - Patients seeking primary care overwhelm local emergency departments. - Primary care services are available but are difficult for many people to navigate.	- Q10d: Told Diabetes - Q21d: No Screening Transportation - Q21k: No Screening Clinic Hours - Q21l: No Screening Doctor Availability - Q21b: No Screening Under Insured - Q21e: No Screening Lacking Trust - Q23a: ER No Appointment	- Chronic Lower Respiratory Disease Mortality - Hypertension Mortality - Liver Cancer Mortality - Liver Disease Mortality - Alzheimer's Disease Mortality - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Breast Cancer Prevalence - Lung Cancer Prevalence

pharmacies, urgent care, telemedicine). - Quality health insurance is unaffordable. - Patients seeking primary care overwhelm local emergency departments. - Primary care services are available but are difficult for many people to navigate. - There is a need for increased access to preventative care including screenings. - There is desire for health care systems, law enforcement and other providers to work together to coordinate care for medically vulnerable residents. - Medicare in-home support care is needed in the area. - There is a need for primary care providers to better care for Alzheimer and dementia patients. - Increased funding is needed for local Federally Qualified Health Centers (FQHCs) and Community Clinics to care for undocumented residents.	- Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine). - There aren't enough primary care service providers in the area. - Too few providers in the area accept Medi-Cal.		- Medically Underserved Area - Income Inequality

6. System Navigation

System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems in order to receive the necessary benefits and supports to improve health outcomes. Research has demonstrated that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities.[7] Furthermore, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

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<tr><td>Key Informant and Focus Group Responses</td><td>Service Provider Survey Responses</td><td>Community Survey Responses</td></tr>
<tr><td>- It is difficult for people to navigate multiple, different healthcare and social support systems.
- Some people just don't know where to start in order to access care or benefits.
- People have trouble understanding their insurance benefits.
- System navigation for foster care in the county needs improvement.
- Coordinating and centralizing services/care would reduce system navigation barriers.</td><td>- It is difficult for people to navigate multiple, different healthcare systems.
- Some people just don't know where to start in order to access care or benefits.
- Automated phone systems can be difficult for those who are unfamiliar with the healthcare system.
- Dealing with medical and insurance paperwork can be overwhelming.
- People have trouble understanding their insurance benefits.
- People may not be aware of the services they are eligible for.
- Medical terminology is confusing.
- The area needs more navigators to help to get people connected to services.</td><td>No data.</td><td>- Liver Cancer Mortality</td></tr>
</table>

[7] Natale-Pereira, A. et. al .2011. The Role of Patient Navigators in Eliminating Health Disparities. US National Library of Medicine, National Institutes of Health, 117:15, 3543-3552.

7. Access to Specialty and Extended Care

Extended care services, which include specialty care, are care provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services that is needed in the community to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

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<tr><td>Key Informant and Focus Group Responses</td><td>Service Provider Survey Responses</td><td>Community Survey Responses</td></tr>
<tr><td>- The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care).
- Not all specialty care is covered by insurance.
- There is a need for specialty care that meets residents where they are as well as reduced barriers to navigation and transportation.
- There is increased need for respite care in the county.</td><td>- Not all specialty care is covered by insurance.
- People have to travel to reach specialists.
- The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care).
- Additional hospice and palliative care options are needed.
- It is difficult to recruit and retain specialists in the area.
- Out-of-pocket costs for specialty and extended care are too high.
- Wait times for specialist appointments are excessively long.
- Too few specialty and extended care</td><td>- Q10d: Told Diabetes</td><td>- Chronic Lower Respiratory Disease Mortality
- Hypertension Mortality
- Liver Cancer Mortality
- Liver Disease Mortality
- Alzheimer's Disease Mortality
- Poor Mental Health Days
- Frequent Mental Distress
- Poor Physical Health Days
- Frequent Physical Distress
- Lung Cancer Prevalence
- Income Inequality</td></tr>
</table>

	providers accept Medi-Cal.		

8. Increased Community Connections

As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all."[8] Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

Primary Data Analysis			**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- Health and social service providers operate in silos; more cross-sector connection/collaboration is needed. - Relations between law enforcement, health care systems, and the community need to be better coordinated. - The community needs to invest more in local public schools and activities for young people. - People in the community lack representation of BIPOC (Black and Indigenous People of Color) communities in local service providers. - City and county leaders need to work together.	- City and county leaders need to work together. - Cross-sector connections are needed. - Health and social service providers operate in silos. - Relations between law enforcement and the community need to be improved. - Building community connections	No data.	- Hypertension Mortality - Hospitalizations for Mental Health Young Adults - Hospitalizations for Mental Health or Substance Use - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Excessive Drinking - Mental Health Care Shortage Area - Medically Underserved Area - Mental Health Providers - Juvenile Arrest Rate - Unemployment - Income Inequality - Households with no Vehicle Available

[8] Robert Wood Johnson Foundation. 2016. Building a Culture of Health: Sense of Community. Retrieved from: https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html

- Public Health is severely under-funded in the county. - More intentional efforts are needed to reduce isolation and bring the community together (e.g., community center, community events, activities). - Increased inclusion of the community voice is needed in countywide decision-making.	doesn't seem like a focus in the area. - People in the community face discrimination from local service providers. - The community needs to invest more in local public schools. - There isn't enough funding for social services in the county.		

9. Safe and Violence-Free Environment

Feeling safe in one's home and community is fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) is having physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences. Furthermore, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.[9]

Primary Data Analysis			**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- There are not enough resources to address domestic violence and sexual assault in the county.	No data.	No data.	- Hypertension Mortality - Hospitalizations for Mental Health Young Adults

[9] Lynn-Whaley, J., & Sugarmann, J. July 2017. The Relationship Between Community Violence and Trauma. Los Angeles: Violence Policy Center.

- Safe public parks and green space are lacking, areas often have criminal activity. - County has seen noticeable increase in criminal activity and acts of gun violence. - Health care professionals are not trained to properly treat residents experiencing the increase threats to safety. - Lack of housing increases criminal activity in the county.			- Hospitalizations for Mental Health or Substance Use - Poor Mental Health Days - Frequent Mental Distress - Frequent Physical Distress - Juvenile Arrest Rate - Motor Vehicle Crash Death - Income Inequality

10. Access to Functional Needs

Functional needs includes adequate transportation access and conditions which promote access for individuals with physical disabilities. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those needs that promote and support a healthy life. The number of people with a disability is also an important indicator for community health and must be examined to ensure that all community members have access to necessities for a high quality of life.

Primary Data Analysis			**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.			The following indicators performed worse in the county when compared to state averages:
Key Informant and Focus Group Responses	Service Provider Survey Responses	Community Survey Responses	
- Many residents do not have reliable personal transportation. - Public transportation service routes are limited. - Public transportation is more difficult for some residents to use (e.g., non-English-speaking).	No data.	- Q21d: No Screening Transportation	- Emergency Department (ED) Falls Ages 65+ - Hospitalizations for Falls Ages 65+ - Frequent Mental Distress - Frequent Physical Distress - Adult Obesity - Income Inequality - Households with no Vehicle Available

- The distance between service providers is inconvenient for those using public transportation. - Using public transportation to reach providers can take a very long time. - The cost of public transportation is too high. - Public transportation schedules are limited. - The geography of the area makes it difficult for those without reliable transportation to get around. - Increased usage of telehealth/mobile medicine would reduce transportation barriers.			

11. Access to Dental Care and Preventive Services

Oral health is important for overall quality of life. When individuals have dental pain, it is difficult to eat, concentrate, and fully engage in life. Oral health disease, including gum disease and tooth decay are preventable chronic diseases that contribute to increased risk of other chronic disease, as well as play a large role in chronic absenteeism from school in children. Poor oral health status impacts the health of the entire body, especially the heart and the digestive and endocrine systems.

<table>
<tr><th colspan="3">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="3">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and respondents of the Service Provider and Community surveys.</td><td rowspan="2">The following indicators performed worse in the county when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Service Provider Survey Responses</td><td>Community Survey Responses</td></tr>
</table>

- Mobile dental services are needed in isolated areas of the county. - Dental caries in the county are high, especially in children. - Assuring adequate access to dental care in Yolo County is important.	- It's hard to get an appointment for dental care. - Quality dental services for kids are lacking. - There aren't enough providers in the area who accept Denti-Cal. - Dental care here is unaffordable, even if you have insurance. - People in the area have to travel to receive dental care. - The lack of access to dental care here leads to overuse of emergency departments. - There aren't enough dental providers in the area.	- Q49: Had Dental Visit	- Emergency Department (ED) Visits for Dental Diagnosis Adult - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Dentists - Income Inequality

Other Health Needs

Systems Change

Key informant and focus group participants spoke about a need for systems, policies, and environments to change in order to better support the health needs of Yolo County residents. Many community health problems cannot be improved solely by individual actions, but by community systems coming together to forge an environment where healthy choices are easy and popular. Though the volume of data did not warrant being listed as a significant priority health need, the mention was so pervasive in the data that it is detailed below.

- Sustainable funding is a must in order to cause lasting change in community prevention efforts. It is very challenging when new programs and organizations have unstable fundings sources and change frequently.
- Resources to fund increased capacity of existing health care and social services agencies is needed in order to better meet the needs of the community.
- Better coordination between law enforcement and health/social services is needed to properly care for those struggling with mental illness and homelessness in the county.
- Increased for social service staff to be culturally reflective of the community they serve.
- Public health is severely underfunded.
- System of care needs to change to better protect the victims of abuse.
- Health in all policy is needed in all sectors.
- Investment in the digital divide for rural areas of the county is an urgent need.
- Housing system (lack of affordable housing, location, and type of affordable housing, etc.) in the county is a major threat to the health and safety of community members.

Healthy Physical Environment

The data assigned to PHN 9 Healthy Physical Environment did not meet the criteria of a significant health need for Yolo County as defined by the analytical process used for this assessment. A healthy and clean physical environment is very important for the overall health of the community. As a healthy physical environment affects and is affected by all other health factors and conditions, partners for this assessment will continue to look for ways to collaborate on projects aimed at improving and maintaining a healthy physical environment.

Methods Overview

Conceptual and Process Models

The data used to conduct the assessment were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[10] This model of population health includes the many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytical stages were developed. For a detailed review of methods, see the technical section of this report.

Public Comments from Previously Conducted CHNAs

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted Implementation Strategy. Both Woodland Memorial Hospital and Sutter Davis Hospital requested written comments from the public on their 2019 CHNA and most recently adopted Implementation Strategy.

At the time of the development of this CHNA report, neither partner had received any comments. However, input from the broader community was incorporated in the 2022 CHNA through key informant interviews, focus groups, a Community Health Status Survey, and the Service Provider Survey. The Yolo County collaborative partners will continue to use their respective websites as tools to solicit public comments and ensure that these comments are integrated as community input in the development of future health assessments.

Data Used in the CHNA

Data collected and analyzed included both primary and secondary data. Primary data included 13 interviews with 29 community health experts, 3 focus groups conducted with a total of 18 community residents or community-facing service providers, a Community Health Status Survey of 1,574 community residents and 14 responses to the Service Provider Survey. (A full listing of all participants can be seen in the technical section of this report.)

Secondary data included multiple datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at subcounty levels was used to identify portions of Yolo County with greater concentrations of populations experiencing undue health burden. A set of county-level indicators was collected from various sources to help identify and prioritize significant

[10] County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

health needs. Additionally, socioeconomic indicators were collected to help describe the overall social conditions within the county. Health outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health factor indicators included measures of 1) health behaviors, such as diet and exercise and tobacco, alcohol, and drug use; 2) clinical care, including access to quality care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, neighborhood safety, and similar; and 4) physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 100 different health outcome and health factor indicators were collected for the health assessment.

Data Analysis

Primary and secondary data were analyzed to identify and prioritize the significant health needs for Yolo County. This included identifying 12 potential health needs (PHNs) in these communities. These potential health needs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the county. After these were identified, health needs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need.

For an in-depth description of the processes and methods used to conduct the CHNA, including primary and secondary data collection, analysis, and results, see the technical section of this report.

Description of Community Served

Yolo County was one of 27 original counties when California became a state in 1850 and is home to well over 200,000 residents. It is located directly west of Sacramento and sits along both the Interstate 5 and 80 corridors. The county is considered a part of the Greater Sacramento metropolitan area and is located in the Sacramento Valley. Yolo County covers over 1,000 square miles, and a large portion is dedicated to agriculture.

Yolo County is governed by a board of supervisors and contains four incorporated cities: Davis, West Sacramento, Winters, and Woodland. While Davis is the largest city in terms of population, Woodland serves as the County Seat. West Sacramento is home to the Port of West Sacramento, an inland port some 80 nautical miles from San Francisco. The port exports many of the agricultural products grown in the County. The Yolo Causeway connects Davis and Sacramento along Interstate 80, and crosses the Yolo Bypass, a large floodplain and wildlife area that received national attention in the late 1990's as a national model for public/private restoration projects.

The City of Woodland has a strong historic heritage and serves as the primary support community for agricultural services. Davis is a unique university community that is internationally known for its commitment to environmental awareness and progressive and socially innovative programs. Winters is a small city located on Putah Creek in the western part of Yolo County and is home to a thriving agricultural industry. West Sacramento sits on the Sacramento River, on the east side of Yolo County, and is home to the Port of Sacramento, which ships over a million tons of agricultural products to worldwide markets. The county is known for growing and processing tomatoes. Less than a quarter of the region's population resides in unincorporated communities, including Esparto, the gateway to Capay Valley, Madison, Yolo, Dunnigan, Clarksburg, Guinda, Knights Landing, Monument Hills, Capay, Plainfield, Brooks, Rumsey, El

Macero, and Zamora. Arbuckle and portions of Dixon are designated as Health Professional Shortage Areas by the U.S. Health Resources and Services Administration.

The total population of the county was 217,352 in 2020. Race and ethnicity data for Yolo County[11] are presented in Figure 2 and a map of Yolo County is shown in Figure 3.

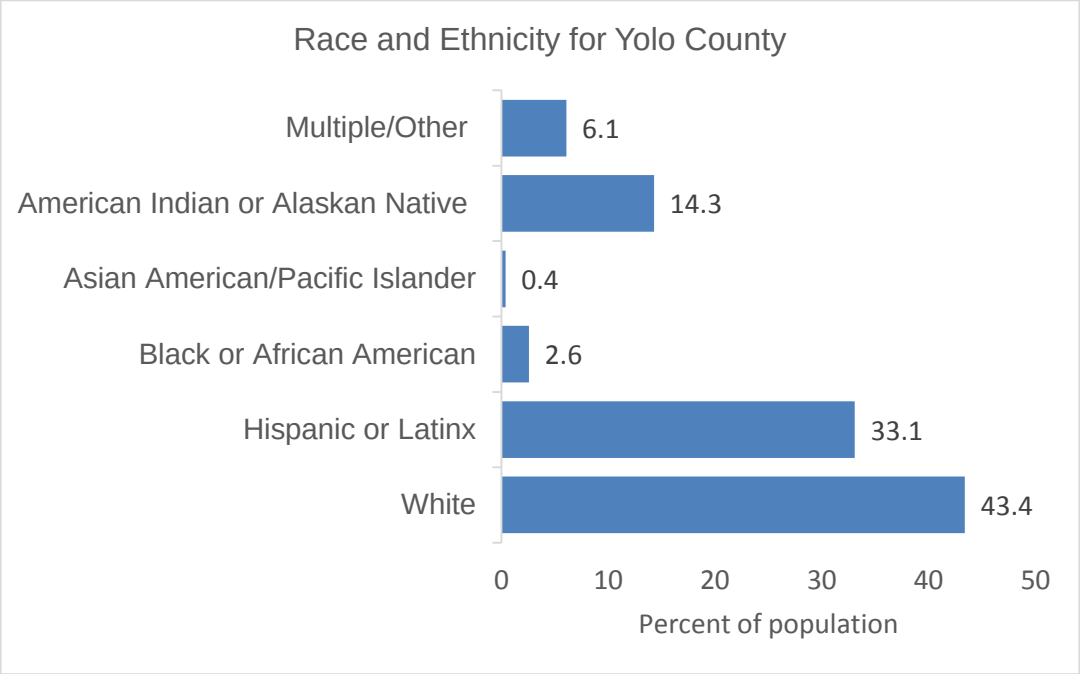


Figure 2: Race and ethnicity for Yolo County.

[11] Race and Ethnicity data for Yolo County are based on 2020 Census data as reported here: https://data.census.gov/cedsci/table?q=Yolo%20County,%20California&tid=DECENNIALPL2020.P2.

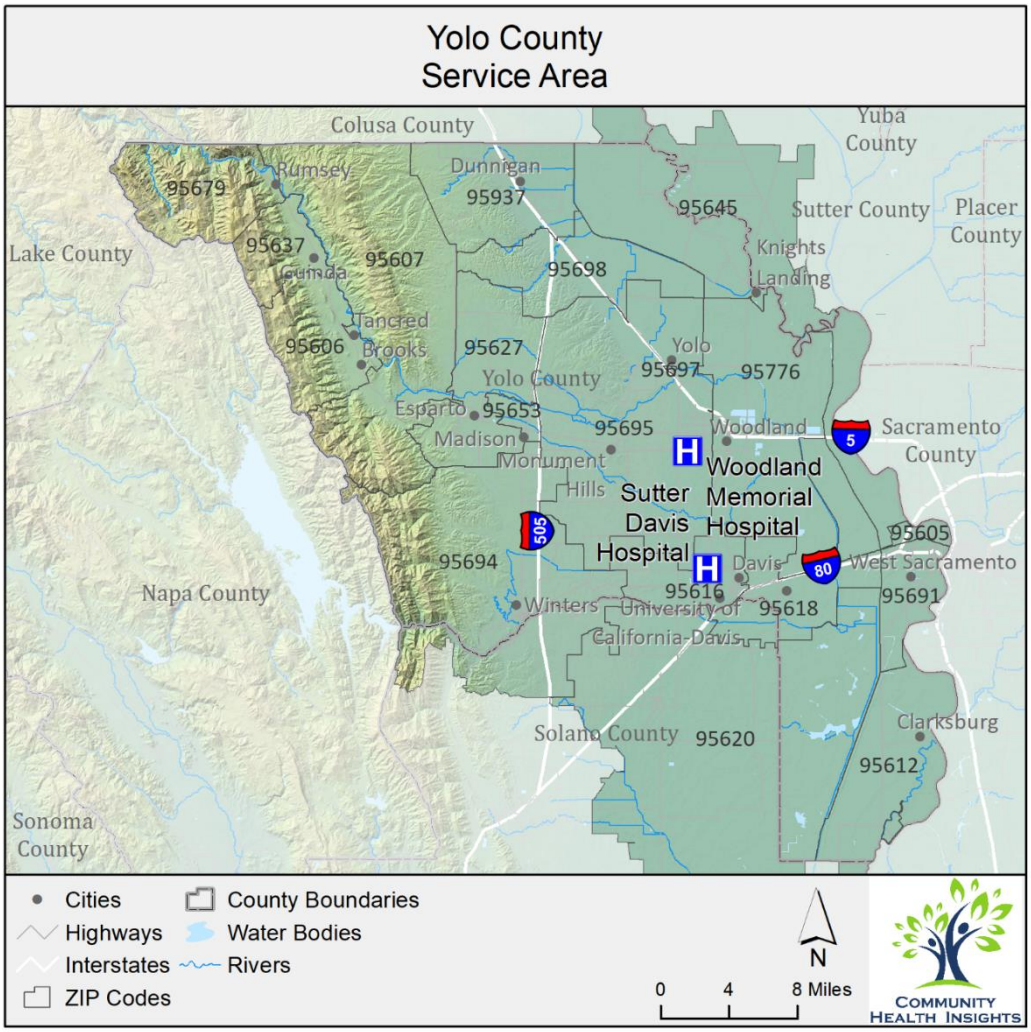


Figure 3: Yolo County Service Area.

Population characteristics for each ZIP Code in Yolo County are presented in Table 2. These are compared to the state and county characteristics for descriptive purposes. Any ZIP Code with values that compared negatively to the state or county is highlighted.

Table 2: Population characteristics for each ZIP Code located in Yolo County.

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (Years)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95605	14,493	58.4	32.3	$51,303	20.6	10.2	5.6	26.3	38.9	12.1
95606	249	70.3	60.1	~	14.1	9	0	19	27.6	55
95607	389	15.4	61.1	$75,964	0	0	0	3.1	21.6	32.4

95612	1,321	46.6	36.1	$95,000	1.2	5.8	3.6	10.8	15.2	3.5
95616	52,212	48	22.9	$55,510	35.6	6.8	3.4	2.1	44.6	6.8
95618	27,519	45.6	31.7	$93,643	22.5	4.7	3	3.5	34.2	7.4
95620	21,954	54	35.1	$82,956	10.2	5.7	7.8	20.7	30.1	11
95627	3,802	59.6	31.9	$75,938	9	4.3	7.8	18.6	26.4	13.6
95637	268	61.6	50.1	$52,917	45.1	0	0	21.4	33	19.4
95645	1,881	76.6	40	$43,696	18.7	10.4	14.4	45	28.1	16
95653	581	99.7	35.3	$41,050	15.7	3.6	11	55.1	57.5	9.8
95679	56	0	48.7	~	0	0	17.9	0	0	26.8
95691	38,690	52.5	34.9	$77,303	13.2	6.3	4	12.8	34.3	9.6
95694	10,495	51	37.3	$84,949	9.5	5.2	5.1	18.7	25.7	9
95695	41,278	53.6	37.7	$64,390	10.5	6.3	7.7	17.8	32.8	12.3
95697	183	69.9	55.3	~	4.9	0	0	44.1	0	23.5
95698	148	16.2	57.5	$26,615	19.6	0	0	30.4	36.4	6.1
95776	23,911	68.6	33.4	$81,184	13.1	4.2	5.4	18.4	36.3	9.9
95937	1,540	53.8	32.1	$51,625	18.3	14.1	6.5	24.3	33.6	16.2
Yolo	217,352	53.3	31	$70,228	19.1	6.2	4.8	13.5	36.1	9.6
California	39,283,497	62.8	36.5	$75,235	13.4	6.1	7.5	16.7	40.6	10.6

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.
~ Data not available.

Health Equity

The following section is a high-level summary of health equity in Yolo County and is not intended to provide an extensive exploration of inequity in the service area. Quantifying and describing inequity in a community is challenging due to data limitations and the fact that inequity is a contributor to all health needs that exist in a community.

The Robert Wood Johnson Foundation's definition of health equity and social justice is used here to help establish a common understanding for the concept of health equity.

"*Health equity means that 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 health care.*"[12]

[12] Robert Wood Johnsons Foundation. (2017, April). What is Health Equity? And What Difference Does a Definition Make? Health Equity Issue Brief #1.
https://buildhealthyplaces.org/content/uploads/2017/05/health_equity_brief_041217.pdf

Inequities experienced early and throughout one's life, such as limited access to a quality education, have health consequences that appear later in life as health disparities. Health disparities are defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation."[13]

In the U.S. and many parts of the world, health inequities are most apparent when comparing health outcomes of various racial and ethnic groups to one another. These comparisons clearly demonstrate that health inequities persist across communities, including in Yolo County.

This section of the report follows the organizing framework used throughout this assessment: the Robert Wood Johnson Foundation's County Health Rankings model.[14] The model shows that health outcomes are the result of health factors which one experiences throughout life. Understanding where health disparities exist helps in the planning of targeted interventions to address these and ultimately improve health equity.

Health Outcomes - The Results of Inequity

The table below displays disparities among racial and ethnic groups for Yolo County for life expectancy, mortality, and low birthweight.

Table 3: Health outcomes comparing racial and ethnic groups in Yolo County.

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	~	~	~	3.3	4.3	3.6
Life Expectancy	Average number of years a person can expect to live.	~	89.7	77.5	84.1	80.6	81.7
Child Mortality	Number of deaths among children under age 18 per 100,000 population.	~	~	~	25.2	28.1	25
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per	472.6	130.6	507.9	217.5	279.6	255.2

[13] Center for Disease Control and Prevention. 2008. Health Disparities Among Racial/Ethnic Populations. Community Health and Program Services (CHAPS): Atlanta: U.S. Department of Health and Human Services.
[14] See: County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

	100,000 population (age-adjusted).						
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	~	2,098.2	9,065.9	4,298.7	5,038.6	4,617
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	~	6.8%	9.1%	5.8%	5.1%	5.8%

~ Data not available

Data sources are included in the technical section of the report.

Health inequities (by race/ethnicity) specific to health outcomes clearly exist in Yolo County. Black community members in Yolo County have lower life expectancy, higher premature age-adjusted mortality, higher premature death (Years of Potential Life Lost before age 75), and higher percentage of low birthweight babies than other racial/ethnic groups in the area.

Health Factors - Inequities in the County

Data reveal inequities in health factors in the service area, such as education attainment and income. These health factors are displayed in Table 4 and are compared across racial and ethnic groups. The indicators used in this table were selected based their ability to describe inequity across racial and ethnic groups across Yolo County. The inclusion of these particular equity-oriented indicators was also guided by a review of previous research.[15]

Table 4: Health factors by race and ethnicity in Yolo County.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Some College[a]	Percentage of adults ages 25 and over with some post-secondary education.	36.7%	81%	71.2%	40.8%	80.2%	68.4%
High School Completion[a]	Percentage of adults ages 25 and over with at least a high school diploma or equivalent.	71.6%	91.3%	93.4%	66.7%	95.6%	86.5%

[15] For example, see: Stillman, L. & Ridini, S. (May 2015). *Embracing Equity in Community Health Improvement*. Health Resources in Action Policy and Practice Report. Accessed: https://hria.org/wp-content/uploads/2016/02/Embracing-Equity-in-Community-Health-Improvement.pdf.

Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests.	~	~	2.3	2.5	3.3	2.9
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests.	~	3.2	2.1	2.3	3	2.7
Children in Poverty	Percentage of people under age 18 in poverty.	15.8%	16.4%	28.2%	20.6%	8.4%	13%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$48,316	$63,271	$39,813	$54,451	$83,307	$70,951
Uninsured Population[b]	Percentage of the civilian non-institutionalized population without health insurance.	11.9%	4.7%	4.2%	8.2%	2.6%	4.8%

~ Data not available

Unless otherwise noted, data sources are included in the technical section of the report.

[a]From 2019 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.

[b]From 2019 American Community Survey 5-year estimates table S2701.

Health and social inequities specific to identified health factors reveal clear disparities for American Indian/Alaskan Native, Hispanics, and Black residents of Yolo County. American Indian/Alaskan Native residents have the lowest percentage of community members attending college, the second lowest high school completion rate, and the highest percentage of uninsured residents. Hispanics have a low percentage of community members attending college and completing high school, one of the lowest third grade reading levels, and the largest percentage of uninsured population. Black residents of Yolo County have the lowest third grade reading level, the highest percentage of children in poverty, and the lowest median household income.

Population Groups and Locations Experiencing Disparities

The figure and table that follow describe populations and specific geographic locations in Yolo County identified through qualitative data analysis as experiencing health disparities.

Interview participants were asked two separate questions:

1. What specific groups of community members experience health issues the most?
2. What specific geographic locations struggle with health issues the most?

For populations, responses were analyzed by counting the total number of times all key informants and focus group participants mentioned a particular group as one experiencing disparities. Figure *4* displays the results of this analysis. The groups are not mutually exclusive—one group could be a subset of another group. One of the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups.

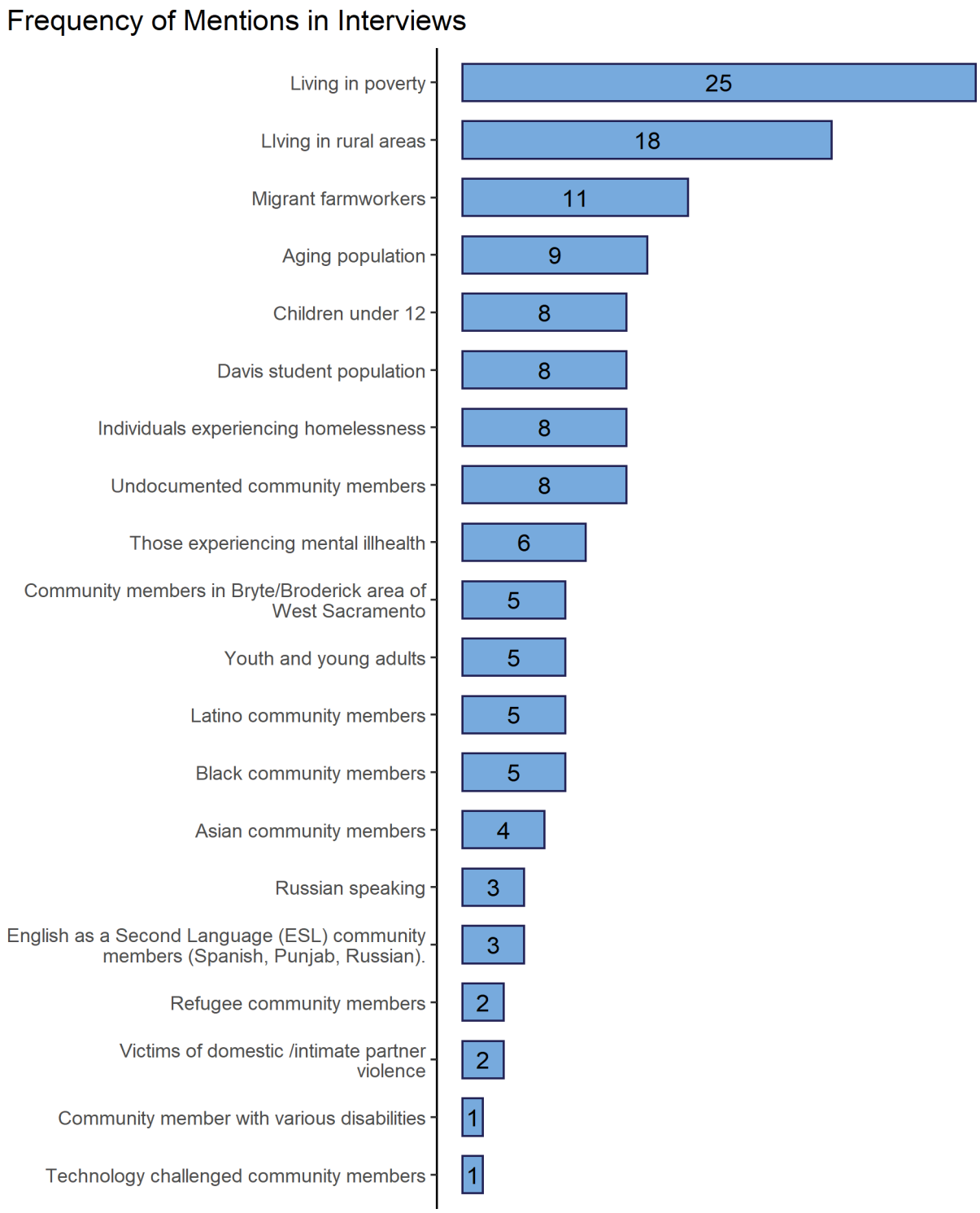


Figure 4: Populations experiencing disparities in Yolo County.

Table *5* details responses from a total of 47 key informants and focus group participants related to geographic locations in Yolo County struggling disproportionately with health issues. The detailed descriptive data from this question are organized by specific location and presented below.

Table 5: Geographic locations struggling with health issues.

"What specific geographic locations struggle with health issues the most?"	
Geographic Locations	**Attributes of Locations**
Clarksburg	Increased drug use and access. Due to decreased police department resources, area has seen rise in crime. Highly dispersed area.
Davis	High student population with food insecurity. Migrant farm worker community. Increased cases of suicide and self-harm. Women's shelters are at capacity. High cases of dementia. Wide distribution of wealth between two main types: high income and low income.
Dunnigan	High rates of poverty. Isolated away from services.
Esparto/Madison	Migrant farm worker community. Small clinic in the area. High dental need. Food insecurity and limited access to health foods. Migrant workers disproportionately affected by COVID due to no paid sick leave – worked through the pandemic. Need for a senior living complex.
Knights Landing	Migrant farm worker community. No community park. Limited access to health foods. UC Davis medical student-run Clinic. Transportation a barrier to access services.
West Sacramento	High poverty, but close to services. High racial/ethnic diversity – Russian, Asian, Hispanic, Afghan, Black. Cultural barriers to care related to services not in their native language. Residents experiencing homelessness. Increased reporting of families living in their vehicles. West Capitol area – 7% African American. High cases of dementia. Need for affordable and safe housing. Few COVID relief programs – all in Davis. **Bryte/Broderick Area:** High rates of poverty, food insecurity, very industrial. Low vaccinations rates and large COVID outbreaks. Abundance of motels, obesity, high rates of mental illness and substance use.
Winters/Capay Valley	Rural Winters - High rates of poverty. Migrant farm worker camp. Transportation a barrier to access services. Must leave area to access health care services. No assisted living opportunities in rural parts. Area outside of Winters city limits, which includes between Winters and Davis, high poverty, isolation, and residents lack access to services.
Woodland	Northeast and northwest areas have high poverty. COVID cases highest in areas of poverty. Seniors living on congregate communities disproportionately impacted by COVID. Need safe places to play and recreate that are heat protective. Residents experiencing homelessness, especially in downtown area. Lack of great space to exercise. Need to bring people back together and gather safely in COVID, increase community connectedness. Housing issues – need affordable housing. High Hispanic population. Childhood obesity rates are high.
Rural areas of county Guinda/ Ramsey/Brooks	Limited access to safe physical activity. Higher rates of poverty. Lower vaccinations rates, highest COVID burden. High rates of poverty. High rates of isolation. Transportation a barrier to access services. High rates of chronic disease like diabetes. Need for affordable and safe housing. Public transportation very limited. High rates of poverty. Need for increased emergency preparedness in the rural areas.

California Healthy Places Index

Figure *5* displays the California Healthy Places Index (HPI)[16] values for Yolo County. The HPI is an index based on 25 health-related measures for communities across California. Measures included in the HPI were selected based on their known relationship to life expectancy and other health outcomes. These values are combined into a final score representing the overall health and well-being of the community, which can then be used to compare the factors influencing health in different communities. Higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present.

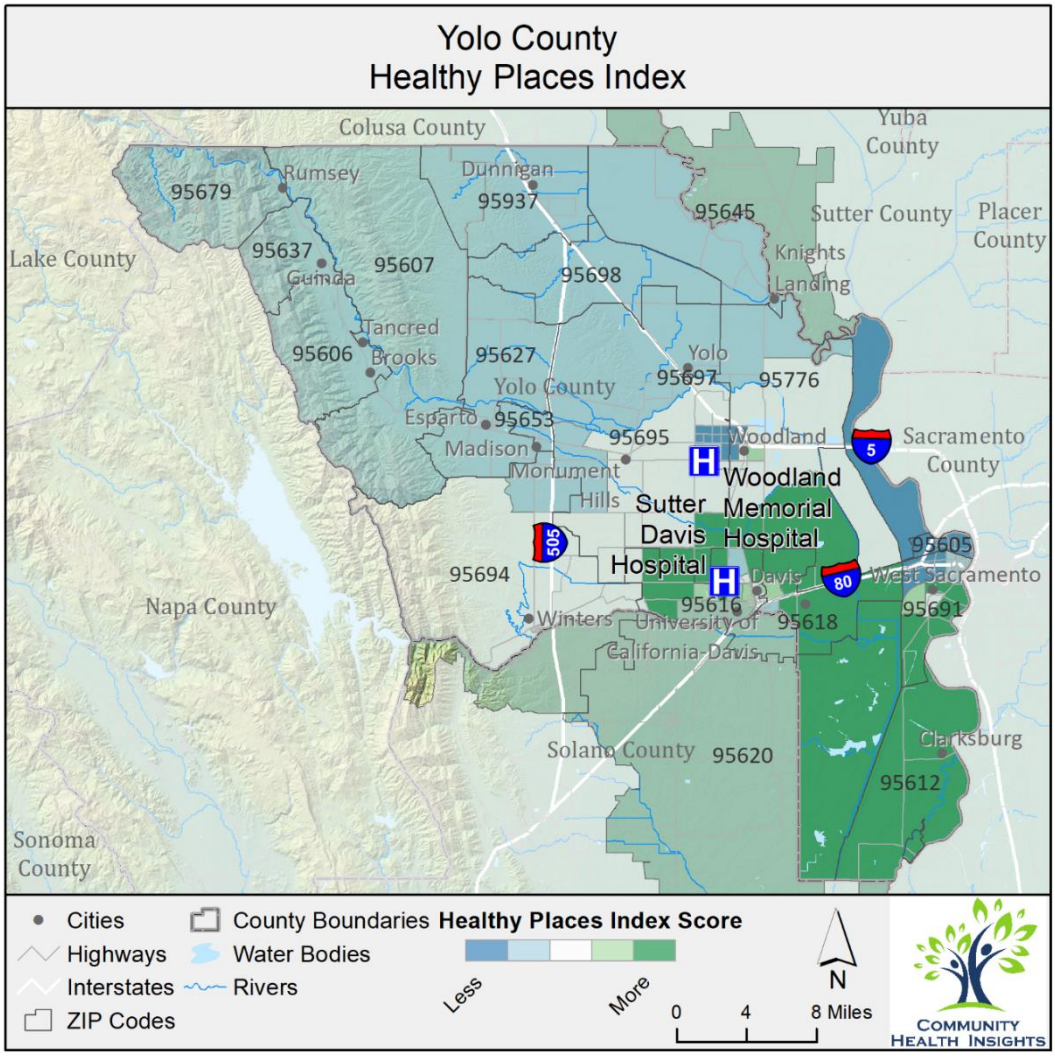


Figure 5: Healthy Places Index for Yolo County.

[16] Public Health Alliance of Southern California. 2021. The California Health Places Index (HPI): About. Retrieved from https://healthyplacesindex.org/about/.

Areas with blue shading in Figure *5* have the lowest and second to lowest overall HPI scores, indicating a higher proportion of unhealthy factors associated with neighborhoods. There is likely to be a higher concentration of residents in these locations experiencing health disparities.

Communities of Concern

Communities of Concern are geographic areas within the county that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA methodology because, after the county is assessed more broadly, they allow for a focus on those portions of the county likely experiencing the greatest health disparities. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the technical section of this report for an in-depth description of how these are identified). Analysis of both primary and secondary data revealed 9 ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 6, with the census population provided for each, and they are displayed in Figure 6.

Table 6: Identified Communities of Concern for Yolo County.

ZIP Code	Community\Area	Population
Primary Communities of Concern		
95605	West Sacramento	14,493
95691	West Sacramento	38,690
95695	Woodland	41,278
95776	Woodland	23,911
Secondary Communities of Concern		
95612	Clarksburg	1,321
95627	Esparto	3,802
95645	Knights Landing	1,881
95653	Madison	581
95937	Dunnigan	1,540
Total Population in Communities of Concern		*127,497*
Total Population in Yolo County		*217,352*
Percentage of Population in Communities of Concern*		*58.7%*

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

*Populations in ZIP codes identified as Communities of Concern (some of which include population outside of the county) divided by total population for Yolo County.

Figure 6 displays the ZIP Codes highlighted in pink (primary) and blue (secondary) that are Communities of Concern in Yolo County.

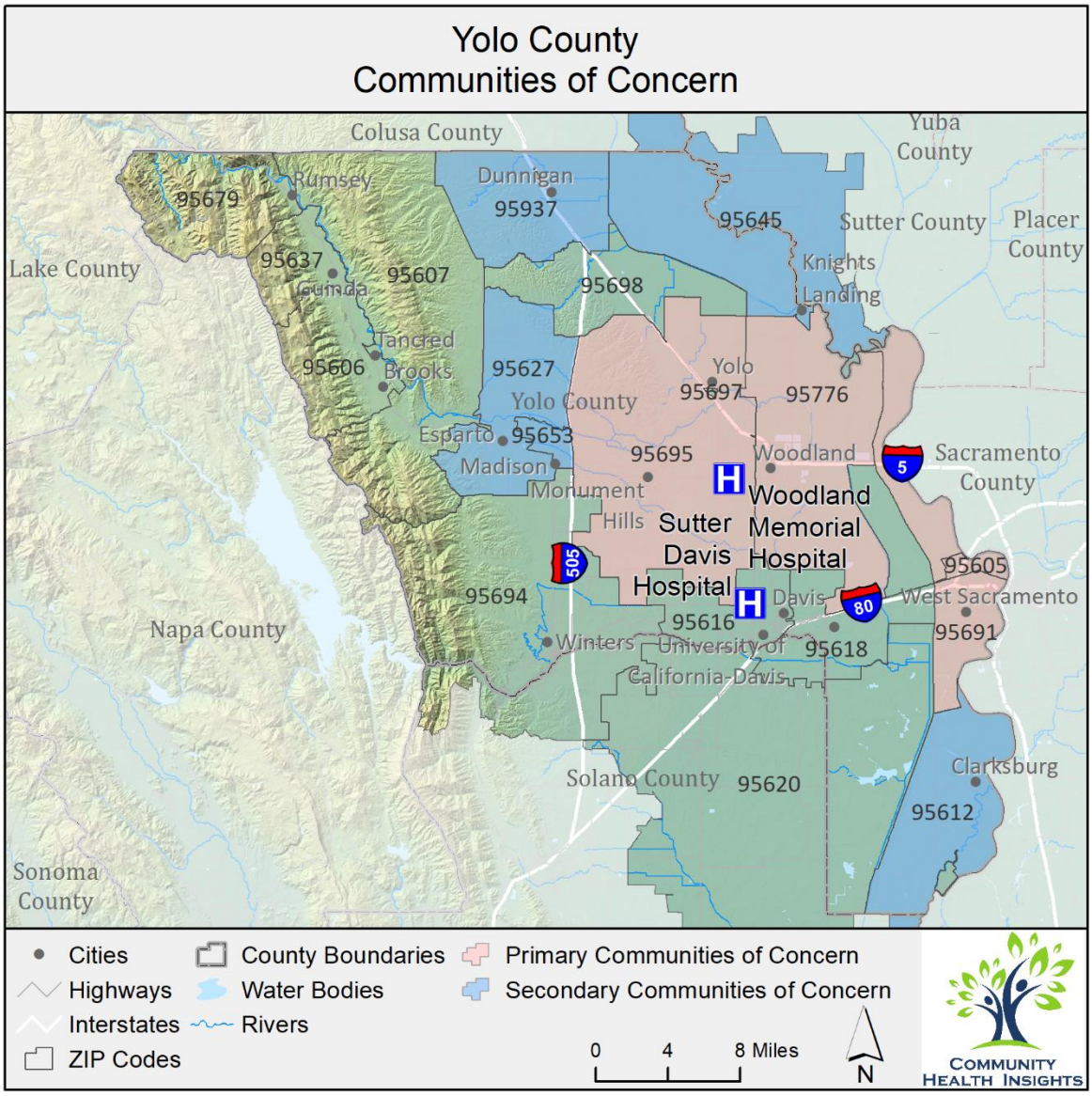


Figure 6: Yolo County Communities of Concern.

The Impact of COVID-19 on Health Needs

COVID-19 related health indicators for Yolo County are noted in Table 7.

Table 7: COVID-19-related rates for Yolo County.

Indicators	Description	Yolo	California	
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	118.2	185.1	Yolo: 118.2 California: 185.1
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory confirmed COVID-19 cases.	1.3%	1.5%	Yolo: 1.3% California: 1.5%
COVID-19 Cumulative Incidence	Number of laboratory confirmed COVID-19 cases per 100,000 population.	9,237.1	12,087.6	Yolo: 9,237.1 California: 12,087.6
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	63,444.1	63,134.6	Yolo: 63,444.1 California: 63,134.6

- Retrieved on November 17th, 2021

Indicators in Table 7 related to COVID-19 for Yolo County, compared to the state, show lower COVID-19 mortality, slightly lower case fatality rate due to COVID-19, lower cumulative incidence, and a higher COVID-19 full vaccination rate. Table *8* displays cases and testing percentages by race and ethnicity for Yolo County.

Table 8: COVID-19 inequities by race and ethnicity in Yolo County.[17]

COVID-19	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White
Percent of County Population	Percentage of population by group	0.6%	19.1%	2.6%	32.1%	42%
Percent COVID-19 Cases	Percentage of COVID-19 cases by race and ethnicity	~	17.3%	~	35.5%	41.5%
Percent testing COVID-19	Percentage of COVID-19 testing by race and ethnicity	~	22.6%	~	21.9%	51.4%

[17] California.gov. California's Commitment to Health Equity. COVID 19 Impact by race and ethnicity. Retrieved from https://covid19.ca.gov/equity/#location-yolo on February 1st, 2022.

COVID-19 Cases per 100,000 population	Case rate of COVID-19 by race and ethnicity	~	3,057	~	3,735	3,336

~ Data not shown because there were fewer than 20,000 people in this group.

Hispanics have the highest COVID-19 case rate per 100,000, a larger percent of cases relative to their percent of the population, and the lowest percent testing of any other group. Both Asians and Whites have higher percent of testing relative to their percent population in the county.

Key informants and focus group participants were asked how the COVID-19 pandemic had impacted the health needs they described during interviews. Service Provider Survey respondents were also asked to identify ways in which COVID-19 impacted health needs in the communities they served. A summary of their responses is shown in Table 9.

Table 9: The impacts of COVID-19 on health need as identified in primary data sources.

Key Informant and Focus Group Responses	Service Provider Survey Responses
- Fear of accessing care for both the acute and chronically ill. - Preventive and emergent health visits placed on hold due to fear of contagion. - Amplified mental health needs in the county. - Limits at receiving care due to lack of devices or tech literacy challenges. - Basic needs have gotten more pronounced (housing, food insecurity). - Many residents (farm workers) continued to work as essential workers during the shutdown. - Seniors were disproportionately affected – especially those in congregate living communities. - COVID-19 disproportionately affected the following groups in Yolo County: Latinos, Seniors, homeless, migrant workers, previously isolated, marginalized. - Breastfeeding rates dropped, while more low birthweight babies were born in the county. - Vaccination rates in Latino migrant and Russian communities are low. - Chronic disease indicators have worsened for many – increased blood pressure, increased blood sugar. - Academic challenges of youth and young adults worsened. - Community and gun violence has increased in the pandemic. **Pandemic silver linings:** - New partnerships among organizations and Yolo Health and Human Services (HHS), and between organizations, were formed. - Vaccination distribution by Yolo HHS was efficient and well organized.	- Isolation is harming the mental health of community members. - Residents delayed healthcare to limit their exposure to the virus. - Residents encounter economic hardships from lost or reduced employment. - Youth no longer have ready access to the services they previously received at school (e.g., free/reduced lunch, mental and physical health services). - Residents in the community are being evicted from their homes.

- Local organizations developed creative ways for vaccine dissemination.	

The Yolo County Community Health Status survey (community survey) asked specific questions about the impact of COVID-19 on various life factors. Question 21 asked, "Have you received healthcare services or medical screenings in the past 12 months? (Routine check-up, blood pressure screening, mammogram, etc.)." Among respondents that indicated "no", 27.84% stated they did not receive healthcare services or medical screenings in the past 12 months due to COVID-19 exposure concerns.

Survey participants were also asked about the top three "negative impacts of the COVID-19 Pandemic on the overall health and wellbeing of the Yolo County community?" The most commonly mentioned negative impacts are as follows with the corresponding percent of the community survey sample selecting each item:

- Job loss or reduction in work hours (46.2%)
- Businesses closing (42.5%)
- Mental health issues (42.3%)
- Illness related to contracting COVID-19 (36.5%)
- Social isolation (30.9%)
- Schools closing (27.3%)
- Lack of childcare for working parents (21.8%)

Resources Potentially Available to Meet the Significant Health Needs

In all, 367 resources in the service area were identified in Yolo County that were potentially available to meet the identified significant health needs. These resources were provided by a total of 112 social service, nonprofit, and governmental organizations, agencies, and programs identified in the assessment. The identification method included starting with the list of resources from the 2019 Yolo County collaborative CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 10.

Table 10: Resources potentially available to meet significant health needs in priority order.

Significant Health Needs (in Priority Order)	Number of Resources
Access to Basic Needs Such as Housing, Jobs, and Food	76
Access to Mental/Behavioral Health and Substance Use Services	47
Injury and Disease Prevention and Management	19
Active Living and Healthy Eating	32
Access to Quality Primary Care Health Services	43
System Navigation	30
Access to Specialty and Extended Care	19
Increased Community Connections	48
Safe and Violence-Free Environment	37
Access to Functional Needs	11
Access to Dental Care and Preventive Services	5
Total Resources	**367**

For more specific examination of resources by significant health need and by geographic location, as well as the detailed method for identifying these, see the technical section of this report.

Impact and Evaluation of Actions Taken by Hospital

Regulations require that each hospital's CHNA report include "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s) (p. 78969)."[18] Each Yolo County collaborative hospital partner invested efforts to address the significant health needs identified in the prior CHNA. Appendix A includes details of those efforts.

Conclusion

Community Health Assessments play an important role in helping community partners determine where to focus community benefit and health improvement efforts, including targeting efforts in geographic locations and on specific populations experiencing inequities leading to health disparities. Data in this report can help provide nonprofit hospitals, local health departments, and community service providers work in collaboration to engage in meaningful community work.

Please send any feedback about this CHNA report to **[insert by Sutter Davis]** with "CHNA Comments" in the subject line. Feedback received will be incorporated into the next community health assessment cycle.

[18] Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

2022 CHNA Technical Section

The following section presents a detailed account of data collection, analysis, and results for Yolo County (Yolo).

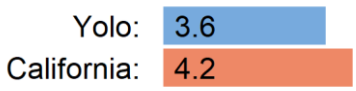
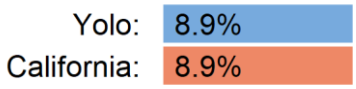
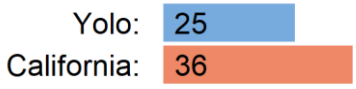
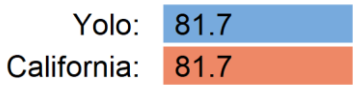
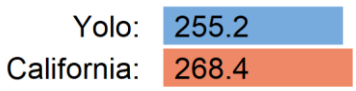
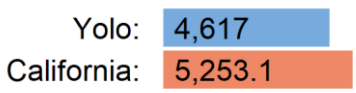
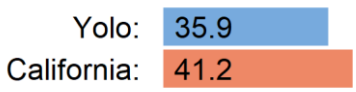
Results of Quantitative Data Analysis

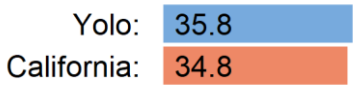
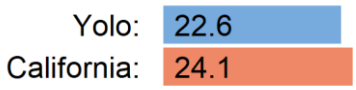
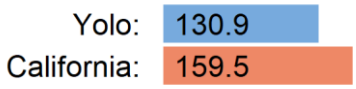
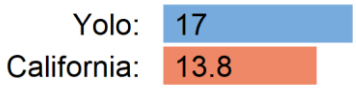
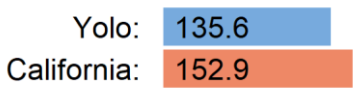
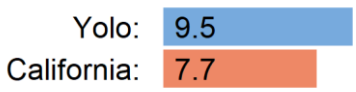
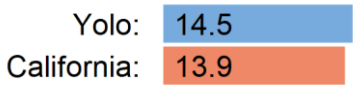
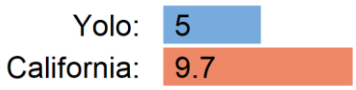
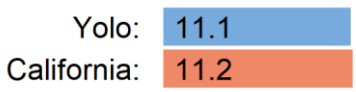
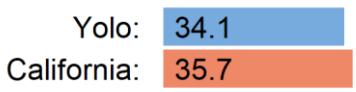
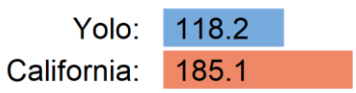
Compiled Secondary Data

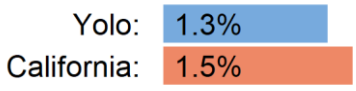
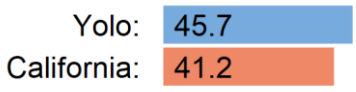
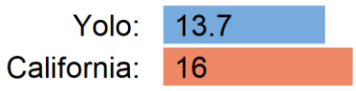
The tables and figures that follow show the specific values for the health need indicators used as part of the health need identification process. Indicator values for Yolo County were compared to the California state benchmark and are highlighted below when the county's performance was worse than the state's value. The associated figures show rates for the county compared to the California state rates.

Length of Life

Table 11: County length of life indicators compared to state benchmarks.

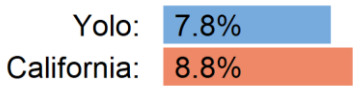
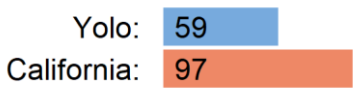
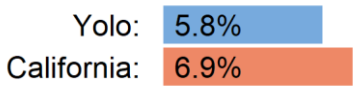
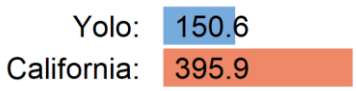
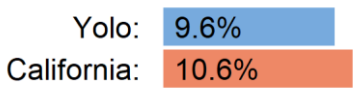
Indicators	Description	Yolo	California	
Early Life				
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	3.6	4.2	
Preterm Birth	Percentage of births preterm (<37 weeks)	8.9%	8.9%	
Child Mortality	Number of deaths among children under age 18 per 100,000 population.	25.0	36.0	
Life Expectancy	Average number of years a person can expect to live.	81.7	81.7	
Overall				
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	255.2	268.4	
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	4,617.0	5,253.1	
Stroke Mortality	Number of deaths due to stroke per 100,000 population.	35.9	41.2	

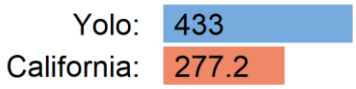
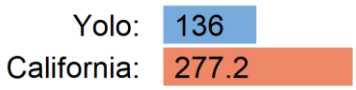
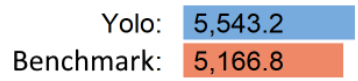
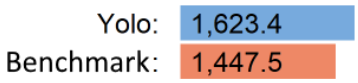
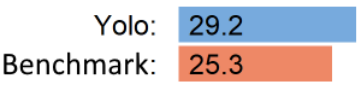
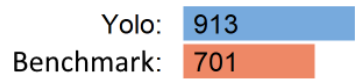
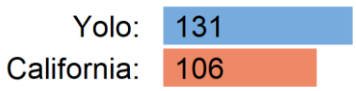
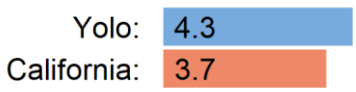
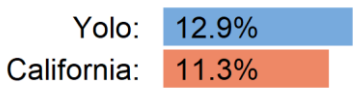
Chronic Lower Respiratory Disease Mortality	Number of deaths due to chronic lower respiratory disease per 100,000 population.	35.8	34.8	
Diabetes Mortality	Number of deaths due to diabetes per 100,000 population.	22.6	24.1	
Heart Disease Mortality	Number of deaths due to heart disease per 100,000 population.	130.9	159.5	
Hypertension Mortality	Number of deaths due to hypertension per 100,000 population.	17.0	13.8	
Cancer, Liver, and Kidney Disease				
Cancer Mortality	Number of deaths due to cancer per 100,000 population.	135.6	152.9	
Liver Cancer Mortality	Number of deaths due to liver cancer per 100,000 population.	9.5	7.7	
Liver Disease Mortality	Number of deaths due to liver disease per 100,000 population.	14.5	13.9	
Kidney Disease Mortality	Number of deaths due to kidney disease per 100,000 population.	5.0	9.7	
Intentional and Unintentional Injuries				
Suicide Mortality	Number of deaths due to suicide per 100,000 population.	11.1	11.2	
Unintentional Injuries Mortality	Number of deaths due to unintentional injuries per 100,000 population.	34.1	35.7	
COVID-19				
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	118.2	185.1	

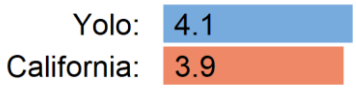
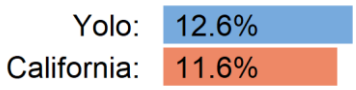
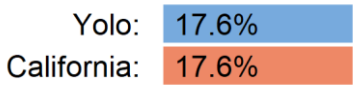
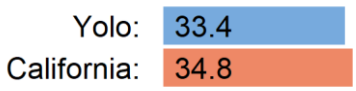
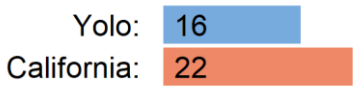
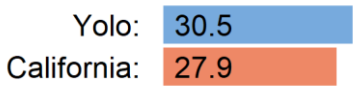
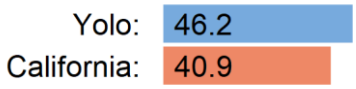
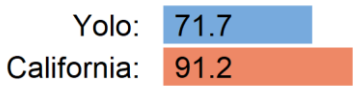
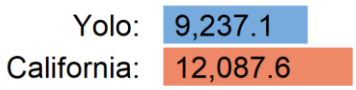
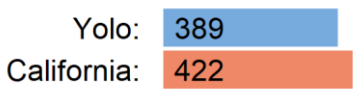
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory confirmed COVID-19 cases.	1.3%	1.5%	
Other				
Alzheimer's Disease Mortality	Number of deaths due to Alzheimer's disease per 100,000 population.	45.7	41.2	
Influenza and Pneumonia Mortality	Number of deaths due to influenza and pneumonia per 100,000 population.	13.7	16.0	

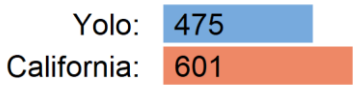
Quality of Life

Table 12: County quality of life indicators compared to state benchmarks.

Indicators	Description	Yolo	California	
Chronic Disease				
Diabetes Prevalence	Percentage of adults ages 20 and above with diagnosed diabetes.	7.8%	8.8%	
Hospitalizations for Diabetes Long Term Complications	Age-sex-adjusted hospitalization rate for long-term complications due to diabetes per 100,000.	59.0	97.0	
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	5.8%	6.9%	
HIV Prevalence	Number of people ages 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	150.6	395.9	
Disability	Percentage of the total civilian noninstitutionalized population with a disability.	9.6%	10.6%	
Dental Health				

Emergency Department (ED) Visits for Dental Diagnosis Adult	ED visits for persons ages 18 and older with dental problems as the primary diagnosis per 100,000.	433.0	277.2[1]	
ED Visits For Dental Diagnosis Child	Emergency department visits for persons under age 18 with dental problems as primary diagnosis per 100,000.	136.0	277.2[1]	
Falls				
ED Falls Ages 65+	Emergency department visits for persons ages 65 or older for accidental falls per 100,000.	5,543.2	5,166.8[2]	
Hospitalizations for Falls Ages 65+	Hospitalizations for persons ages 65 or older for accidental falls per 100,000.	1,623.4	1,447.5[2]	
Mental Health				
Hospitalizations for Self-Inflicted Injuries Youth	Non-fatal hospitalizations for self-inflicted injury for persons ages 15-24 per 100,000.	29.2	25.3[3]	
Hospitalizations for Mental Health Young Adults	Hospitalizations for Mental Health (MDC 19) for persons ages 15-24 per 100,000.	913.0	701.0[4]	
Hospitalizations for Mental Health or Substance Use	Hospitalizations for mental health or alcohol- or drug-related diagnoses per 100,000.	131.0	106.0	
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	4.3	3.7	
Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	12.9%	11.3%	

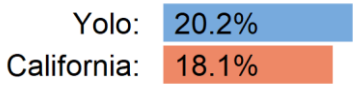
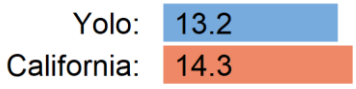
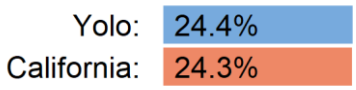
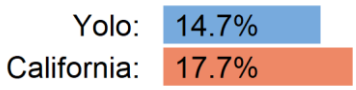
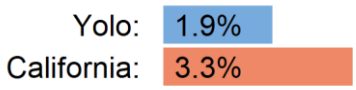
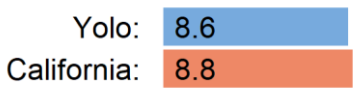
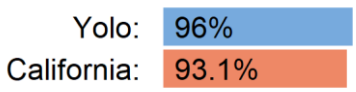
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	4.1	3.9	
Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	12.6%	11.6%	
Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	17.6%	17.6%	
Cancer				
Colorectal Cancer Prevalence	Colon and rectum cancers per 100,000 population (age-adjusted).	33.4	34.8	
Cancer Colon Hospitalizations	Hospitalizations for with colon cancer as the primary diagnosis per 100,000	16.0	22.0	
Breast Cancer Prevalence	Female in situ breast cancers per 100,000 female population (age-adjusted).	30.5	27.9	
Lung Cancer Prevalence	Lung and bronchus cancers per 100,000 population (age-adjusted).	46.2	40.9	
Prostate Cancer Prevalence	Prostate cancers per 100,000 male population (age-adjusted).	71.7	91.2	
COVID-19				
COVID-19 Cumulative Incidence	Number of laboratory confirmed COVID-19 cases per 100,000 population.	9,237.1	12,087.6	
Other				
Asthma Emergency Department (ED) Rates	Emergency department visits due to asthma per 10,000 (age-adjusted).	389.0	422.0	

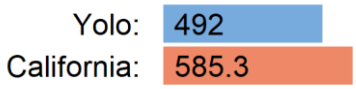
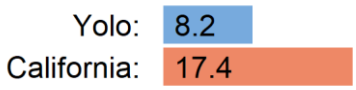
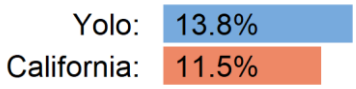
Asthma ED Rates for Children	Emergency department visits due to asthma among ages 5-17 per 10,000 population ages 5-17 (age-adjusted).	475.0	601.0	

[1]Benchmarked against state rate for all ages
[2]Benchmarked against 2016 Yolo county rate
[3]Benchmarked against 2013-2016 Yolo county rate
[4]Benchmarked against 2012-2015 Yolo county rate

Health Behavior

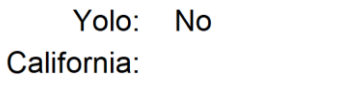
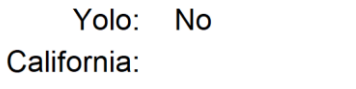
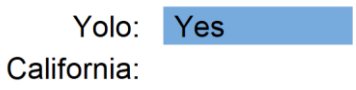
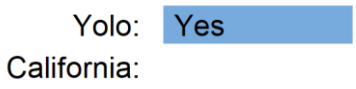
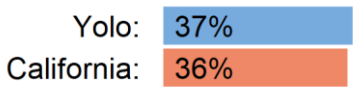
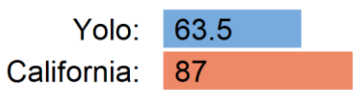
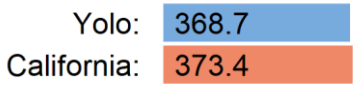
Table 13: County health behavior indicators compared to state benchmarks.

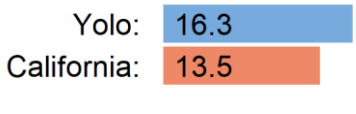
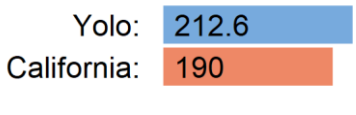
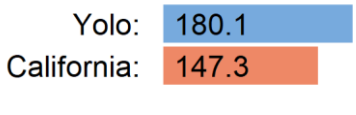
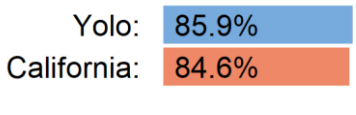
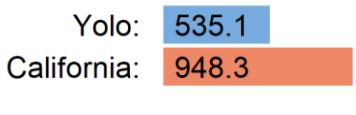
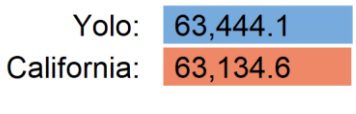
Indicators	Description	Yolo	California	
Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	20.2%	18.1%	
Drug Induced Death	Drug induced deaths per 100,000 (age-adjusted).	13.2	14.3	
Adult Obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.	24.4%	24.3%	
Physical Inactivity	Percentage of adults ages 20 and over reporting no leisure-time physical activity.	14.7%	17.7%	
Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	1.9%	3.3%	
Food Environment Index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	8.6	8.8	
Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity.	96.0%	93.1%	

Chlamydia Incidence	Number of newly diagnosed chlamydia cases per 100,000 population.	492.0	585.3	
Teen Birth Rate	Number of births per 1,000 female population ages 15-19.	8.2	17.4	
Adult Smoking	Percentage of adults who are current smokers (age-adjusted).	13.8%	11.5%	

Clinical Care

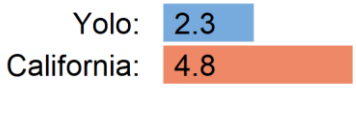
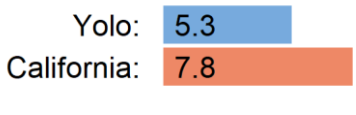
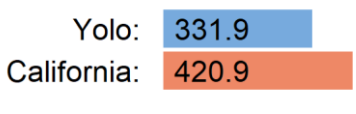
Table 14: County clinical care indicators compared to state benchmarks.

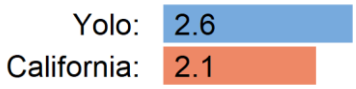
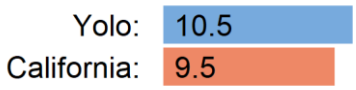
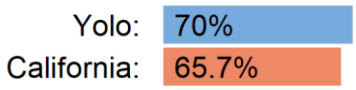
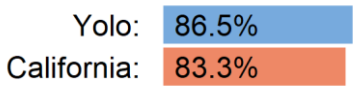
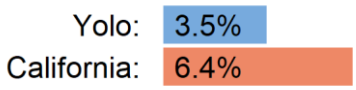
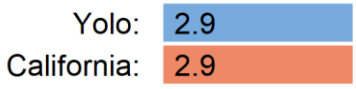
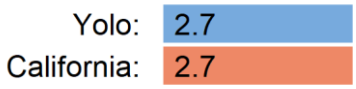
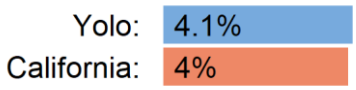
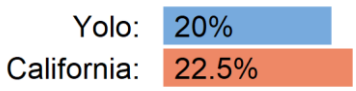
Indicators	Description	Yolo	California	
Primary Care Shortage Area	Presence of a primary care health professional shortage area within the county.	No	NA	
Dental Care Shortage Area	Presence of a dental care health professional shortage area within the county.	No	NA	
Mental Health Care Shortage Area	Presence of a mental health professional shortage area within the county.	Yes	NA	
Medically Underserved Area	Presence of a medically underserved area within the county.	Yes	NA	
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.	37.0%	36.0%	
Dentists	Dentists per 100,000 population.	63.5	87.0	
Mental Health Providers	Mental health providers per 100,000 population.	368.7	373.4	

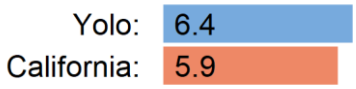
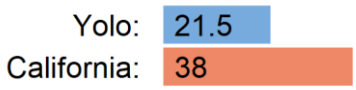
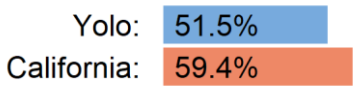
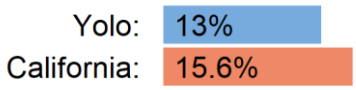
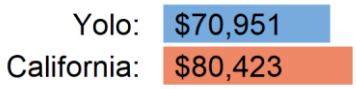
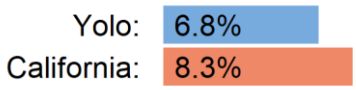
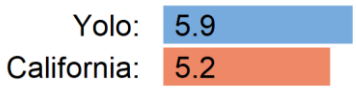
Psychiatry Providers	Psychiatry providers per 100,000 population.	16.3	13.5	
Specialty Care Providers	Specialty care providers (non-primary care physicians) per 100,000 population.	212.6	190.0	
Primary Care Providers	Primary care physicians per 100,000 population + other primary care providers per 100,000 population.	180.1	147.3	
Prenatal Care	Percentage of live births receiving prenatal care in the first trimester	85.9%	84.6%	
Preventable Hospitalization	Preventable hospitalizations per 100,000 (age-sex-poverty adjusted).	535.1	948.3	
COVID-19				
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	63,444.1	63,134.6	

Socio-Economic and Demographic Factors

Table 15: County socio-economic and demographic factors indicators compared to state benchmarks.

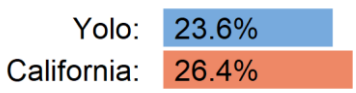
Indicators	Description	Yolo	California	
Community Safety				
Homicide Rate	Number of deaths due to homicide per 100,000 population.	2.3	4.8	
Firearm Fatalities Rate	Number of deaths due to firearms per 100,000 population.	5.3	7.8	
Violent Crime Rate	Number of reported violent crime offenses per 100,000 population.	331.9	420.9	

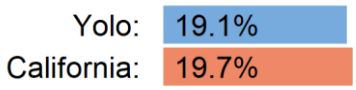
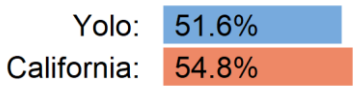
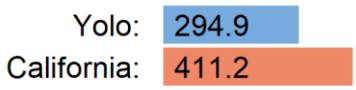
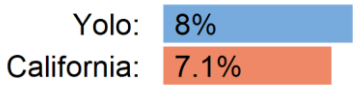
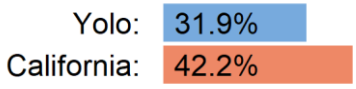
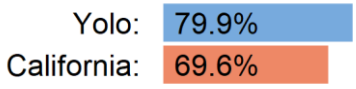
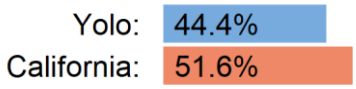
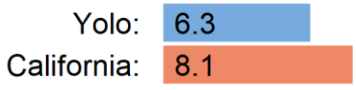
Juvenile Arrest Rate	Felony juvenile arrests per 1,000 juveniles.	2.6	2.1	
Motor Vehicle Crash Death	Number of motor vehicle crash deaths per 100,000 population.	10.5	9.5	
Education				
Some College	Percentage of adults ages 25-44 with some post-secondary education.	70.0%	65.7%	
High School Completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	86.5%	83.3%	
Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	3.5%	6.4%	
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests.	2.9	2.9	
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests.	2.7	2.7	
Employment				
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	4.1%	4.0%	
Family and Social Support				
Children in Single-Parent Households	Percentage of children that live in a household headed by single parent.	20.0%	22.5%	

Social Associations	Number of membership associations per 10,000 population.	6.4	5.9	
Residential Segregation (Non-White/White)	Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents.	21.5	38.0	
Income				
Children Eligible for Free Lunch	Percentage of children enrolled in public schools that are eligible for free or reduced-price lunch.	51.5%	59.4%	
Children in Poverty	Percentage of people under age 18 in poverty.	13.0%	15.6%	
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$70,951.0	$80,423.0	
Uninsured Population under 64	Percentage of population under age 65 without health insurance.	6.8%	8.3%	
Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	5.9	5.2	

Physical Environment

Table 16: County physical environment indicators compared to state benchmarks.

Indicators	Description	Yolo	California	
Housing				
Severe Housing Problems	Percentage of households with at least 1 of 4 housing	23.6%	26.4%	

	problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.			
Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing.	19.1%	19.7%	
Homeownership	Percentage of occupied housing units that are owned.	51.6%	54.8%	
Homelessness Rate	Number of homeless individuals per 100,000 population.	294.9	411.2	
Transit				
Households with no Vehicle Available	Percentage of occupied housing units that have no vehicles available.	8.0%	7.1%	
Long Commute - Driving Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	31.9%	42.2%	
Access to Public Transit	Percentage of population living near a fixed public transportation stop.	79.9%	69.6%	
Air and Water Quality				
Pollution Burden Percent	Percentage of population living in a census tract with a CalEnviroscreen 3.0 pollution burden score percentile of 50 or greater.	44.4%	51.6%	
Air Pollution - Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	6.3	8.1	

Drinking Water Violations	Presence of health-related drinking water violations in the county.	No	NA	Yolo: No California:

Yolo Community Health Status Survey Results

Table 17 shows the results from the Yolo Community Health Status Survey. Survey questions, the percent of sample responding to each question, and the comparable benchmark(s) are shown. Benchmarks are listed in the table and include benchmarking data to the same question in the 2018 community survey, or 2020 California Health Interview Survey (CHIS) data.

Table 17: Yolo County Community Health Status Survey responses compared to selected benchmarks.

Question Number	Question	Value	Benchmark	Benchmark Source	
Q8	Do you have a condition that substantially limits one or more physical activities? (Yes)	21.4%	29%	2018 county survey	Value: 21.4% Benchmark: 29%
Q10a	Have you ever been told you have asthma/lung disease/COPD/emphysema? (Yes)	18.2%	15.4%	2020 CHIS (California)	Value: 18.2% Benchmark: 15.4%
Q10b	Have you ever been told you have autoimmune disease (Lupus, Type 1 diabetes)? (Yes)	8.8%	5.2%	2018 county survey	Value: 8.8% Benchmark: 5.2%
Q10c	Have you ever been told you have cancer? (Yes)	4.6%	5.8%	2018 county survey	Value: 4.6% Benchmark: 5.8%
Q10d	Have you ever been told you have diabetes? (Yes)	11.3%	10.9%	2020 CHIS (California)	Value: 11.3% Benchmark: 10.9%
Q10f	Have you ever been told you have heart disease (Yes)	2.9%	6.5%	2020 CHIS (California)	Value: 2.9% Benchmark: 6.5%
Q10g	Have you ever been told you have hypertension? (Yes)	17%	25.1%	2020 CHIS (California)	Value: 17% Benchmark: 25.1%
Q10h	Have you ever been told you have mental illness? (Yes)	13.5%	12.2%	2020 CHIS (California)	Value: 13.5% Benchmark: 12.2%

Q10e	Have you ever been told you have a drug or alcohol problem? (Yes)	2.4%	2.8%	2018 county survey	Value: 2.4% Benchmark: 2.8%
Q10j	Have you ever been told you have a physical disability? (Yes)	7.4%	8.5%	2018 county survey	Value: 7.4% Benchmark: 8.5%
Q10i	Have you ever been told that you have obesity/overweight? (Yes)	19.5%	28.5%	2020 CHIS (California)	Value: 19.5% Benchmark: 28.5%
Q11	Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your mental health, emotions, nerves, or use of alcohol or drugs? (Yes)	34.9%	20.9%	2020 CHIS (California)	Value: 34.9% Benchmark: 20.9%
Q44	Do you have health insurance? (No)	3.3%	7.5%	ACS 5-year (2019) TableID: DP03 (California)	Value: 3.3% Benchmark: 7.5%
Q15	How long does it normally take you to get to your regular doctor's office from your home? (Over 30 Minutes)	8%	14.5%	2018 county survey	Value: 8% Benchmark: 14.5%
Q18	Were you satisfied with how quickly you were able to get an appointment? (No)	13.1%	15.3%	2018 county survey	Value: 13.1% Benchmark: 15.3%
Q21g	If not satisfied, select I have to wait too long to see a doctor	9%	11.3%	2018 county survey	Value: 9% Benchmark: 11.3%
Q21j	If not satisfied, select: The doctor does not speak the same language as I do	0.3%	3.3%	2018 county survey	Value: 0.3% Benchmark: 3.3%
Q21d	If not satisfied, select I did not have transportation to the medical clinic	3.6%	3.5%	2018 county survey	Value: 3.6% Benchmark: 3.5%

Q21k	If not satisfied, select: The medical clinic is not open all of the time, so it is difficult to get an appt.	4.9%	4.4%	2018 county survey	Value: 4.9% Benchmark: 4.4%
Q21l	If not satisfied, select: There are not enough doctors in my area, so it is difficult to get an appt.	4.4%	3.3%	2018 county survey	Value: 4.4% Benchmark: 3.3%
Q21a	If not satisfied, select I did/do not have insurance	10.3%	11.7%	2018 county survey	Value: 10.3% Benchmark: 11.7%
Q21b	If not satisfied, select I did/do have health insurance, but it does not cover all of my costs	8.2%	7.7%	2018 county survey	Value: 8.2% Benchmark: 7.7%
Q21e	If not satisfied, select I do not trust the healthcare providers	3.1%	2.4%	2018 county survey	Value: 3.1% Benchmark: 2.4%
Q23a	Why visit ER: Could not get an urgent care appointment with my doctor	20.3%	14.9%	2018 county survey	Value: 20.3% Benchmark: 14.9%
Q23c	Why visit ER: Needed to refill a prescription	1.7%	4.9%	2018 county survey	Value: 1.7% Benchmark: 4.9%
Q23d	Why visit ER: Thought it seemed more convenient than waiting for an appointment	8.1%	10.6%	2018 county survey	Value: 8.1% Benchmark: 10.6%
Q23b	Why visit ER: Do not have a regular doctor or dentist, this is my usual source of care	4.7%	5.1%	2018 county survey	Value: 4.7% Benchmark: 5.1%
Q48	Do you have dental insurance? (Yes)	82.1%	70.4%	2020 CHIS (California)	Value: 82.1% Benchmark: 70.4%
Q49	Have you been to the dentist in the past 12 months? (Yes)	63.8%	67.2%	2020 CHIS (California)	Value: 63.8% Benchmark: 67.2%
Q50	Do you have reliable internet at home? (No)	13.4%	13.1%	ACS 5-year (2019) TableID: S2801 (California)	Value: 13.4% Benchmark: 13.1%

Service Provider Survey Results

Service Provider Survey results are included in Table 18 for Yolo County. The county snapshot lists the 5 most commonly reported health needs by the survey sample, the top 3 priority health needs selected by the sample, and the top three descriptions selected by the sample to describe each priority health need.

Table 18: Yolo Service Provider Survey Results Summary

Service Provider Survey Snapshot | Yolo County			
Health Needs			**% Reporting**
Most Frequently Reported			
	Access to Mental/Behavioral Health and Substance Use Services		78.6%
	System Navigation		78.6%
	Active Living and Healthy Eating		71.4%
	Access to Basic Needs		71.4%
	Access to Specialty and Extended Care		71.4%
	Increased Community Connection		71.4%
Top 3/ Priority *(Most Frequently Reported Characteristics)*			
	Access to Mental/Behavioral Health and Substance-Use Services		50.0%
		There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).	
		Substance use is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse).	
		There aren't enough services here for those who are homeless and dealing with substance use issues.	
	Access to Basic Needs		50.0%
		Lack of affordable housing is a significant issue in the area.	
		It is difficult to find affordable childcare.	
		Many people in the area do not make a living wage.	
	Access to Specialty and Extended Care		35.7%
		Not all specialty care is covered by insurance.	
		People have to travel to reach specialists.	
		The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care).	

CHNA Methods and Processes

Two related models were foundational in this assessment. The first is a conceptual model that expresses the theoretical understanding of community health used in the analysis. This model is important because it provides the framework for the collection of primary and secondary data. It is the tool used to ensure that the results are based on a rigorous understanding of those factors that influence the health of a community. The second model is a process model that describes the various stages of the analysis. It is the

tool that ensures that the resulting analysis is based on a tight integration of community voice and secondary data and that the analysis meets federal regulations for conducting hospital CHNAs.

Conceptual Model

The conceptual model used in this needs assessment is shown in Figure *7*. This model organizes a population's individual health-related characteristics in relation to up- or downstream health and health disparities factors. This model illustrates how health outcomes (quality and length of life) result from the influence of health factors describing interrelated individual, environmental, and community characteristics, which in turn are influenced by underlying policies and programs.

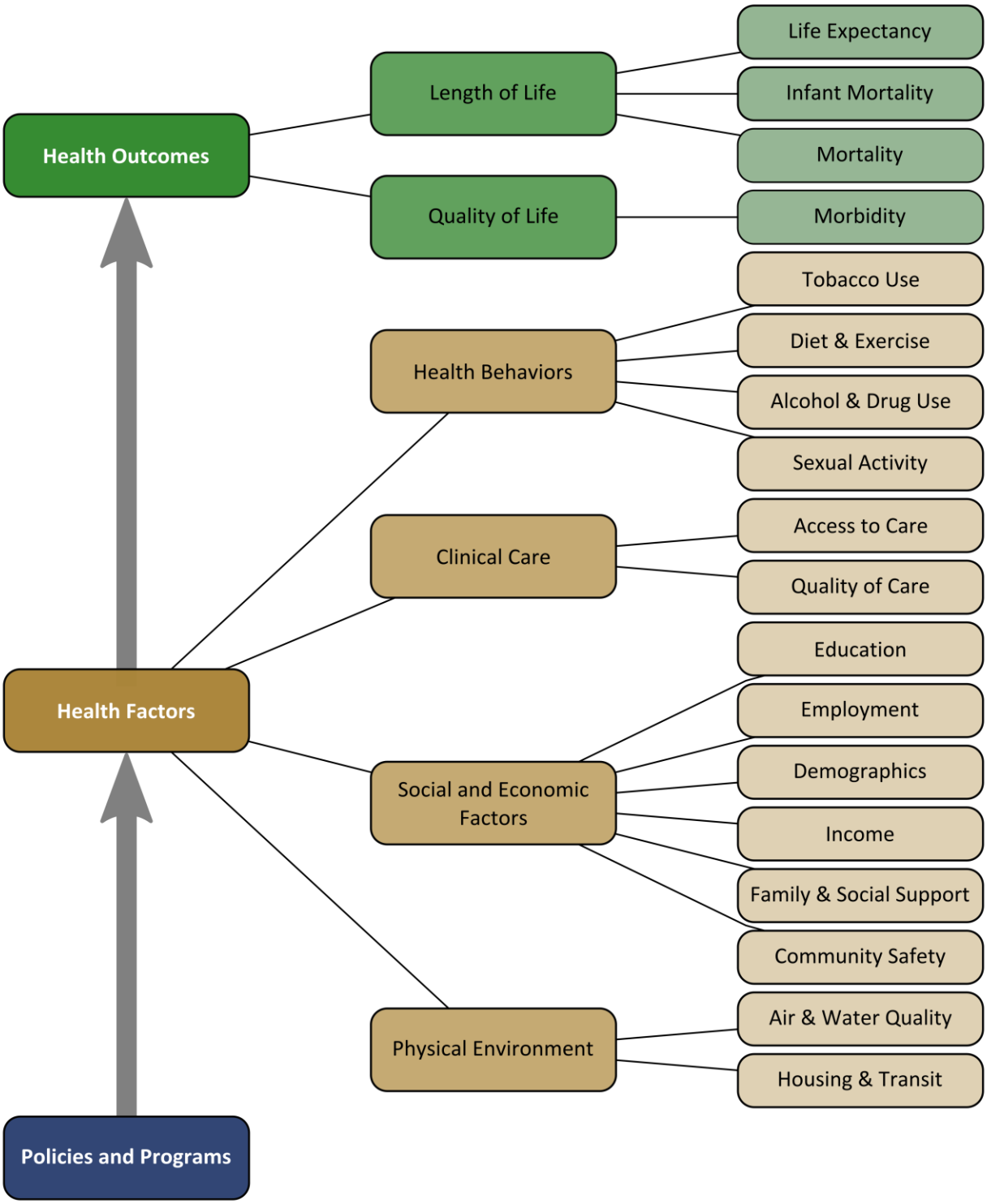


Figure 7: Community Health Assessment Conceptual Model as modified from the County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2015.

This model was used to guide the selection of secondary indicators in this analysis as well as to illustrate how these upstream health factors lead to the downstream health outcomes. It also suggests that poor

health outcomes within the county can be improved through policies and programs that address the health factors contributing to them. This conceptual model is a slightly modified version of the County Health Rankings Model used by the Robert Wood Johnson Foundation. It was primarily altered by adding a "Demographics" category to the "Social and Economic Factors" in recognition of the influence of demographic characteristics on health outcomes.

To generate the list of secondary indicators for the assessment, each conceptual model category was reviewed to identify potential indicators that could be used to fully represent the category. The results were then used to guide secondary data collection.

Process Model

Figure *8* outlines the data collection and analysis stages of this process. The process began by confirming the service area for Yolo County for which the CHNA would be conducted. Primary data collection included both key informant and focus group interviews with community health experts and residents. Initial key informant interviews were used to identify Communities of Concern which are areas or population subgroups within the county experiencing health disparities.

Overall primary and secondary data were integrated to identify significant health needs for the county. Significant health needs were then prioritized based on analysis of the primary data. Finally, information was collected regarding the resources available within the community to meet the identified health needs. An evaluation of the impact of the hospital's prior efforts was obtained from hospital representatives and any written comments on the previous CHNA were gathered and included in the report.

Greater detail on the collection and processing of the secondary and primary data is given in the next two sections. This is followed by a more detailed description of the methodology utilized during the main analytical stages of the process.

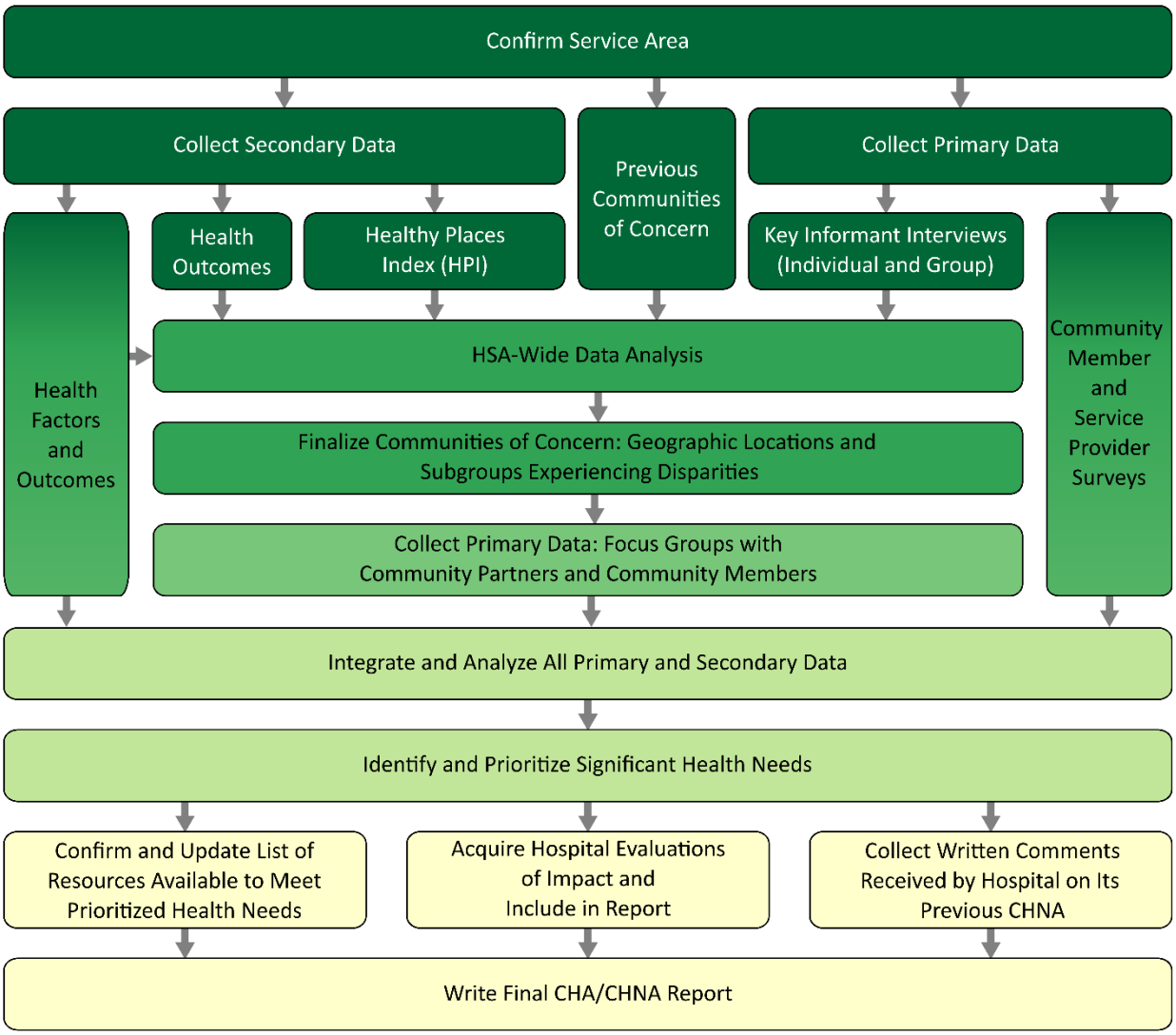


Figure 8: CHNA process model for Yolo Collaborative.

Primary Data Collection and Processing

Key Informant and Focus Group Data Collection

Input from the community served by Yolo County was collected through two main mechanisms. First, key informant interviews were conducted with community health experts and area service providers (i.e., members of social service nonprofit organizations and related healthcare organizations). These interviews occurred in both one-on-one and in group interview settings. Second, focus groups were conducted with community residents that were identified as members or representatives of populations experiencing disparities.

All participants were given an informed consent form prior to their participation, which provided information about the project, asked for permission to record the interview, and listed the potential benefits and risks for involvement in the interview. All interview data were collected through note taking and, in some instances, recording.

Key Informant Results

Primary data collection with key informants included two phases. Phase one began by interviewing area-wide service providers with knowledge of the county, including input from the designated Public Health Department. Data from these area-wide informants, coupled with socio-demographic data, were used to identify additional key informants for the assessment that were included in phase two.

As a part of the interview process, all key informants were asked to identify vulnerable populations. The interviewer asked each participant to verbally describe vulnerable populations existed in the county. As needed for a visual aid, key informants were provided with a map of county to directly point to the geographic locations of these vulnerable communities. Additional key informant interviews were focused on the geographic locations and/or subgroups identified in the earlier phase.

Table 19 contains a listing of community health experts, or key informants, that contributed input to the health assessment. The table describes the name of the represented organization, the number of participants and area of expertise, the populations served by the organization, and the date of the interview. Some interview data were obtained via a data sharing agreement with Harder and Co, a consulting firm conducting local Kaiser Permanente CHNAs with service areas in Yolo County.

Table 19: Key Informant List.

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Woodland Memorial Hospital	05/20/2021	2	Acute Care Hospital: Healthcare services	Countywide; special focus on LatinX Spanish Speaking Community
Sutter Davis Hospital	05/24/2021	1	Acute Care Hospital: Healthcare services	Low-income residents of Yolo County; uninsured and underinsured
Woodland Memorial Hospital	05/27/2021	5	Acute Care Hospital: Healthcare services	Residents of Yolo County; Central Woodland community members, low-income, uninsured, and underinsured community members
Sutter Davis Hospital	05/28/2021	1	Acute Care Hospital: Healthcare services	All residents of Yolo County
Yolo County Public Health	06/08/2021	4	Public Health	Countywide; special focus on women, infants, children, and families.
Yolo County Public Health	06/10/2021	5	Public Health	Countywide; community members experiencing health and social inequities

Winters Health	06/30/2021	1	FQHC: Healthcare services	Rural, Hispanic, migrant communities
CommuniCare	07/16/2021	1	FQHC: Healthcare services	Low income, underserved
Yolo Food Bank	07/22/2021	3	Food insecurity	Seniors, low-income families
Fourth and Hope	07/23/2021	1	Food, shelter, social services	Homeless
Woodland Joint Unified School District	07/26/2021	3	Education	School aged children; Hispanic
Rural Innovations in Social Economics (RISE)	07/27/2021	1	Food, clothing, referrals, after school programs	Low income, Hispanic, migrant community
Yolo County Children's Alliance[19]	08/01/2021	1	Child abuse prevention, policy, and advocacy	Children and families of Yolo County

Key Informant Interview Guide

The following questions served as the interview guide for key informant interviews.

2022 CHNA Group/Key Informant Interview Protocol

1. BACKGROUND
    a. Please tell me about your current role and the organization you work for?
        i. Probe for:
            1. Public health (division or unit)
            2. Hospital health system
            3. Local non-profit
            4. Community member
    b. How would you define the community (ies) you or your organization serves?
        ii. Probe for:
            1. Specific geographic areas?
            2. Specific populations served?
            3. Who? Where? Racial/ethnic make-up, physical environment (urban/ rural, large/small)
2. CHARACTERISTICS OF A HEALTHY COMMUNITY
    a. In your view, what does a healthy community look like?
        iii. Probe for:
            1. Social factors

[19] The Yolo County Children's Alliance Interview was provided to the Yolo CHNA collaborative as part of a data sharing agreement with Harder and Co, the consulting firm conducting local Kaiser Permanente CHNAs with service areas in Yolo County.

2. Economic factors
3. Clinical care
4. Physical/built environment (food environment, green spaces)
5. Neighborhood safety

3. HEALTH ISSUES
    a. What would you say are the biggest health needs in the community?
        iv. Probe for:
            1. How has the presence of COVID impacted these health needs?
    b. INSERT MAP exercise: Please use the map provided to help our team understand where communities that experience the greatest health disparities live.
        v. Probe for:
            1. What specific geographic locations struggle with health issues the most?
            2. What specific groups of community members experience health issues the most?
2. CHALLENGES/BARRIERS
    a. Looking through the lens of equity, what are the challenges (barriers or drivers) to being healthy for the community as a whole?
        i. Do these inequities exist among certain population groups?
        vi. Probe for:
            1. Health behaviors (maladaptive, coping)
            2. Social factors (social connections, family connectedness, relationship with law enforcement)
            3. Economic factors (income, access to jobs, affordable housing, affordable food)
            4. Clinical care factors (access to primary care, secondary care, quality of care)
            5. Physical (built) environment (safe and healthy housing, walkable communities, safe parks)
3. SOLUTIONS
    a. What solutions are needed to address the health needs and or challenges mentioned?
        vii. Probe for:
            1. Policies
            2. Care coordination
            3. Access to care
            4. Environmental change
4. PRIORITY
    a. Which would you say are currently the most important or urgent health issues or challenges to address (at least 3 to 5) in order to improve the health of the community?
5. RESOURCES
    a. What resources exist in the community to help people live healthy lives?
        viii. Probe for:
            1. Barriers to accessing these resources.
            2. New resources that were created since 2019
            3. New partnerships/projects/funding
6. PARTICIPANT DRIVEN SAMPLING:
    a. What other people, groups or organizations would you recommend we speak to about the health of the community?
        ix. Name 3 types of service providers that you would suggest we include in this work.
        x. Name 3 types of community members that you would recommend we speak to in this work.

7. OPEN: Is there anything else you would like to share with our team about the health of the community?

Focus Group Results

Focus group interviews were conducted with community members or service providers living or working in geographic areas of the county identified as locations or populations disproportionately experiencing poor socioeconomic conditions and poor health outcomes. Recruitment consisted of referrals from designated service providers representing vulnerable populations, as well as direct outreach to special population groups.

Table 20 contains a listing of participants in focus groups that contributed input to the CHNA. The table describes the hosting organization of the focus group, the date it occurred, the total number of participants, and populations represented by focus group members.

Table 20: Focus Group List.

Hosting Organization	Date	Number of Participants	Population Represented
Woodland Area Educators	07/26/2021	3	Woodland; county hub; high school educators; focus on youth and young adults; mental health; impact of COVID on youth and young adults
RISE	09/01/2021	5	Esparto, rural; agricultural workers; Latino/a,/X community members; under or un resourced
CommuniCare	09/03/2021	10	West Sacramento based service providers and residents; under and uninsured; low income

Focus Group Interview Guide

The following questions served as the interview guides for focus group interviews.

2022 CHNA Focus Group Interview Protocol

1. Let's start by introducing ourselves. Please tell us your name, the town you live in, and one thing that you are proud of about your community.
2. We would like to hear about the community where you live. Tell us in a few words what you think of as "your community". What it is like to live in your community?
3. What do you think a "healthy environment" is?
4. When thinking about your community based on the healthy environment you just described, what are the biggest health needs in your community?
5. Are needs more prevalent in a certain geographic area, or within a certain group of the community?
6. How has the presence of COVID impacted these health needs?
7. What are the challenges or barriers to being healthy in your community?
8. What are some solutions that can help solve the barriers and challenges you talked about?
9. Based on what we have discussed so far, what are currently the most important or urgent top 3 health issues or challenges to address to improve the health of the community?
10. Are these needs that have recently come up or have they been around for a long time?

11. What are resources that exist in the community that help your community live healthy lives and address the health issues and inequity we have discussed?
12. Is there anything else you would like to share with our team about the health of the community?

Key Informant and Focus Group Data Processing

Key informant and focus group data were analyzed using qualitative analytic software. Content analysis included thematic coding to potential health need categories, the identification of special populations experiencing health issues, and the identification of resources. In some instances, data were coded in accordance with the interview question guide. Results were aggregated to inform the determination of prioritized significant health needs.

Service Provider Survey

A web-based survey was administered to service providers who delivered health and social services to community residents of the county). A list of service providers (affiliated with the nonprofit hospitals included in this report) was used as the initial sampling frame and an email recruitment message was sent to these providers detailing the survey's aims and inviting them to participate. A snowball sampling technique was also implemented, encouraging participants to forward the recruitment message to other providers in their networks. The survey was designed using Qualtrics, an online survey platform, and was available for approximately two weeks. Survey respondents were also given the opportunity to be acknowledged by name for their participation in the report and are listed as follows:

> Tracy Fauver, Louise Joyce, Chris Kelsch, Jeneba Lahai, Aide Long, Melissa Marshall, Diane Sommers, Nancy Ullrey, Oscar Velasco, Aileen Wetzel, and Doug Zeck.

After providing socio-demographic information including the county they served and their affiliated organization(s), survey respondents were shown a list of 12 potential health needs and asked to identify which were unmet health needs in their community. In order to reduce any confusion or ambiguity that could introduce bias, participants could scroll over each health need for a definition. Respondents were then asked to select which of the needs they identified as unmet in their community were the priority to address (up to three health needs). Upon selection of these priority unmet health needs, respondents were asked about the characteristics of each as it is expressed in their community. Depending upon the specific health need, respondents were shown a list of between 7-12 characteristics and could select all that apply. Respondents were also offered the opportunity to provide additional information about the health need in their community if it was not provided as a response option. Finally, a set of questions was included about how the COVID-19 pandemic impacted the health needs of the community.

When the survey period was over, incomplete, and duplicate responses were removed from the dataset and the survey responses were double-checked for accuracy. Descriptive statistics and frequencies were run to summarize the health needs. This information was used along with other data sources to both identify and rank significant health needs in the community and to describe how the health needs are expressed.

Yolo Public Health Community Health Status Survey

Countywide Community Health Status Survey Results

A countywide Community Health Status survey was distributed from July 1, 2021, through August 31, 2021. The survey is a component of the collaborative county-wide community Health Needs Assessment

(CHNA) development process and was primarily based on the 2018 community health survey, with additional questions added regarding health equity (Questions 36 and 37), as well as new response options to capture the impacts of the COVID-19 pandemic. The updated survey was reviewed by all partners, as well as diverse community organizations. The target sample size was 1,800 participants. The target sample size was not reached largely due to two factors. First was the impact of the COVID-19 pandemic and wildfire smoke on outreach activities (reduced number, reduced participation in the community, and also shortened times that staff were at events when smoke was extreme), as well as the shortened survey period as compared to previous years (60 days in 2021 as opposed to approximately 90 days in 2018). However, outreach efforts were robust, reaching all cities and demographics through in-person, social media, flyering, events, and partner agency promotion strategies. The total sample for the 2022 CHNA Community Health Status Survey was 1,574.

The survey was administered and analyzed by the Yolo County Health and Human Services Community Health Branch. Partners working on the CHNA helped with dissemination by both direct survey distribution and collection as well as by connecting with other area partners. The survey was available in hard copy and via an electronic submission link in English, Spanish, and Russian. Survey distribution included health providers (CommuniCare, Winters Healthcare Dignity Health, and Sutter Health), countywide food bank distribution sites, direct text messages to WIC participants, Yolo County service centers, the Yolo County Multicultural Committee, farmers markets, car seat safety clients, community-based organizations, and affordable housing properties. Social media announcements were shared on the Yolo County Health and Human Service page, and ads were placed in local newspapers and on public buses. Participants could choose to be entered to win one of two $100 grocery gift cards. Gift card winners were selected in September 2021. Data entry of the community surveys occurred from August to September 2021. The survey instrument is contained in Appendix A of this report. Figure *9* displays the racial/ethnic profile of the survey respondents compared to census counts for the county.[20]

[20] Race and Ethnicity data for Yolo County are based on 2020 Census data as reported here: https://data.census.gov/cedsci/table?q=Yolo%20County,%20California&tid=DECENNIALPL2020.P2.

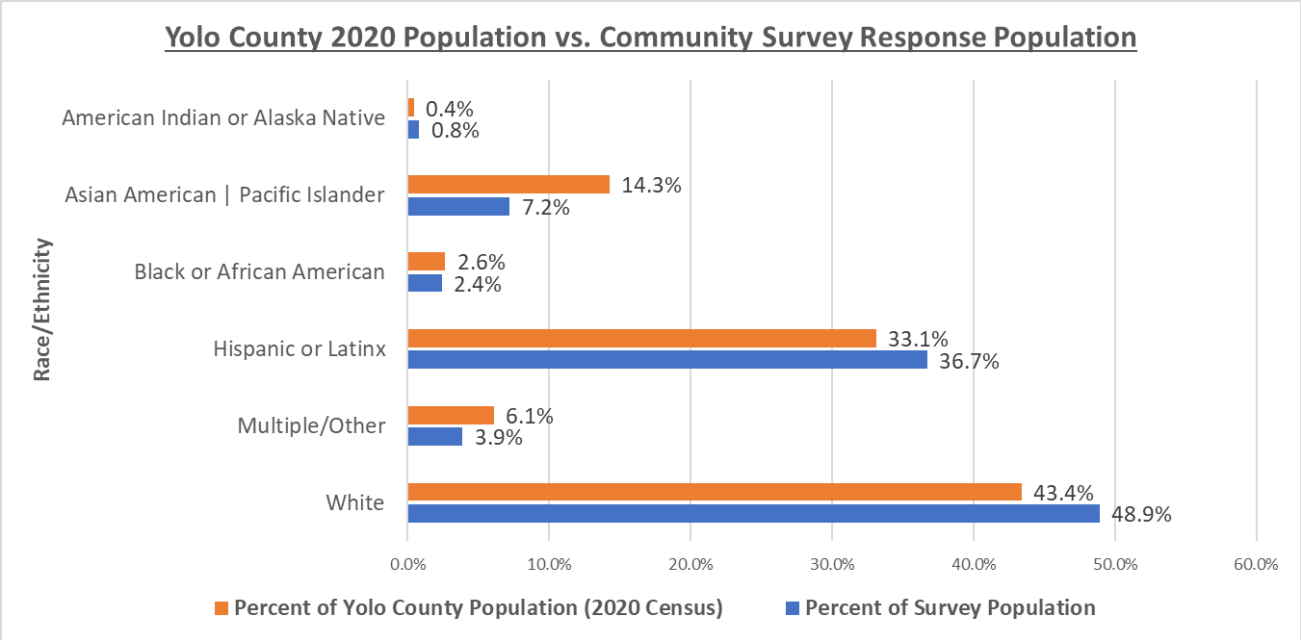


Figure 9: Yolo County 2020 population vs. Community Survey response population.

Secondary Data Collection and Processing

"Secondary data" refer to those quantitative variables used in this analysis that were obtained from third party sources. Secondary data were used to 1) inform the identification of Communities of Concern, 2) support the identification of health needs, and 3) describe the population and highlight health inequities within Yolo County. This section details the data sources as well as the process for collecting the secondary data and preparing them for analysis.

Community of Concern Identification Datasets

Two main secondary data sources were used in the identification of Communities of Concern: California Healthy Places Index (HPI),[21] derived from health factor indicators available at the US Census tract level, and mortality data from the California Department of Public Health (CDPH),[22] health outcome indicators available at the ZIP Code level. The CDPH mortality data report the number of deaths that occurred in each ZIP Code from 2015-2019 due to each of the causes listed in Table 21.

Table 21: Mortality indicators used in Community of Concern Identification.

Cause of Death	ICD 10 Codes
Alzheimer's disease	G30
Malignant neoplasms (cancers)	C00-C97
Chronic lower respiratory disease (CLRD)	J40-J47

[21] Public Health Alliance of Southern California. 2021. HPI_MasterFile_2021-04-22.zip. Data file. Retrieved 1 May 2021 from https://healthyplacesindex.org/wp-content/uploads/2021/04/HPI_MasterFile_2021-04-22.zip.
[22] State of California, Department of Public Health. 2021. California Comprehensive Master Death File (Static), 2015-2019.

Diabetes mellitus	E10-E14
Diseases of heart	I00-I09, I11, I13, I20-I51
Essential hypertension and hypertensive renal disease	I10, I12, I15
Accidents (unintentional injuries)	V01-X59, Y85-Y86
Chronic liver disease and cirrhosis	K70, K73-K74
Nephritis, nephrotic syndrome, and nephrosis	N00-N07, N17-N19, N25-N27
Pneumonia and influenza	J09-J18
Cerebrovascular disease (stroke)	I60-I69
Intentional self-harm (suicide)	*U03, X60-X84, Y87.0

While the HPI dataset was used as-is, additional processing was required to prepare the mortality data for analysis. This included two main steps. First, ZIP Codes associated with PO Boxes were merged with the larger ZIP Codes in which they were located. Once this was completed, smoothed mortality rates were calculated for each resulting ZIP Code.

ZIP Code Consolidation

The mortality indicators used here included deaths reported for the ZIP Code at the decedent's place of residence. ZIP Codes are defined by the U.S. Postal Service as a single location (such as a PO Box), or a set of roads along which addresses are located. The roads that comprise such a ZIP Code may not form contiguous areas and do not match the areas used by the U.S. Census Bureau (the main source of population and demographic data in the United States) to report population. Instead of measuring the population along a collection of roads, the Census reports population figures for distinct, largely contiguous areas. To support the analysis of ZIP Code data, the U.S. Census Bureau created ZIP Code Tabulation Areas (ZCTAs). ZCTAs are created by identifying the dominant ZIP Code for addresses in a given census block (the smallest unit of census data available), and then grouping blocks with the same dominant ZIP Code into a corresponding ZCTA. The creation of ZCTAs allows for population figures that make it possible to calculate mortality rates for each ZCTA. However, the difference in the definition between mailing ZIP Codes and ZCTAs has two important implications for analyses of ZIP Code level data.

First, ZCTAs are approximate representations of ZIP Codes rather than exact matches. While this is not ideal, it is nevertheless the nature of the data being analyzed. Second, not all ZIP Codes have corresponding ZCTAs. Some PO Box ZIP Codes or other unique ZIP Codes (such as a ZIP Code assigned to a single facility) may not have enough addressees residing in a given census block to ever result in the creation of a corresponding ZCTA. But residents whose mailing addresses are associated with these ZIP Codes will still show up in reported health-outcome data. This means that rates cannot be calculated for these ZIP Codes individually because there are no matching ZCTA population figures.

To incorporate these data into the analysis, the point location (latitude and longitude) of all ZIP Codes in California[23] were compared to ZCTA boundaries.[24] These unique ZIP Codes were then assigned to either the ZCTA in which they fell or, in the case of rural areas that are not completely covered by ZCTAs, the ZCTA closest to them. The CDPH information associated with these PO Boxes or unique ZIP Codes were then added to the ZCTAs to which they were assigned.

[23] Datasheet, L.L.C. 2018. ZIP Code Database Free. Retrieved 16 Jul 2018 from http://www.Zip-Codes.com.
[24] US Census Bureau. 2021. TIGER/Line Shapefile, 2019, 2010 nation, U.S., 2010 Census 5-Digit ZIP Code Tabulation Area (ZCTA5) National. Retrieved 9 Feb 2021 from https://www.census.gov/cgi-bin/geo/shapefiles/index.php.

Rate Calculation and Smoothing

The next step in the analysis process was to calculate rates for each of these indicators. However, rather than calculating raw rates, empirical Bayes smoothed rates (EBRs) were created for all indicators possible.[25] Smoothed rates are considered preferable to raw rates for two main reasons. First, the small population of many ZCTAs meant that the rates calculated for these areas would be unstable. This problem is sometimes referred to as the small numbers problem. Empirical Bayes smoothing seeks to address this issue by adjusting the calculated rate for areas with small populations so that they more closely resemble the mean rate for the entire study area. The amount of adjustment is greater in areas with smaller populations, and less in areas with larger populations.

Because EBRs were created for all ZCTAs in the state, ZCTAs with small populations that may have unstable high rates had their rates "shrunk" to match the overall indicator rate more closely for ZCTAs in the entire state. This adjustment can be substantial for ZCTAs with very small populations. The difference between raw rates and EBRs in ZCTAs with very large populations, on the other hand, is negligible. In this way, the stable rates in large-population ZIP Codes are preserved, and the unstable rates in smaller-population ZIP Codes are shrunk to match the state norm more closely. While this may not entirely resolve the small numbers problem in all cases, it does make the comparison of the resulting rates more appropriate. Because the rate for each ZCTA is adjusted to some degree by the EBR process, this also has a secondary benefit of better preserving the privacy of patients within the ZCTAs.

EBRs were calculated for each mortality indicator using the total population figure reported for ZCTAs in the 2017 American Community Survey 5-year Estimates table B03002. Data for 2017 were used because this represented the central year of the 2015–2019 range of years for which CDPH data were collected. The population data for 2017 were multiplied by five to match the five years of mortality data used to calculate smoothed rates. The smoothed mortality rates were then multiplied by 100,000 so that the final rates represented deaths per 100,000 people.

Significant Health Need Identification Dataset

The second main set of data used in the CHNA includes the health factor and health outcome indicators used to identify significant health needs. The selection of these indicators was guided by the previously identified conceptual model. Table 22 lists these indicators, their sources, the years they were measured, and the health-related characteristics from the conceptual model they are primarily used to represent.

Table 22: Health factor and health outcome indicators used in health need identification.

Conceptual Model Alignment			**Indicator**	**Data Source**	**Time Period**
Health Outcomes	Length of Life	Infant Mortality	Infant Mortality	County Health Rankings	2013 - 2019
		Life Expectancy	Preterm Birth	CDC Wonder	2019
			Child Mortality	County Health Rankings	2016 - 2019

[25] Anselin, Luc. 2003. Rate Maps and Smoothing. Retrieved 14 Jan 2018 from http://www.dpi.inpe.br/gilberto/tutorials/software/geoda/tutorials/w6_rates_slides.pdf

			Life Expectancy	County Health Rankings	2017 - 2019
			Premature Age-Adjusted Mortality	County Health Rankings	2017 - 2019
			Premature Death	County Health Rankings	2017 - 2019
			Stroke Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Chronic Lower Respiratory Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Diabetes Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Heart Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Hypertension Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Cancer Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
		Mortality	Liver Cancer Mortality	California Cancer Registry	2018
		Life Expectancy	Liver Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Kidney Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Suicide Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Unintentional Injuries Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			COVID-19 Mortality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2021-11-17
			COVID-19 Case Fatality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2021-11-17

			Alzheimer's Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Influenza and Pneumonia Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
	Quality of Life	Morbidity	Diabetes Prevalence	County Health Rankings	2017
			Hospitalizations for Diabetes Long Term Complications	OSHPD	2019
			Low Birthweight	County Health Rankings	2013 - 2019
			HIV Prevalence	County Health Rankings	2018
			Disability	2019 American Community Survey 5-year estimate variable S1810_C03_001E	2015 - 2019
			Emergency Department (ED) Visits for Dental Diagnosis Adult	OSHPD	2019
			ED Visits For Dental Diagnosis Child	OSHPD	2019
			ED Falls Ages 65+	OSHPD	2019
			Hospitalizations for Falls Ages 65+	OSHPD	2019
			Hospitalizations for Self-Inflicted Injuries Youth	OSHPD	2017 - 2019
			Hospitalizations for Mental Health Young Adults	OSHPD	2016 - 2019
			Hospitalizations for Mental Health or Substance Use	OSHPD	2019
			Poor Mental Health Days	County Health Rankings	2018

			Frequent Mental Distress	County Health Rankings	2018
			Poor Physical Health Days	County Health Rankings	2018
			Frequent Physical Distress	County Health Rankings	2018
			Poor or Fair Health	County Health Rankings	2018
			Colorectal Cancer Prevalence	California Cancer Registry	2013 - 2017
			Cancer Colon Hospitalizations	OSHPD	2018
			Breast Cancer Prevalence	California Cancer Registry	2013 - 2017
			Lung Cancer Prevalence	California Cancer Registry	2013 - 2017
			Prostate Cancer Prevalence	California Cancer Registry	2013 - 2017
			COVID-19 Cumulative Incidence	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2021-11-17
			Asthma ED Rates	Tracking California	2018
			Asthma ED Rates for Children	Tracking California	2018
Health Factors	Health Behavior	Alcohol and Drug Use	Excessive Drinking	County Health Rankings	2018
			Drug Induced Death	CDPH 2021 County Health Status Profiles	2017 - 2019
		Diet and Exercise	Adult Obesity	County Health Rankings	2017
			Breastfeeding	CDPH	2019
			Physical Inactivity	County Health Rankings	2017
			Limited Access to Healthy Foods	County Health Rankings	2015
			Food Environment Index	County Health Rankings	2015 & 2018
			Access to Exercise Opportunities	County Health Rankings	2010 & 2019
		Sexual Activity	Chlamydia Incidence	County Health Rankings	2018
			Teen Birth Rate	County Health Rankings	2013 - 2019

		Tobacco Use	Adult Smoking	County Health Rankings	2018
	Clinical Care	Access to Care	Primary Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Dental Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Mental Health Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Medically Underserved Area	U.S. Heath Resources and Services Administration	2021
			Mammography Screening	County Health Rankings	2018
			Dentists	County Health Rankings	2019
			Mental Health Providers	County Health Rankings	2020
			Psychiatry Providers	County Health Rankings	2020
			Specialty Care Providers	County Health Rankings	2020
			Primary Care Providers	County Health Rankings	2018; 2020
			Prenatal Care	CDC Wonder	2019
		Quality Care	Preventable Hospitalization	California Office of Statewide Health Planning and Development Prevention Quality Indicators for California	2019
			COVID-19 Cumulative Full Vaccination Rate	CDPH COVID-19 Vaccine Progress Dashboard Data	Collected on 2021-11-17
	Socio-Economic and Demographic Factors	Community Safety	Homicide Rate	County Health Rankings	2013 - 2019
			Firearm Fatalities Rate	County Health Rankings	2015 - 2019
			Violent Crime Rate	County Health Rankings	2014 & 2016

			Juvenile Arrest Rate	Criminal Justice Data: Arrests, OpenJustice, California Department of Justice	2015 - 2019
			Motor Vehicle Crash Death	County Health Rankings	2013 - 2019
		Education	Some College	County Health Rankings	2015 - 2019
			High School Completion	County Health Rankings	2015 - 2019
			Disconnected Youth	County Health Rankings	2015 - 2019
			English Language Learners	California Department of Education	2019 - 2020
			Third Grade Reading Level	County Health Rankings	2018
			Third Grade Math Level	County Health Rankings	2018
		Employment	Unemployment	County Health Rankings	2019
		Family and Social Support	Children in Single-Parent Households	County Health Rankings	2015 - 2019
			Social Associations	County Health Rankings	2018
			Residential Segregation (Non-White/White)	County Health Rankings	2015 - 2019
		Income	Children Eligible for Free Lunch	County Health Rankings	2018 - 2019
			Children in Poverty	County Health Rankings	2019
			Median Household Income	County Health Rankings	2019
			Uninsured Population under 64	County Health Rankings	2018
			Income Inequality	County Health Rankings	2015 - 2019
		Housing and Transit	Severe Housing Problems	County Health Rankings	2013 - 2017

	Physical Environment		Severe Housing Cost Burden	County Health Rankings	2015 - 2019
			Homeownership	County Health Rankings	2015 - 2019
			Homelessness Rate	US Dept. of Housing and Urban Development 2020 Annual Homeless Assessment Report	2020
			Households with no Vehicle Available	2019 American Community Survey 5-year estimate variable DP04_0058PE	2015 - 2019
			Long Commute - Driving Alone	County Health Rankings	2015 - 2019
			Access to Public Transit	OpenMobilityData, Transitland, TransitWiki.org, Santa Ynez Valley Transit; US Census Bureau	2021; 2020
		Air and Water Quality	Pollution Burden Percent	California Office of Environmental Health Hazard Assessment	2018
			Air Pollution - Particulate Matter	County Health Rankings	2016
			Drinking Water Violations	County Health Rankings	2019

The following sections give further details about the sources of these data and any processing applied to prepare them for use in the analysis.

County Health Rankings Data

All indicators listed with County Health Rankings (CHR) as their source were obtained from the 2021 County Health Rankings[26] dataset. This was the most common source of data, with 52 associated indicators included in the analysis. Indicators were collected at both the county and state levels. County-level indicators were used to represent the health factors and health outcomes in the county. State-level indicators served as benchmarks for comparison purposes. All variables included in the CHR dataset were

[26] University of Wisconsin Population Health Institute. 2021. County Health Rankings State Report 2021. Retrieved 6 May 2021 from https://www.countyhealthrankings.org/app/oregon/2021/downloads and https://www.countyhealthrankings.org/app/california/2021/downloads.

obtained from other data providers. The original data providers for each CHR variable are given in Table 23.

Table 23: Sources and time periods for indicators obtained from County Health Rankings.

CHR Indicator	Time Period	Data Source
Infant Mortality	2013 - 2019	National Center for Health Statistics - Mortality Files
Child Mortality	2016 - 2019	National Center for Health Statistics - Mortality Files
Life Expectancy	2017 - 2019	National Center for Health Statistics - Mortality Files
Premature Age-Adjusted Mortality	2017 - 2019	National Center for Health Statistics - Mortality Files
Premature Death	2017 - 2019	National Center for Health Statistics - Mortality Files
Diabetes Prevalence	2017	United States Diabetes Surveillance System
Low Birthweight	2013 - 2019	National Center for Health Statistics - Natality files
HIV Prevalence	2018	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Poor Mental Health Days	2018	Behavioral Risk Factor Surveillance System
Frequent Mental Distress	2018	Behavioral Risk Factor Surveillance System
Poor Physical Health Days	2018	Behavioral Risk Factor Surveillance System
Frequent Physical Distress	2018	Behavioral Risk Factor Surveillance System
Poor or Fair Health	2018	Behavioral Risk Factor Surveillance System
Excessive Drinking	2018	Behavioral Risk Factor Surveillance System
Adult Obesity	2017	United States Diabetes Surveillance System
Physical Inactivity	2017	United States Diabetes Surveillance System
Limited Access to Healthy Foods	2015	USDA Food Environment Atlas
Food Environment Index	2015 & 2018	USDA Food Environment Atlas, Map the Meal Gap from Feeding America
Access to Exercise Opportunities	2010 & 2019	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files
Chlamydia Incidence	2018	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Teen Birth Rate	2013 - 2019	National Center for Health Statistics - Natality files
Adult Smoking	2018	Behavioral Risk Factor Surveillance System
Mammography Screening	2018	Mapping Medicare Disparities Tool
Dentists	2019	Area Health Resource File/National Provider Identification file
Mental Health Providers	2020	CMS, National Provider Identification
Psychiatry Providers	2020	Area Health Resource File
Specialty Care Providers	2020	Area Health Resource File

Primary Care Providers	2018; 2020	Area Health Resource File/American Medical Association; CMS, National Provider Identification
Homicide Rate	2013 - 2019	National Center for Health Statistics - Mortality Files
Firearm Fatalities Rate	2015 - 2019	National Center for Health Statistics - Mortality Files
Violent Crime Rate	2014 & 2016	Uniform Crime Reporting - FBI
Motor Vehicle Crash Death	2013 - 2019	National Center for Health Statistics - Mortality Files
Some College	2015 - 2019	American Community Survey, 5-year estimates
High School Completion	2015 - 2019	American Community Survey, 5-year estimates
Disconnected Youth	2015 - 2019	American Community Survey, 5-year estimates
Third Grade Reading Level	2018	Stanford Education Data Archive
Third Grade Math Level	2018	Stanford Education Data Archive
Unemployment	2019	Bureau of Labor Statistics
Children in Single-Parent Households	2015 - 2019	American Community Survey, 5-year estimates
Social Associations	2018	County Business Patterns
Residential Segregation (Non-White/White)	2015 - 2019	American Community Survey, 5-year estimates
Children Eligible for Free Lunch	2018 - 2019	National Center for Education Statistics
Children in Poverty	2019	Small Area Income and Poverty Estimates
Median Household Income	2019	Small Area Income and Poverty Estimates
Uninsured Population under 64	2018	Small Area Health Insurance Estimates
Income Inequality	2015 - 2019	American Community Survey, 5-year estimates
Severe Housing Problems	2013 - 2017	Comprehensive Housing Affordability Strategy (CHAS) data
Severe Housing Cost Burden	2015 - 2019	American Community Survey, 5-year estimates
Homeownership	2015 - 2019	American Community Survey, 5-year estimates
Long Commute - Driving Alone	2015 - 2019	American Community Survey, 5-year estimates
Air Pollution - Particulate Matter	2016	Environmental Public Health Tracking Network
Drinking Water Violations	2019	Safe Drinking Water Information System

The provider rates for the primary care physicians and other primary care provider indicators obtained from CHR were summed to create the final primary care provider indicator used in this analysis.

California Department of Public Health

By-Cause Mortality Data

By-cause mortality data were obtained at the county and state level from the CDPH Cal-ViDa[27] online data query system for the years 2015-2019. Empirically Bayes smoothed rates (EBRs) were calculated for each mortality indicator using the total county population figure reported in the 2017 American Community Survey 5-year Estimates table B03002. Data for 2017 were used because this represented the central year of the 2015–2019 range of years for which CDPH data were collected. The population data for 2017 were multiplied by five to match the five years of mortality data used to calculate smoothed rates. The smoothed mortality rates were then multiplied by 100,000 so that the final rates represented deaths per 100,000 people.

CDPH masks the actual number of deaths that occur in a county for a given year and cause if there are between 1 and 10 total deaths recorded. Because of this, the following process was used to estimate the total number of deaths for counties whose actual values were masked. First, mortality rates for each cause and year were calculated for the state. The differences between the by-cause mortality for the state and the total by-cause mortality reported across all counties in the state for each cause and year were also calculated.

Next, the state by-cause mortality rate was applied for each cause and year to estimate mortality at the county level if the reported value was masked. This was done by multiplying the cause/year appropriate state-level mortality rate by the 2017 populations of counties with masked values. Resulting estimates that were less than 1 or greater than 10 were set to 1 and 10 respectively to match the known CDPH masking criteria.

The total number of deaths estimated for counties that had masked values for each year/cause was then compared to the difference between the reported total county and state deaths for the corresponding year/cause. If the number of estimated county deaths exceeded this difference, county estimates were further adjusted. This was done by iteratively ranking county estimates for a given year/cause, then from highest to lowest, reducing the estimates by 1 until they reached a minimum of 1 death. This continued until the estimated deaths for counties with masked values equaled the difference between the state and total reported county values.

COVID-19 Data

Data on the cumulative number of cases and deaths[28] and completed vaccinations[29] for COVID-19 were used to calculate mortality, case-fatality, incidence, and vaccination rates. County mortality, incidence, and vaccination rates were calculated by dividing each of the respective values by the total population

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[27] State of California, Department of Public Health. 2021. California Vital Data (Cal-ViDa), Death Query. Retrieved 1 Jun 2021 from https://cal-vida.cdph.ca.gov/.

[28] State of California, Department of Public Health. 2021. Statewide COVID-19 Cases Deaths Tests. Retrieved 20 December 2021 from https://data.chhs.ca.gov/dataset/f333528b-4d38-4814-bebb-12db1f10f535/resource/046cdd2b-31e5-4d34-9ed3-b48cdbc4be7a/download/covid19cases_test.csv.

[29] State of California, Department of Public Health. 2021. COVID-19 Vaccine Progress Dashboard Data . Retrieved 20 December 2021 from https://data.chhs.ca.gov/dataset/e283ee5a-cf18-4f20-a92c-ee94a2866ccd/resource/130d7ba2-b6eb-438d-a412-741bde207e1c/download/covid19vaccinesbycounty.csv.

variable from the 2019 American Community Survey 5-year estimates table B01001, and then multiplying the resulting value by 100,000 to create rates per 100,000. Case-fatality rates were calculated by dividing COVID-19 mortality by the total number of cases, then multiplying by 100, representing the percentage of cases that ended in death.

Drug-Induced Deaths Data

Drug-induced death rates were obtained from Table 19 of the 2021 County Health Status Profiles[30] and report age-adjusted deaths per 100,000.

U.S. Heath Resources and Services Administration

Indicators related to the availability of healthcare providers were obtained from the Health Resources and Services Administration[31] (HRSA). These included Dental, Mental Health, and Primary Care Health Professional Shortage Areas and Medically Underserved Areas/Populations. They also included the number of specialty care providers and psychiatrists per 100,000 residents, derived from the county-level Area Health Resource Files.

Health Professional Shortage Areas

The health professional shortage area and medically underserved area data were not provided at the county level. Rather, they show all areas in the state that were designated as shortage areas. These areas could include a portion of a county or an entire county, or they could span multiple counties. To develop measures at the county level to match the other health-factor and health-outcome indicators used in health need identification, these shortage areas were compared to the boundaries of each county in the state. Counties that were partially or entirely covered by a shortage area were noted.

Psychiatry and Specialty Care Providers

HRSA's Area Health Resource Files provide information on physicians and allied healthcare providers for U.S. counties. This information was used to determine the rate of specialty care providers and the rate of psychiatrists for each county and for the state. For the purposes of this analysis, a specialty care provider was defined as a physician who was not defined by HRSA as a primary care provider. This was found by subtracting the total number of primary care physicians (both MDs and DOs, primary care, patient care, and non-federal, excluding hospital residents and those 75 years of age or older) from the total number of physicians (both MDs and DOs, patient care, non-federal) in 2018. This number was then divided by the 2018 total population given in the 2018 American Community Survey 5-year Estimates table B03002, and then multiplied by 100,000 to give the total number of specialty care physicians per 100,000 residents.

The total of specialty care physicians in each county was summed to find the total specialty care physicians in the state, and state rates were calculated following the same approach as used for county rates. This same process was also used to calculate the number of psychiatrists per 100,000 for each county and the

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[30] State of California, Department of Public Health, Vital Records Data and Statistics. 2021. County Health Status Profiles 2021: CHSP 2021 Tables 1-29. Spreadsheet. Retrieved on 21 Jul 2021 from https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP_2021_Tables_1-29_04.16.2021.xlsx.
[31] US Health Resources & Services Administration. 2021. Area Health Resources Files and Shortage Areas. Retrieved on 3 Feb 2021 from https://data.hrsa.gov/data/download.

state using the number of total patient care, non-federal psychiatrists from the Area Health Resource Files. It should be noted that psychiatrists are included in the list of specialty care physicians, so that indicator represents a subset of specialty care providers rather than a separate group.

California Cancer Registry

Data obtained from the California Cancer Registry[32] include age-adjusted incidence rates for colon and rectum, female breast, lung and bronchus, and prostate cancer sites for counties and the state. Reported rates were based on data from 2013-2017, and report cases per 100,000. For low-population counties, rates were calculated for a group of counties rather than for individual counties. That group rate was used in this report to represent incidence rates for each individual county in the group.

Tracking California

Data on emergency department visits rates for all ages as well as children ages 5 to 17 were obtained from Tracking California.[33] These data report age-adjusted rates per 10,000. They were multiplied by 100 in this analysis to convert them to rates per 100,000 to make them more comparable to the standard used for other rate indicators.

U.S. Census Bureau

Data from the U.S. Census Bureau was used for two additional indicators: the percentage of households with no vehicles available (table DPO4, variable 0058PE), and the percentage of the civilian non-institutionalized population with some disability (table S1810, variable C03_001E). Values for both of these variables were obtained from the 2019 American Community Survey 5-year Estimates dataset.

California Office of Environmental Health Hazard Assessment

Data used to calculate the pollution burden percent indicator were obtained from the CalEnviroscreen 3.0[34] dataset produced by the California Office of Environmental Health Hazard Assessment. This indicator reports the percentage of the population within a given county, or within the state as a whole, that live in a US Census tract with a CalEnviroscreen 3.0 Pollution Burden score in the 50th percentile or higher. Data on total population came from Table B03002 from the 2019 American Community Survey 5-year Estimates dataset.

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[32] California Cancer Registry. 2021. Age-Adjusted Invasive Cancer Incidence Rates in California. Retrieved on 22 Jan 2021 from https://www.cancer-rates.info/ca/.
[33] Tracking California, Public Health Institute. 2021. Asthma Related Emergency Department & Hospitalization data. Retrieved on 24 Jun 2021 from www.trackingcalifornia.org/asthma/query.
[34] California Office of Environmental Health Hazard Assessment. 2018. CalEnviroScreen 3.0. Retrieved on 22 Jan 2021 from https://oehha.ca.gov/calenviroscreen/maps-data.

California Department of Health Care Access and Information

Data on preventable hospitalizations were obtained from the California Department of Health Care Access and Information (formerly Office of Statewide Health Planning and Development) Prevention Quality Indicators.[35] These data are reported as risk-adjusted rates per 100,000.

California Department of Justice

Data reporting the total number of juvenile felony arrests was obtained from the California Department of Justice.[36] This indicator reports the rate of felony arrests per 1,000 juveniles under the age of 18. It was calculated by dividing the total number of juvenile felony arrests for each county or state from 2015 - 2019 by the total population under 18 as reported in Table B01001 in the 2017 American Community Survey 5-year Estimates program. Population data from 2017 were used as this was the central year of the period over which juvenile felony arrest data were obtained. Population figures from 2017 were multiplied by 5 to match the years of arrest data used. Empirical Bayes smoothed rates were calculated to increase the reliability of rates calculated for small counties. Finally, juvenile felony arrest rates were also calculated for Black, White, and Hispanic populations following the same manner, but using input population data from 2017 American Community Survey 5-year Estimates Tables B01001H, B01001B, and B01001I respectively.

U.S. Department of Housing and Urban Development

Data from the U.S. Department of Housing and Urban Development's 2020 Annual Homeless Assessment Report[37] were used to calculate homelessness rates for the counties and states. These data report point-in-time (PIT) homelessness estimates for individual Continuum of Care (CoC) organizations across the state. Each CoC works within a defined geographic area, which could be a group of counties, an individual county, or a portion of a county.

To calculate county rates, CoC were first related to county boundaries. Rates for CoC that covered single counties were calculated by dividing the CoC PIT estimate by the county population. If a given county was covered by multiple CoC, their PIT was totaled and then divided by the total county population to calculate the rate. When a single CoC covered multiple counties, the CoC PIT was divided by the total of all included county populations, and the resulting rate was applied to each individual county.

Population data came from the total population value reported in Table B03002 from the 2019 American Community Survey 5-year Estimates dataset. Derived rates were multiplied by 100,000 to report rates per 100,000.

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[35] Office of Statewide Health Planning and Development. 2021. Prevention Quality Indicators (PQI) for California. Data files for Statewide and County. Retrieved on 12 Mar 2021 from https://oshpd.ca.gov/data-and-reports/healthcare-quality/ahrq-quality-indicators/.

[36] California Department of Justice, OpenJustice. 2021. Criminal Justice Data: Arrests. Retrieved on 17 Jun 2021 from https://data-openjustice.doj.ca.gov/sites/default/files/dataset/2020-07/OnlineArrestData1980-2019.csv.

[37] US Department of Housing and Urban Development. 2021. 2020 Annual Homeless Assessment Report: 2007 - 2020 Point-in-Time Estimates by CoC. Retrieved on 14 Jul 2021 from https://www.huduser.gov/portal/sites/default/files/xls/2007-2020-PIT-Estimates-by-CoC.xlsx.

Proximity to Transit Stops

The proximity to transit stops indicator reports the percent of county and state population that lives in a US Census block located within 1/4 mile of a fixed transit stop. Two sets of information were needed in order to calculate this indicator: total population at the Census block level, and the location of transit stops. Likely due to delays in data releases stemming from the COVID-19 pandemic, the most recent census block population data available at the time of the analysis was from the 2010 Decennial Census,[38] so this was the data used to represent the distribution of population for this indicator.

Transit stop data were identified first by using tools in the TidyTransit[39] library for the R statistical programming language.[40] This was used to identify transit providers with stops located within 100 miles of the state's boundaries. A search for transit stops for these agencies, as well as all other transit agencies in the state, was conducted by reviewing three main online sources: OpenMobilityData,[41] Transitland,[42] Transitwiki.org,[43] and Santa Ynez Valley Transit.[44] Each of these websites list public transit data that were made public by transit agencies. Transit data from all providers that could be identified were downloaded, and fixed transit stop locations were extracted from them.

The sf[45] library in R was then used to calculate 1/4-mile (402.336 meter) buffers around each of these transit stops, and then to identify which Census blocks fell within these areas. The total population of all tracts within the stops' buffer was then divided by the total population of each county or state to generate the final indicator value.

Detailed Analytical Methodology

The collected and processed primary and secondary data were integrated in three main analytical stages. First, secondary health outcome and health factor data were combined with area-wide key informant interviews to help identify Communities of Concern. These Communities of Concern potentially included geographic regions as well as specific sub-populations bearing disproportionate health burdens. This information was used to focus the remaining interview and focus group collection efforts on those areas

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[38] US Census Bureau. 2011. Census Blocks with Population and Housing Counts. Retrieved on 7 Jun 2021 from https://www2.census.gov/geo/tiger/TIGER2010BLKPOPHU/.
[39] Flavio Poletti, Daniel Herszenhut, Mark Padgham, Tom Buckley, and Danton Noriega-Goodwin. 2021. tidytransit: Read, Validate, Analyze, and Map Files in the General Transit Feed Specification. R package version 1.0.0. https://CRAN.R-project.org/package=tidytransit.
[40] R Core Team (2021). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL https://www.R-project.org/.
[41] OpenMobilityData. 2021. California, USA. Retrieved all feeds listed on 31 May to 1 June 2021 from https://openmobilitydata.org/l/67-california-usa.
[42] Transitland. 2021. Transitland Operators. Retrieved all operators with California locations on 31 May to 1 June 2021 from https://www.transit.land/operators.
[43] Transitwiki.org. 2021. List of publicly accessible transportation data feeds: dynamic and others. Retrieved on 31 May to 1 June 2021 from https://www.transitwiki.org/TransitWiki/index.php/Publicly-accessible_public_transportation_data#List_of_publicly-accessible_public_transportation_data_feeds:_dynamic_data_and_others.
[44] Santa Ynez Valley Transit. GTFS Files. Retrieved on 1 Jun 2021 from http://www.cityofsolvang.com/DocumentCenter/View/2756/syvt_gtfs_011921.
[45] Pebesma, E., 2018. Simple Features for R: Standardized Support for Spatial Vector Data. The R Journal 10 (1), 439-446, https://doi.org/10.32614/RJ-2018-009.

and subpopulations. Next, the resulting data, along with the results from the Service Provider Survey, were combined with secondary health need identification data to identify significant health needs within the county service area. Finally, primary data were used to prioritize those identified significant health needs. The specific details for these analytical steps are given in the following three sections.

Community of Concern Identification

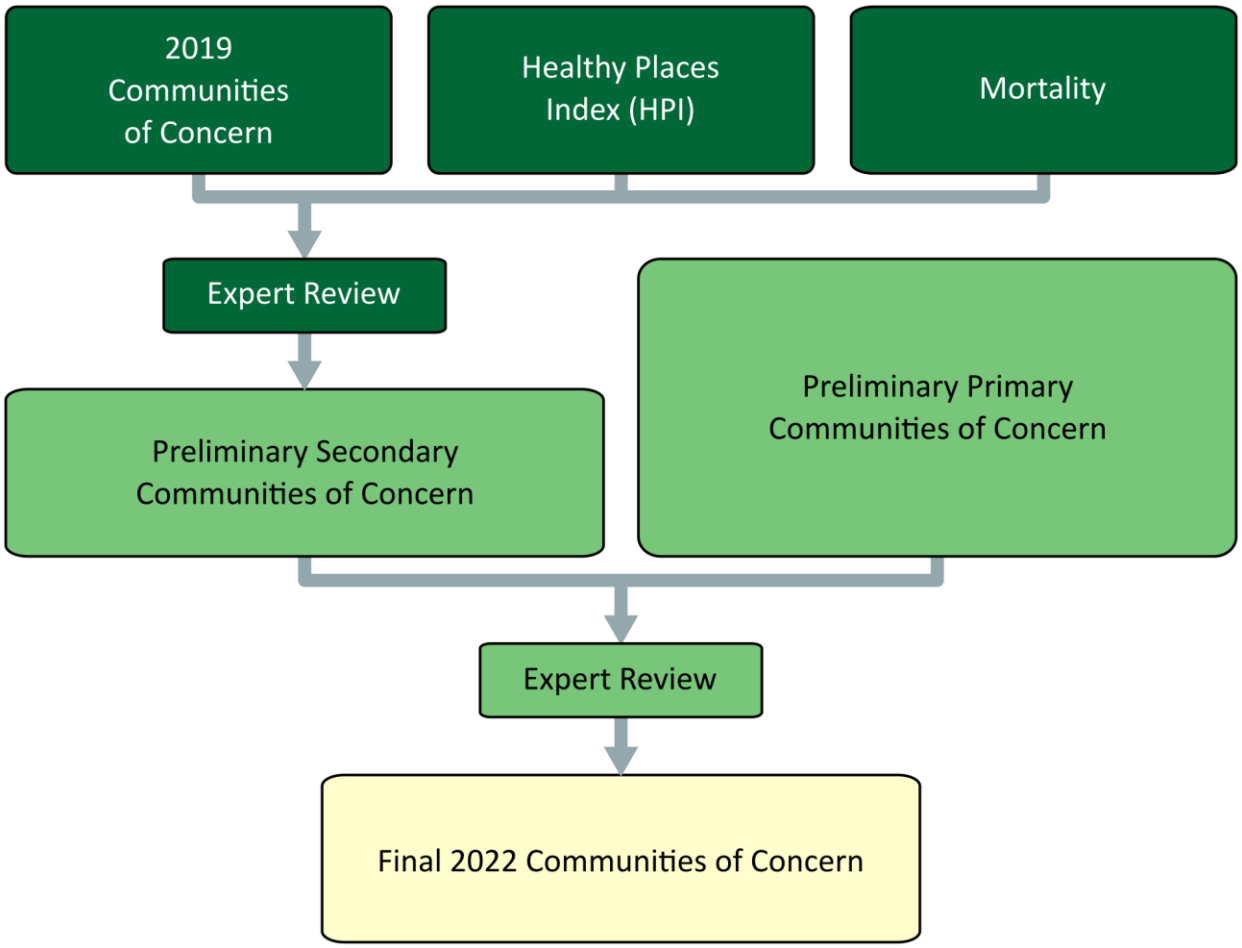

Figure 10: Community of Concern identification process.

As illustrated in Figure *10*, 2022 Communities of Concern were identified through a process drawing upon both primary and secondary data. Three main secondary data sources were used in this analysis: Communities of Concern identified in the 2019 CHNA; the census tract-level California Healthy Places Index (HPI); and the CDPH ZCTA-level mortality data.

An evaluation procedure was developed for each of these datasets and applied to each ZCTA within the county. The following secondary data selection criteria were used to identify preliminary Communities of Concern.

2019 Community of Concern

A ZCTA was included if it was included in the 2019 CHNA Community of Concern list for the county. This was done to allow greater continuity between CHNA rounds.

Healthy Places Index (HPI)

A ZCTA was included if it intersected a census tract whose HPI value fell within the lowest 20% of those in the county. These census tracts represent areas with consistently high concentrations of demographic subgroups identified in the research literature as being more likely to experience health-related disadvantages.

CDPH Mortality Data

The review of ZCTAs based on mortality data utilized the ZCTA-level CDPH health outcome indicators described previously. These indicators were heart disease, cancer, stroke, CLD, Alzheimer's disease, unintentional injuries, diabetes, influenza and pneumonia, chronic liver disease, hypertension, suicide, and kidney disease mortality rates per 100,000 people. The number of times each ZCTA's rates, for these indicators fell within the top 20% in the county, was counted. Those ZCTAs whose counted values exceeded the 80th percentile for all of the ZCTAs in the county met the Community of Concern mortality selection criteria.

Integration of Secondary Criteria

Any ZCTA that met any of the three selection criteria (2019 Community of Concern, HPI, and Mortality) was reviewed for inclusion as a 2022 Community of Concern, with greater weight given to those ZCTAs meeting two or more of the selection criteria. An additional round of expert review was applied to determine if any other ZCTAs not thus far indicated should be included based on some other unanticipated secondary data consideration. This resulting list became the final Preliminary Secondary Communities of Concern.

Preliminary Primary Communities of Concern

Preliminary primary Communities of Concern were identified by reviewing the geographic locations or population subgroups that were consistently identified by the area-wide primary data sources.

Integration of Preliminary Primary and Secondary Communities of Concern

Any ZCTA that was identified in either the Preliminary Primary or Secondary Community of Concern list was considered for inclusion as a 2022 Community of Concern. An additional round of expert review was then conducted to determine if, based on any primary or secondary data consideration, final adjustments should be made to this list. The resulting set of ZCTAs was then used as the final 2022 Communities of Concern.

Significant Health Need Identification

The general methods through which significant health needs (SHNs) were identified are shown in Figure *11* and described here in greater detail. The first step in this process was to identify a set of potential health needs (PHNs) from which significant health needs could be selected. This was done by reviewing the health needs identified during prior assessments among various hospitals throughout Central and Northern California and then supplementing this list based on a preliminary analysis of the primary qualitative data collected for the current CHNA. This resulted the list of PHNs shown in Table 24.

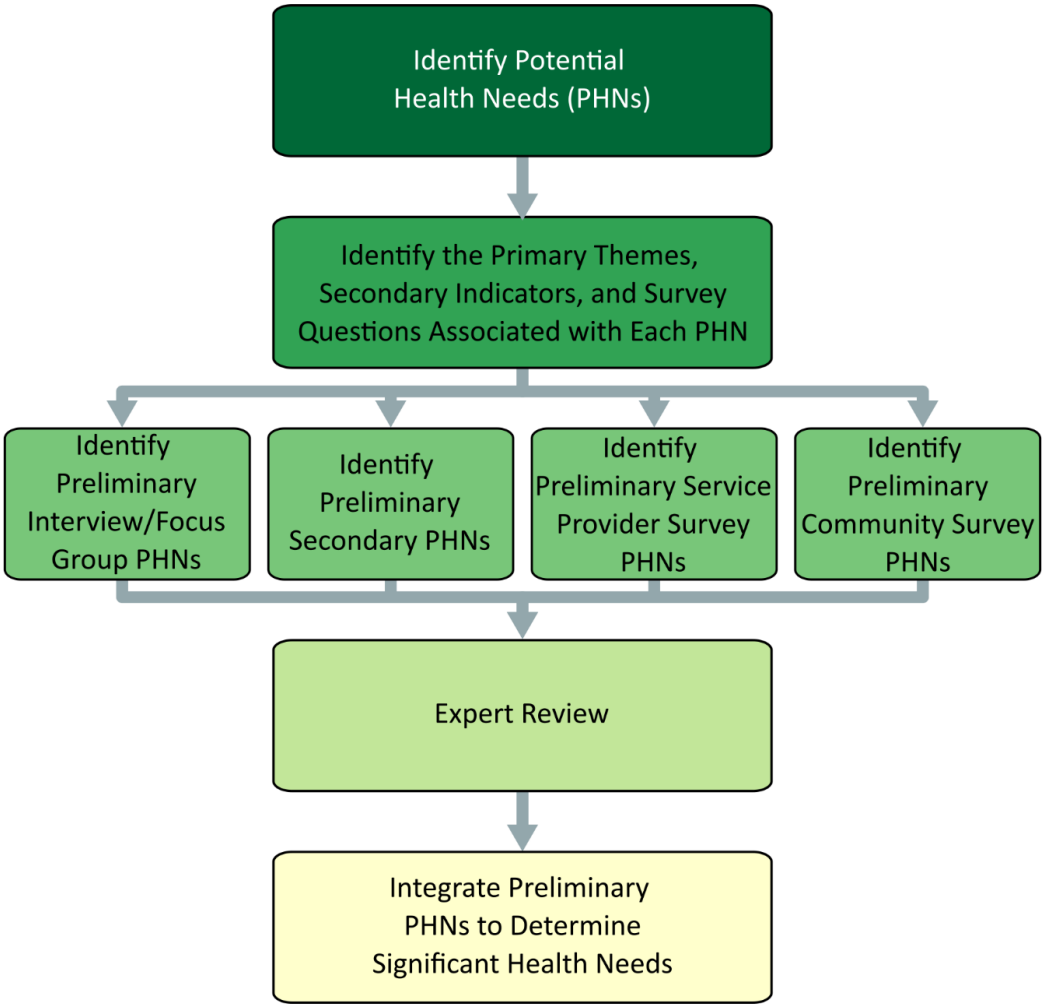

Figure 11: Significant health need identification process.

Table 24: 2022 Potential Health Needs.

Potential Health Needs (PHNs)	
PHN1	Access to Mental/Behavioral Health and Substance Use Services
PHN2	Access to Quality Primary Care Health Services
PHN3	Active Living and Healthy Eating
PHN4	Safe and Violence-Free Environment
PHN5	Access to Dental Care and Preventive Services
PHN6	Healthy Physical Environment
PHN7	Access to Basic Needs Such as Housing, Jobs, and Food
PHN8	Access to Functional Needs
PHN9	Access to Specialty and Extended Care
PHN10	Injury and Disease Prevention and Management
PHN11	Increased Community Connections
PHN12	System Navigation

The next step in the process was to identify primary themes and secondary indicators associated with each of these health needs as shown in Tables 25 through 36. Primary theme associations were used to guide coding of the primary data sources to specific PHNs.

Access to Mental/Behavioral Health and Substance Use Services

Table 25: Primary themes and secondary indicators associated with PHN1.

Primary Themes	Secondary Indicators
There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups). The cost for mental/behavioral health treatment is too high. Treatment options in the area for those with Medi-Cal are limited. Awareness of mental health issues among community members is low. Additional services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in the schools). The stigma around seeking mental health treatment keeps people out of care. Additional services for those who are homeless and dealing with mental/behavioral health issues are needed. The area lacks the infrastructure to support acute mental health crises. Mental/behavioral health services are available in the area, but people do not know about them. It's difficult for people to navigate for mental/behavioral healthcare. Substance use is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse). There are too few substance-use treatment services in the area (e.g., detox centers, rehabilitation centers). Substance use treatment options for those with Medi-Cal are limited. There aren't enough services here for those who are homeless and dealing with substance-use issues. The use of nicotine delivery products such as e-cigarettes and tobacco are a problem in the community. Substance use is an issue among youth in particular. There are substance use treatment services available here, but people do not know about them.	Preterm Birth Life Expectancy Premature Age-Adjusted Mortality Premature Death Liver Cancer Mortality Liver Disease Mortality Suicide Mortality Hospitalizations for Self-Inflicted Injuries Youth Hospitalizations for Mental Health Young Adults Hospitalizations for Mental Health or Substance Use Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health Excessive Drinking Drug Induced Death Adult Smoking Primary Care Shortage Area Mental Health Care Shortage Area Medically Underserved Area Mental Health Providers Psychiatry Providers Firearm Fatalities Rate Juvenile Arrest Rate Disconnected Youth Social Associations Residential Segregation (Non-White/White) Income Inequality Severe Housing Cost Burden Homelessness Rate

Access to Quality Primary Care Health Services

Table 26: Primary themes and secondary indicators associated with PHN2.

Primary Themes	Secondary Indicators
Insurance is unaffordable. Wait times for appointments are excessively long. Out-of-pocket costs are too high. There aren't enough primary care service providers in the area. Patients have difficulty obtaining appointments outside of regular business hours. Too few providers in the area accept Medi-Cal. It is difficult to recruit and retain primary care providers in the region. Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine). The quality of care is low (e.g., appointments are rushed, providers lack cultural competence). Patients seeking primary care overwhelm local emergency departments. Primary care services are available, but are	Infant Mortality Preterm Birth Child Mortality Life Expectancy Premature Age-Adjusted Mortality Premature Death Stroke Mortality Chronic Lower Respiratory Disease Mortality Diabetes Mortality Heart Disease Mortality Hypertension Mortality Cancer Mortality Liver Cancer Mortality Liver Disease Mortality Kidney Disease Mortality COVID-19 Mortality COVID-19 Case Fatality Alzheimer's Disease Mortality Influenza and Pneumonia Mortality Diabetes Prevalence Hospitalizations for Diabetes Long Term Complications Low Birthweight Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health Colorectal Cancer Prevalence Cancer Colon Hospitalizations Breast Cancer Prevalence Lung Cancer Prevalence Prostate Cancer Prevalence Asthma (Emergency Department) ED Rates Asthma ED Rates for Children Primary Care Shortage Area Medically Underserved Area Mammography Screening Primary Care Providers Prenatal Care Preventable Hospitalization COVID-19 Cumulative Full Vaccination Rate Residential Segregation (Non-White/White) Uninsured Population under 64

	Income Inequality Homelessness Rate

Active Living and Healthy Eating

Table 27: Primary themes and secondary indicators associated with PHN3.

Primary Themes	Secondary Indicators
There are food deserts in the area where fresh, unprocessed foods are not available. Fresh, unprocessed foods are unaffordable. Food insecurity is an issue here. Students need healthier food options in schools. The built environment doesn't support physical activity (e.g., neighborhoods aren't walkable, roads aren't bike-friendly, or parks are inaccessible). The community needs nutrition education programs. Homelessness in parks or other public spaces deters residents from their use. Recreational opportunities in the area are unaffordable (e.g., gym memberships, recreational activity programming. There aren't enough recreational opportunities in the area (e.g., organized activities, youth sports leagues). The food available in local homeless shelters and food banks is not nutritious. Grocery store options are limited in the area.	Life Expectancy Premature Age-Adjusted Mortality Premature Death Stroke Mortality Diabetes Mortality Heart Disease Mortality Hypertension Mortality Cancer Mortality Liver Cancer Mortality Kidney Disease Mortality Diabetes Prevalence Hospitalizations for Diabetes Long Term Complications Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health Colorectal Cancer Prevalence Cancer Colon Hospitalizations Breast Cancer Prevalence Prostate Cancer Prevalence Asthma Emergency Department (ED) Rates Asthma ED Rates for Children Adult Obesity Breastfeeding Physical Inactivity Limited Access to Healthy Foods Food Environment Index Access to Exercise Opportunities Residential Segregation (Non-White/White) Income Inequality Severe Housing Cost Burden Homelessness Rate Long Commute - Driving Alone Access to Public Transit

Safe and Violence-Free Environment

Table 28: Primary themes and secondary indicators associated with PHN4.

Primary Themes	Secondary Indicators
People feel unsafe because of crime. There are not enough resources to address domestic violence and sexual assault. Isolated or poorly lit streets make pedestrian travel unsafe. Public parks seem unsafe because of illegal activity taking place. Youth need more safe places to go after school. Specific groups in this community are targeted because of characteristics like race/ethnicity or age. There isn't adequate police protection. Gang activity is an issue in the area. Human trafficking is an issue in the area. The current political environment makes some concerned for their safety.	Life Expectancy Premature Death Hypertension Mortality Hospitalizations for Self-Inflicted Injuries Youth Hospitalizations for Mental Health Young Adults Hospitalizations for Mental Health or Substance Use Poor Mental Health Days Frequent Mental Distress Frequent Physical Distress Poor or Fair Health Physical Inactivity Access to Exercise Opportunities Homicide Rate Firearm Fatalities Rate Violent Crime Rate Juvenile Arrest Rate Motor Vehicle Crash Death Disconnected Youth Social Associations Income Inequality Severe Housing Problems Severe Housing Cost Burden Homelessness Rate

Access to Dental Care and Preventive Services

Table 29: Primary themes and secondary indicators associated with PHN5.

Primary Themes	Secondary Indicators
There aren't enough providers in the area who accept Denti-Cal. The lack of access to dental care here leads to overuse of emergency departments. Quality dental services for kids are lacking. It's hard to get an appointment for dental care. People in the area have to travel to receive dental care. Dental care here is unaffordable, even if you have insurance.	Emergency Department (ED) Visits for Dental Diagnosis Adult ED Visits For Dental Diagnosis Child Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health Dental Care Shortage Area Dentists Residential Segregation (Non-White/White) Income Inequality Homelessness Rate

Healthy Physical Environment

Table 30: Primary themes and secondary indicators associated with PHN6.

Primary Themes	Secondary Indicators
The air quality contributes to high rates of asthma. Poor water quality is a concern in the area. Agricultural activity harms the air quality. Low-income housing is substandard. Residents' use of tobacco and e-cigarettes harms the air quality. Industrial activity in the area harms the air quality. Heavy traffic in the area harms the air quality. Wildfires in the region harm the air quality.	Infant Mortality Life Expectancy Premature Age-Adjusted Mortality Premature Death Chronic Lower Respiratory Disease Mortality Hypertension Mortality Cancer Mortality Frequent Mental Distress Frequent Physical Distress Poor or Fair Health Colorectal Cancer Prevalence Breast Cancer Prevalence Lung Cancer Prevalence Prostate Cancer Prevalence Asthma Emergency Department (ED) Rates Asthma ED Rates for Children Adult Smoking Income Inequality Severe Housing Cost Burden Homelessness Rate Long Commute - Driving Alone Pollution Burden Percent Air Pollution - Particulate Matter Drinking Water Violations

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

Table 31: Primary themes and secondary indicators associated with PHN7.

Primary Themes	Secondary Indicators
Lack of affordable housing is a significant issue in the area. The area needs additional low-income housing options. Poverty in the county is high. Many people in the area do not make a living wage. Employment opportunities in the area are limited. Services for homeless residents in the area are insufficient. Services are inaccessible for Spanish-speaking and immigrant residents.	Infant Mortality Child Mortality Life Expectancy Premature Age-Adjusted Mortality Premature Death Hypertension Mortality COVID-19 Mortality COVID-19 Case Fatality Diabetes Prevalence Low Birthweight Emergency Department (ED) Visits for Dental Diagnosis Adult ED Visits For Dental Diagnosis Child

Many residents struggle with food insecurity. It is difficult to find affordable childcare. Educational attainment in the area is low.	ED Falls Ages 65+ Hospitalizations for Falls Ages 65+ Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health COVID-19 Cumulative Incidence Asthma ED Rates Asthma ED Rates for Children Drug Induced Death Adult Obesity Limited Access to Healthy Foods Food Environment Index Medically Underserved Area COVID-19 Cumulative Full Vaccination Rate Some College High School Completion Disconnected Youth English Language Learners Third Grade Reading Level Third Grade Math Level Unemployment Children in Single-Parent Households Social Associations Residential Segregation (Non-White/White) Children Eligible for Free Lunch Children in Poverty Median Household Income Uninsured Population under 64 Income Inequality Severe Housing Problems Severe Housing Cost Burden Homeownership Homelessness Rate Households with no Vehicle Available Long Commute - Driving Alone

Access to Functional Needs

Table 32: Primary themes and secondary indicators associated with PHN8.

Primary Themes	Secondary Indicators
Many residents do not have reliable personal transportation. Medical transport in the area is limited. Roads and sidewalks in the area are not well maintained.	Disability Emergency Department (ED) Falls Ages 65+ Hospitalizations for Falls Ages 65+ Frequent Mental Distress Frequent Physical Distress

The distance between service providers is inconvenient for those using public transportation. Using public transportation to reach providers can take a very long time. The cost of public transportation is too high. Public transportation service routes are limited. Public transportation schedules are limited. The geography of the area makes it difficult for those without reliable transportation to get around. Public transportation is more difficult for some to residents to use (e.g., non-English speakers, seniors, parents with young children). There aren't enough taxi and ride-share options (e.g., Uber, Lyft).	Poor or Fair Health Adult Obesity COVID-19 Cumulative Full Vaccination Rate Income Inequality Homelessness Rate Households with no Vehicle Available Long Commute - Driving Alone Access to Public Transit

Access to Specialty and Extended Care

Table 33: Primary themes and secondary indicators associated with PHN9.

Primary Themes	Secondary Indicators
Wait times for specialist appointments are excessively long. It is difficult to recruit and retain specialists in the area. Not all specialty care is covered by insurance. Out-of-pocket costs for specialty and extended care are too high. People have to travel to reach specialists. Too few specialty and extended care providers accept Medi-Cal. The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care). There isn't enough OB/GYN care available. Additional hospice and palliative care options are needed. The area lacks a kind of specialist or extended care option not listed here.	Infant Mortality Preterm Birth Life Expectancy Premature Age-Adjusted Mortality Premature Death Stroke Mortality Chronic Lower Respiratory Disease Mortality Diabetes Mortality Heart Disease Mortality Hypertension Mortality Cancer Mortality Liver Cancer Mortality Liver Disease Mortality Kidney Disease Mortality COVID-19 Mortality COVID-19 Case Fatality Alzheimer's Disease Mortality Diabetes Prevalence Hospitalizations for Diabetes Long Term Complications Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health

	Cancer Colon Hospitalizations Lung Cancer Prevalence Asthma Emergency Department (ED) Rates Asthma ED Rates for Children Drug Induced Death Psychiatry Providers Specialty Care Providers Preventable Hospitalization Residential Segregation (Non-White/White) Income Inequality Homelessness Rate

Injury and Disease Prevention and Management

Table 34: Primary themes and secondary indicators associated with PHN10.

Primary Themes	Secondary Indicators
There isn't really a focus on prevention around here. Preventive health services for women are needed (e.g., breast and cervical cancer screening). There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease). Vaccination rates are lower than they need to be. Health education in the schools needs to be improved. Additional HIV and sexually transmitted infection (STI) prevention efforts are needed. The community needs nutrition education opportunities. Schools should offer better sexual health education. Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, the elderly, LGBTQ individuals, immigrants). Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision).	Infant Mortality Child Mortality Stroke Mortality Chronic Lower Respiratory Disease Mortality Diabetes Mortality Heart Disease Mortality Hypertension Mortality Liver Cancer Mortality Liver Disease Mortality Kidney Disease Mortality Suicide Mortality Unintentional Injuries Mortality COVID-19 Mortality COVID-19 Case Fatality Alzheimer's Disease Mortality Diabetes Prevalence Hospitalizations for Diabetes Long Term Complications Low Birthweight HIV Prevalence Emergency Department (ED) Visits for Dental Diagnosis Adult ED Visits For Dental Diagnosis Child ED Falls Ages 65+ Hospitalizations for Falls Ages 65+ Hospitalizations for Self-Inflicted Injuries Youth Hospitalizations for Mental Health Young Adults Hospitalizations for Mental Health or Substance Use Poor Mental Health Days Frequent Mental Distress Frequent Physical Distress

	Poor or Fair Health Cancer Colon Hospitalizations COVID-19 Cumulative Incidence Asthma ED Rates Asthma ED Rates for Children Excessive Drinking Drug Induced Death Adult Obesity Breastfeeding Physical Inactivity Chlamydia Incidence Teen Birth Rate Adult Smoking Prenatal Care COVID-19 Cumulative Full Vaccination Rate Firearm Fatalities Rate Juvenile Arrest Rate Motor Vehicle Crash Death Disconnected Youth Third Grade Reading Level Third Grade Math Level Income Inequality Homelessness Rate

Increased Community Connections

Table 35: Primary themes and secondary indicators associated with PHN11.

Primary Themes	Secondary Indicators
Health and social service providers operate in silos; we need cross-sector connection. Building community connections doesn't seem like a focus in the area. Relations between law enforcement and the community need to be improved. The community needs to invest more in the local public schools. There isn't enough funding for social services in the county. People in the community face discrimination from local service providers. City and county leaders need to work together.	Infant Mortality Child Mortality Life Expectancy Premature Age-Adjusted Mortality Premature Death Stroke Mortality Diabetes Mortality Heart Disease Mortality Hypertension Mortality Suicide Mortality Unintentional Injuries Mortality Diabetes Prevalence Low Birthweight Hospitalizations for Self-Inflicted Injuries Youth Hospitalizations for Mental Health Young Adults Hospitalizations for Mental Health or Substance Use Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days

	Frequent Physical Distress Poor or Fair Health Excessive Drinking Drug Induced Death Physical Inactivity Access to Exercise Opportunities Teen Birth Rate Primary Care Shortage Area Mental Health Care Shortage Area Medically Underserved Area Mental Health Providers Psychiatry Providers Specialty Care Providers Primary Care Providers Preventable Hospitalization COVID-19 Cumulative Full Vaccination Rate Homicide Rate Firearm Fatalities Rate Violent Crime Rate Juvenile Arrest Rate Some College High School Completion Disconnected Youth Unemployment Children in Single-Parent Households Social Associations Residential Segregation (Non-White/White) Income Inequality Homelessness Rate Households with no Vehicle Available Long Commute - Driving Alone Access to Public Transit

System Navigation

Table 36: Primary themes and secondary indicators associated with PHN12.

Primary Themes	Secondary Indicators
People may not be aware of the services they are eligible for. It is difficult for people to navigate multiple, different healthcare systems. The area needs more navigators to help to get people connected to services. People have trouble understanding their insurance benefits.	Preterm Birth Liver Cancer Mortality Hospitalizations for Diabetes Long Term Complications Cancer Colon Hospitalizations Prenatal Care

Automated phone systems can be difficult for those who are unfamiliar with the healthcare system. Dealing with medical and insurance paperwork can be overwhelming. Medical terminology is confusing. Some people just don't know where to start in order to access care or benefits.	

Next, values for the secondary health factor and health outcome indicators identified were compared to state benchmarks to determine if a secondary indicator performed poorly within the county. Some indicators were considered problematic if they exceeded the benchmark, others were considered problematic if they were below the benchmark, and the presence of certain other indicators within the county, such as health professional shortage areas, indicated issues. Table 37 lists each secondary indicator and describes the comparison made to the benchmark to determine if it was problematic. Table 38 lists each question from the Yolo County community health survey used in health need identification and describes the comparison made to the relevant benchmark to determine if it was problematic.

Table 37: Benchmark comparisons to show indicator performance.

Indicator	**Benchmark Comparison Indicating Poor Performance**
Infant Mortality	Higher
Preterm Birth	Higher
Child Mortality	Higher
Life Expectancy	Lower
Premature Age-Adjusted Mortality	Higher
Premature Death	Higher
Stroke Mortality	Higher
Chronic Lower Respiratory Disease Mortality	Higher
Diabetes Mortality	Higher
Heart Disease Mortality	Higher
Hypertension Mortality	Higher
Cancer Mortality	Higher
Liver Cancer Mortality	Higher
Liver Disease Mortality	Higher
Kidney Disease Mortality	Higher
Suicide Mortality	Higher
Unintentional Injuries Mortality	Higher
COVID-19 Mortality	Higher
COVID-19 Case Fatality	Higher
Alzheimer's Disease Mortality	Higher
Influenza and Pneumonia Mortality	Higher
Diabetes Prevalence	Higher
Hospitalizations for Diabetes Long Term Complications	Higher
Low Birthweight	Higher

HIV Prevalence	Higher
Disability	Higher
Emergency Department (ED) Visits for Dental Diagnosis Adult	Higher
ED Visits For Dental Diagnosis Child	Higher
ED Falls Ages 65+	Higher
Hospitalizations for Falls Ages 65+	Higher
Hospitalizations for Self-Inflicted Injuries Youth	Higher
Hospitalizations for Mental Health Young Adults	Higher
Hospitalizations for Mental Health or Substance Use	Higher
Poor Mental Health Days	Higher
Frequent Mental Distress	Higher
Poor Physical Health Days	Higher
Frequent Physical Distress	Higher
Poor or Fair Health	Higher
Colorectal Cancer Prevalence	Higher
Cancer Colon Hospitalizations	Higher
Breast Cancer Prevalence	Higher
Lung Cancer Prevalence	Higher
Prostate Cancer Prevalence	Higher
COVID-19 Cumulative Incidence	Higher
Asthma ED Rates	Higher
Asthma ED Rates for Children	Higher
Excessive Drinking	Higher
Drug Induced Death	Higher
Adult Obesity	Higher
Breastfeeding	Lower
Physical Inactivity	Higher
Limited Access to Healthy Foods	Higher
Food Environment Index	Lower
Access to Exercise Opportunities	Lower
Chlamydia Incidence	Higher
Teen Birth Rate	Higher
Adult Smoking	Higher
Primary Care Shortage Area	Present
Dental Care Shortage Area	Present
Mental Health Care Shortage Area	Present
Medically Underserved Area	Present
Mammography Screening	Lower
Dentists	Lower
Mental Health Providers	Lower
Psychiatry Providers	Lower
Specialty Care Providers	Lower
Primary Care Providers	Lower
Prenatal Care	Lower

Preventable Hospitalization	Higher
COVID-19 Cumulative Full Vaccination Rate	Lower
Homicide Rate	Higher
Firearm Fatalities Rate	Higher
Violent Crime Rate	Higher
Juvenile Arrest Rate	Higher
Motor Vehicle Crash Death	Higher
Some College	Lower
High School Completion	Lower
Disconnected Youth	Higher
English Language Learners	Lower
Third Grade Reading Level	Lower
Third Grade Math Level	Lower
Unemployment	Higher
Children in Single-Parent Households	Higher
Social Associations	Lower
Residential Segregation (Non-White/White)	Higher
Children Eligible for Free Lunch	Higher
Children in Poverty	Higher
Median Household Income	Lower
Uninsured Population under 64	Higher
Income Inequality	Higher
Severe Housing Problems	Higher
Severe Housing Cost Burden	Higher
Homeownership	Lower
Homelessness Rate	Higher
Households with no Vehicle Available	Higher
Long Commute - Driving Alone	Higher
Access to Public Transit	Lower
Pollution Burden Percent	Higher
Air Pollution - Particulate Matter	Higher
Drinking Water Violations	Present

Table 38: Benchmark comparisons for Yolo Community Health Status Survey.

Question	**Benchmark Comparison Indicating Poor Performance**
Do you have a condition that limits one or more physical activities? Same – question 8	Higher
Have you ever been told you have asthma/lung disease/COPD/emphysema? Same – question 10	Higher
Have you ever been told you have autoimmune disease (Lupus, Type 1 diabetes)? Same – question 10	Higher
Have you ever been told you have cancer? Same – question 10	Higher
Have you ever been told you have diabetes? Same – question 10	Higher

Have you ever been told you have heart disease Same – question 10	Higher
Have you ever been told you have hypertension? Same – question 10	Higher
Have you ever been told you have mental illness? Same – question 10	Higher
Have you ever been told you have a drug or alcohol problem? Same – question 10	Higher
Have you ever been told you have a physical disability? Same – question 10	Higher
Have you ever been told that you have obesity/overweight? Same – question 10	Higher
Needed behavioral health care in past 12 months – Question 11 (**Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your mental health, emotions, nerves, or use of alcohol or drugs?**)	Higher
Needed behavioral health care but didn't get it because of cost omitted	Higher
Needed behavioral health care but didn't get it because of lack of comfort talking about it omitted	Higher
Needed behavioral health care but didn't get it because of stigma omitted	Higher
Needed behavioral health care but didn't get it because of lack of insurance coverage omitted	Higher
Needed behavioral health care but didn't get it because appt availability omitted	Higher
Needed behavioral health care but didn’t get it because didn't know where to go omitted	Higher
Do you have health insurance? (Response: No) Question 45	Higher
Takes more than 30 minutes to get to doctor? Question 15 (**How long does it normally take you to get to your regular doctor's office from your home?**)	Higher
Unsatisfied or very unsatisfied with getting an appointment quickly Question 18 (**Were you satisfied with how quickly you were able to get an appointment?**)	Higher
Didn't receive medical screenings because it took too long Question 21	Higher
Didn't receive medical screenings because of language issues Question 21	Higher
Didn't receive medical screenings because of transportation Question 21	Higher
Didn't receive medical screenings because of clinic hours Question 21	Higher

Didn't receive medical screenings because of doctor availability Question 21	Higher
Didn't receive medical screenings because of lack of health insurance Question 21	Higher
Didn't receive medical screenings because of inadequate insurance Question 21	Higher
Didn't receive medical screenings because of lack of trust with providers Question 21	Higher
Went to ER because I couldn't get urgent care appointment Question 23	Higher
Went to ER for prescription refill Question 23	Higher
Went to ER because more convenient Question 23	Higher
Went to ER because lack usual source of care Question 23	Higher
Do you have dental insurance? (Response: Yes) Question 48	Lower
Been to dentist in last 12 months (Response: Yes) Question 49	Lower

Once poorly performing quantitative indicators were identified, they were used to determine preliminary secondary significant health needs. This was done by calculating the percentage of all secondary indicators associated with a given potential health need (PHN) that were identified as performing poorly within the county. While all PHNs represented actual health needs within the county to a greater or lesser extent, a PHN was considered a preliminary secondary health need if the percentage of poorly performing indicators exceeded one of a number of established thresholds: any poorly performing associated secondary indicators; or at least 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80% of the associated indicators were found to perform poorly. A similar set of standards was used to identify the preliminary interview and focus-group health needs: any of the survey respondents mentioned a theme associated with a PHN, or if at least 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80% of the respondents mentioned an associated theme. Finally, similar thresholds (any mention, 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80%) were also applied to the percent of survey respondents selecting a particular health need as one of the top health needs in the county.

These sets of criteria (any mention, 10%, 20%, 30%, 40%, 50%, 60%, 70%, or 80%) were used because it was not feasible to anticipate which specific standard would be most meaningful within the context of the county. Having multiple objective decision criteria allows the process to be more easily described while still allowing for enough flexibility to respond to evolving conditions in the county. To this end, a final round of expert reviews was used to compare the set selection criteria to find the level at which the criteria converged towards a final set of SHNs.

For this report, a PHN was selected as a significant health need (SHN) if one of the following conditions applied:

1) 40% of the associated quantitative indicators were identified as performing poorly,

2) 40% of Service Provider Survey respondents indicated it was a health need,

3) 50% or more of the key informant and focus group primary sources indicated it was a health need, or

4) 50% of the assigned Community Health Status Survey data assigned to the PHN performed poorly.

Health Need Prioritization

The final step in the analysis was to prioritize the identified significant health needs (SHNs). To reflect the voice of the community, significant health need prioritization was based solely on primary data. Key informants and focus group participants were asked to identify the three most significant health needs in their communities. These responses were associated with one or more of the potential health needs. This, along with the responses across the rest of the interviews and focus groups, was used to derive two measures for each significant health need. First, the total percentage of all primary data sources that mentioned themes associated with a significant health need at any point was calculated. This number was taken to represent how broadly a given significant health need was recognized within the community. Next, the percentage of times a theme associated with a significant health was mentioned as one of the top three health needs in the community was calculated. Since primary data sources were asked to prioritize health needs in this question, this number was taken to represent the intensity of the need. Finally, the number of times each health need was selected as one of the top health needs by survey respondents was also included.

These three measures were then rescaled so that the SHN with the maximum value for each measure equaled one, the minimum equaled zero, and all other SHNs had values appropriately proportional to the maximum and minimum values. The rescaled values were then summed to create a combined SHN prioritization index. SHNs were ranked in descending order based on this index value so that the SHN with the highest value was identified as the highest-priority health need, the SHN with the second highest value was identified as the second highest-priority health need, and so on.

Detailed List of Resources to Address Health Needs

Table 39: Resources available to meet health needs.

Organization Information			Significant Health Needs											Other Health Needs
Name	ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Mental/Behavioral Health and	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 Preventive Services	Healthy Physical Environment
211	County-wide	www.211yolocounty.com	x	x	x	x	x	x	x	x	x	x	x	x
ACES – Yolo County office of Education	95776	www.ycoe.org/districts				x					x			
Agency on Again – Area 4	95815	agencyonaging4.org	x	x	x		x		x	x	x			
All Leaders Must Serve	95776	www.allleadersmustserve.org	x							x				
Alternatives Pregnancy Center	95825	alternativespc.org		x			x							
Alzheimer's Association	95815	www.alz.org/norcal		x	x				x	x				
American Cancer Society	95815	www.cancer.org			x		x			x		x		
American Red Cross	95815	www.redcross.org	x				x			x				
Another Choice Another Chance	95823	acacsac.org		x						x				
Apex Care	95825	apexcare.com	x	x			x		x			x		
Big Brothers Big Sisters	95825	bbbs-sac.org		x						x	x			
Breathe California of Sacramento-Emigrant Trails	95814	sacbreathe.org			x		x			x				x
Bryte and Broderick Community Action Network	95605	www.bryteandbroderick.org	x			x		x		x		x		
Cache Creek Conservancy	95695	cachecreekconservancy.org	x			x				x				x

Organization Information			Significant Health Needs											Other Health Needs
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California Accountable Communities for Health Initiative (CACHI)	95605	cachi.org	x		x		x							
Capay Valley	95627	www.capayvalleyvision.net	x			x					x	x		
Children's Home Society of California – Woodland	95695	www.chs-ca.org	x					x		x				
Citizens Who Care	95695	www.citizenswhocare.us						x	x	x	x			
CommuniCare Health Centers	95605, 95616, 95627, 95695	communicarehc.org		x	x	x	x	x		x			x	
Community Housing Opportunity Corp	95695	www.chochousing.org	x							x				
Davis Community Meals	95616	daviscommunitymeals.org	x							x				
Davis Community Transit	95616	www.cityofdavis.org										x		
Davis Senior Center	95616	www.cityofdavis.org/city-hall/parks-and-community-services/senior-services	x			x	x	x	x	x	x			
Del Oro Caregiver Resource Center	95610	www.deloro.org		x	x		x		x					
Dignity Health Woodland Davis	Yolo County	www.dignityhealth.org/sacramento/medical-group/woodland-davis					x							
Dixon Migrant Farm Labor Camp	95620	ych.ca.gov	x											

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Elica Health Centers	95691, 95816, 95818, 95825, 95838	www.elicahealth.org		x			x	x					x	
Empower Yolo	95695	empoweryolo.org	x	x				x		x	x			
Empower Yolo- Knights Landing Family Resource Center	95645	empoweryolo.org/resource-centers/	x		x		x	x		x	x			
Eskaton	95608	www.eskaton.org	x	x		x	x		x		x			
Explorit Science Center	95618	www.explorit.org	x							x				
First 5 Yolo	95618	www.first5yolo.org	x	x		x	x			x				
First In Relief for Evacuees	95695	firstinrelief.com	x							x				
Fourth and Hope	95776	fourthandhope.org	x								x			
Gender Health Center	95817	thegenderhealthcenter.org	x	x			x	x			x			
Girl Scouts Heart of Central California	95695	www.girlscoutshcc.org	x			x				x				
Golden Days Adult Day Health	95691	(916) 371-6011					x		x		x			
Goodwill-Sacramento Valley & Northern Nevada	95776	www.goodwillsacto.org	x											
Habitat for Humanity Greater Sacramento	95695	habitatgreatersac.org/								x				

Organization Information			Significant Health Needs											Other Health Needs
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Head Start – Yolo County Office of Education	95605, 95616, 95627, 95695	www.ycoe.org/pf4/cms2/view_page?d=x&group_id=1531973257093&vdid=igq2w4c1x83d26q	x	x		x					x			
Health Education Council	95691	healthedcouncil.org				x					x			
Holy Cross Church	95605	www.scd.org/parish/holy-cross-parish-west-sacramento	x							x				
Knights Landing One Health Center	95645	knightslandingclinic.org					x	x						
Legal Services of Northern California – Health Rights	95814	lsnc.net/office/lsnc-health-program	x											
Lilliput Children's Services	95695	www.lilliput.org	x											
Madison Migrant Center (Child Development Centers)	95834	cdicdc.org				x					x			
Meals on Wheels Yolo County	95776	www.mowyolo.com	x							x				
Mercy Housing	95838	www.mercyhousing.org	x											
Mercy Housing- West Beamer Place Housing	95695	www.mercyhousing.org/california/west-beamer/	x											
My Sister's House	95818	www.my-sisters-house.org	x	x			x				x			
NAMI Yolo	95695	namiyolo.org		x				x		x				
Northern California Children's Therapy Center	95695	www.ctchelpkids.org					x	x	x					

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Outa Sight Group	95695	www.outasightgroup.com	x			x				x				
Pregnancy Support Group	95695	pregnancysupportgroup.org	x	x				x		x				
PRIDE Industries	95747	www.prideindustries.com	x											
Progress House	95695	progresshouseinc.org	x	x										
Resilient Yolo (Aces Connection)	95776	www.pacesconnection.com/g/yolo-county-ca-aces	x	x				x		x				
RISE Inc.	95695	www.riseinc.org/	x	x		x	x	x		x	x			
Sacramento LGBT Community Center	95811	saccenter.org	x	x			x	x			x			
Safety Center Inc.	95695	safetycenter.org			x					x	x			
Saint John's Retirement Village	95695	sjrv.org	x	x		x	x		x		x			
Saint Luke's Episcopal Church	95695	stlukeswoodland.org	x							x				
Saint Vincent de Paul Sacramento Council	95816	www.svdp-sacramento.org	x					x		x				
Salvation Army	95695	www.salvationarmyusa.org	x											
Senior Link of Yolo County	95695	lsnc.net/seniorlink	x	x		x	x		x					
Shingle Springs Tribal TANF Program	95825	www.shinglespringsrancheria.com/tanf	x					x						
Shores of Hope	95605	www.shoresofhope.org	x	x		x					x	x		
Short Term Emergency Aide Committee (STEAC)	95616	steac.org	x							x				

Organization Information			Significant Health Needs												Other Health Needs
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Shriner's Hospital for Children – Northern California	95817	www.shrinerschildrens.org/locations/northern-california			x		x	x	x						
Slavic Assistance Center	95825	www.slaviccenter.us	x												
Soroptimist International of Woodland	95776	www.soroptimistofwoodland.org	x							x					
St. Luke's- Woodland Ecumenical and Multi-Faith Ministries	95695	stlukeswoodland.org/collaborate/serve-the-community/woodland-ecumenical-and-multi-faith-ministries/	x							x					
Stanford Sierra Youth and Families / Stanford Youth Solutions	95826	www.ssyaf.org/	x	x							x				
Suicide Prevention and Crisis Services of Yolo County	95617	www.suicidepreventionyolocounty.org		x						x	x				
Summer House Inc.	95616	summerhouseinc.org	x	x		x	x				x	x	x		
Sutter Davis Hospital	95616	www.sutterhealth.org/davis		x	x	x	x	x							
The Californian Assisted Living and Dementia Care	95695	thecalifornian.net	x	x		x	x		x		x				
The Keaton's Childhood Cancer Alliance	95661	childcancer.org			x										
The Mental Health America of California	95814	www.mhac.org		x											
Tuleyome	95695	www.tuleyome.org				x				x				x	
Turning Point Community Programs	95670	www.tpcp.org	x	x											

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United Cerebral Palsy (UCP) of Sacramento & Northern Calif.	95841	ucpsacto.org	x			x			x		x	x		
University of California, Davis	95616	www.ucdavis.edu	x											
VA Northern California Health Care System	95655	www.va.gov/northern-california-health-care/	x	x			x	x						
Volunteers of America – Northern California & Northern Nevada	95821	www.voa-ncnn.org	x	x										
Walter's House – Fourth and Hope	95695	fourthandhope.org	x	x						x				
WarmLine Family Resource Center	95818	www.warmlinefrc.org	x	x			x							
West Sacramento Community Center	95691	www.cityofwestsacramento.org/residents				x				x				
Wind Youth Services	95817	www.windyouth.org	x	x							x			
Winter's Healthcare Foundation	95694	www.wintershealth.org		x	x	x	x	x					x	
Woodland Community Care Car	95776	www.communitycarecar.org										x		
Woodland Community College Foundation	95776	wcc.yccd.edu/foundation/	x											
Woodland Community College STAY Well Center	95776	wcc.yccd.edu/student/wellness-center		x			x							
Woodland Community Senior Center	95776	cityofwoodland.org/351/Seniors	x			x	x		x	x				

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Woodland Joint Unified School District	95695	www.wjusd.org	x											
Woodland Memorial Hospital	95695	www.dignityhealth.org/sacramento/locations/woodland-memorial-hospital		x	x		x	x		x				
Woodland United Way	95695	www.yourlocalunitedway.org/woodland-office	x	x			x							
YMCA of Superior California	95695	www.ymcasuperiorcal.org				x				x	x			
Yolo Adult Day Health Center – Woodland Healthcare	95695	www.dignityhealth.org/sacramento/services/yolo-adult-day-health-services	x	x	x	x	x	x	x		x			
Yolo Bus	95776	yolobus.com										x		
Yolo Center for Families	95695	yolofamilies.org, localwiki.org/davis/Yolo_Center_for_Families	x				x			x	x			
Yolo Community Care Continuum	95695	www.y3c.org	x	x							x			
Yolo County CASA	95695	www.yolocasa.org		x							x			
Yolo County Children's Alliance	95616	www.yolokids.org	x				x	x		x	x			
Yolo County Health and Human Services Agency	95695	www.yolocounty.org/health-human-services	x	x	x	x	x	x			x			x
Yolo County Housing	95695	www.ych.ca.gov	x											
Yolo County WIC	95695	www.yolocounty.org/government/general-government-departments/health-human-services/children-youth/women-infants-children-wic			x	x	x	x						
Yolo Crisis Nursery	95618	yolocrisisnursery.org/programs/	x	x				x			x			

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Yolo Employment Services	95695	www.yoloes.org	x											
Yolo Food Bank	95776	yolofoodbank.org	x			x								
Yolo Healthy Aging Alliance	95616	www.yolohealthyaging.org	x	x	x	x	x		x	x				
Yolo Hospice	95618	yolohospice.org	x				x	x	x	x	x			

Limits and Information Gaps

Study limitations for this CHNA included obtaining secondary quantitative data specific to population subgroups and ensuring community representation through primary data collection. Most quantitative data used in this assessment were not available by race/ethnicity. The timeliness of the data also presented a challenge, as some of the data were collected in different years; however, this is clearly noted in the report to allow for proper comparison.

It was challenging to gain access to participants best representing the populations needed for this assessment's primary data collection (i.e., key information interviews, focus groups, and Service Provider survey). The COVID-19 pandemic made it more difficult to recruit community members to participate in focus groups. In addition, the effect of the COVID-19 pandemic on the health status of the community is profound, and hard to measure in totality. The Yolo collaborative partners believe that the impact of the COVID-19 pandemic may have greatly influenced the selection of health needs by community members and service providers during primary data collection efforts, and efforts were made to ask questions using an open-ended approach and through multiple data sources for triangulation of results. In addition, a separate COVID-19 section was included in the report in order to examine the specific responses related to the pandemic's effects on the health of the community.

Finally, though this CHNA was conducted with an equity focus, data that point to differences among population subgroups that are more prevention-focused are not as available as those data that detail the resulting health disparities. Having a clearer picture of early-in-life opportunity differences, as experienced by various populations, that result in later-in-life disparities can help direct community health improvement efforts for maximum impact. Though an effort was made to verify all resources (assets) through a web search, ultimately some resources that exist in the county may not be listed.

Appendix A: Impact of Actions Taken For Sutter Davis Hospital Since 2019 CHNA

ACCESS TO MENTAL/BEHAVIORAL/SUBSTANCE ABUSE SERVICES

Name of program/activity/initiative	Area Wide Mental Health Strategy
Description	The need for mental health services and resources, especially for the underserved, has reached a breaking point across the Sutter Health Valley Operating Unit. This is why we are focused on building a comprehensive mental health strategy that integrates key elements such as policy and advocacy, county specific investments, stigma reduction, increased awareness, and education, with tangible outreach such as expanded mental health resources to professionals in the workplace and tele psych options to the underserved.
Goals	By linking these various strategies and efforts through engaging in statewide partnerships, replicating best practices, and securing innovation grants and award opportunities, we have the ability to create a seamless network of mental health care resources so desperately needed in the communities we serve.
Outcomes	In 2020, the mental health strategy helped with the following initiatives: • Advance legislation that expands the California Mental Health Parity Act and ensures that medical necessity coverage determinations are consistent with generally accepted standards of care. This legislation -- Senate Bill 855 – passed in June 2020. • Additionally, based on parity advocacy, the Governor publicly touted parity enforcement as a priority on a number of occasions and the enacted budget for California includes over $2.7 million in additional resources for the Department of Managed Health Care (DMHC) to enforce parity this year with $4.7 million annually thereafter. In 2021, the mental health strategy helped with the following initiatives: • Launch the 988 crisis line going live on July 26, 2022 • Pass SB803 for peer certification. • Secure funding for SB71/Bring CA Home in amount of $2 billion over two years and an unspecified amount future funding. • Advocate for funding for board and care with the County Behavioral Health Directors Association and other organizations serving people living with severe mental illness and/or substance use disorder. Resulting in securing $803 million, with program details still to be fleshed out. • Propose Children and Youth Initiative and assist Secretary Ghaly to develop what became one of the Governor's signature

	budget achievements: $4.5 billion over five years to meet the behavioral health needs of children.
Name of program/activity/initiative	Health and Wellness Program (Formerly Suicide Prevention Follow Up Program)
Description	In 2020, the program was redesigned as the Health and Wellness Support program to include an upstream approach that treats not only those in crisis, acts in those with low-level indicator to prevent crisis from occurring. The program provides individuals with mental or physical health support and connection to community resources. The program has the unique ability to serve a wide range of patient needs from navigating services and friendly check-in calls to dealing with more complex issues, like managing a mental health crisis. The goal of early intervention is to give clients a support system by having a live person to speak to when needed and help mitigate stressors before they become difficult to manage. The frequency of check-ins with patients depend on individual needs and can vary from multiple times a week to once per month. The program is completely voluntary, and patients can discontinue follow-up services at any point.
Goals	The goal of the Health and Wellness program is to have an upstream approach by intervening with support for patients with low level indicators to prevent crisis from occurring and for those experiencing crisis to help the patient get to a manageable place with their health. This is accomplished by wrapping patients with services and support to alleviate additional stressors that when left unaddressed may lead to suicide attempts or ideations.
Outcomes	In 2019, 24 patients received supportive services and were referred to 54 community resources. In 2020, 83 patients received supportive services and were referred to 150 community resources. In the first half of 2021, 57 patients received supportive services totaling 456 connections and were referred to 68 community resources.
Name of program/activity/initiative	Employ and Empower Case Management Services
Description	Newly funded program in 2021. 3SGF will provide case management services to survivors of human trafficking or individuals at risk of exploitation between the ages of 16 and 50. Social workers will assist with goal setting, mental health services, childcare, obtain legal documentation, career development, job skills and education. Each client is assessed to allow for accurate case plan goals. Clients are connected to mental health resources and support at no cost. Financial assistance is provided to clients to help secure daycare until they remain consistently employed. Career development includes helping clients access documents necessary for employment, transportation education, purchasing professional clothing, promoting financial literacy skills, career goal setting, job readiness skills, job training, job placement and retention services.

Goals	The goal is to provide mental health and wrap around services to survivors or human trafficking or individuals at risk for exploitation, as well as obtain job placement.
Outcomes	In the first half of 2021, the program provided 24 services and connections to 6 community resources.
Name of program/activity/initiative	School Based Mental Health Services
Description	School Based Mental Health Services targets Sacramento City Unified School District (nearly 50,000 students) and Washington Unified School District (over 8,000 students). Student outreach is conducted through education around mental health wellness to reduce stigma related to mental health and promote access to mental health services. Students are provided referrals and linkages to appropriate mental health services. The program includes Family & Youth Partnership, which is peer partner services and support groups designed to inform, educate, support, and empower parents/caregivers to be able to advocate and be fully engaged with their child/youth's educational and social well-being. Access is given to skill building and targeted behavior groups and Sutter Health's funding will cover group costs for students who do not qualify for Medi-Cal. Sutter's funding will also help provide school supplies for low-income students and Life Fund, which offers strategic, targeted assistance to at-risk youth and families by providing financial resources to meet basic needs (i.e. access to food, clothing, housing, and/or transportation) and/or provide educational or social opportunities as youth work toward completing treatment and recovery goals.
Goals	The goal is to provide provided referrals and linkages to appropriate mental health services.
Outcomes	In 2020, the program served 457 individuals with 16,497 services and connected to 199 community resources in Sacramento and Yolo counties. In the first half of 2021, the program served 593 individuals in Yolo County.
Name of program/activity/initiative	Salud Clinic Outdoor Play Area
Description	Newly funded program in 2021. Sutter Health is funding the rebuild of the preschool's outdoor play space at the Salud Clinic in West Sacramento. They recently experienced a tragic fire that rendered the space unusable. The area is used for hands on learning and outdoor play therapy for children of patients receiving treatment through the Perinatal Day Program, which is for pregnant and parenting mothers struggling with substance use issues and is the only program of its kind in Yolo County.
Goals	The goal is to rebuild play area to allow children to experiencing hands on learning and outdoor play therapy while parents receive treatment through the Perinatal Day Program.

Outcomes	As a result of the pandemic, the space is still in the planning stages. Demolition is anticipated to begin in 2021 and then construction. There is no program data or demographics to report at this time.
Name of program/activity/initiative	Haven House Interim Care Program
Description	In partnership with Dignity Health, Sutter Health invests in the Haven House with Yolo Community Care Continuum (YCCC). Haven House is an interim care program that offers people experiencing homelessness a safe place to recover after hospitalization. Haven House offers four respite beds for up to 29 days. During their stay, the homeless will be assisted by YCCC, who will work with them to provide connections to other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing.
Goals	The goal is to allow a safe space for people experiencing homelessness to recover after hospitalization.
Outcomes	In 2019, the program served 28 people with 1,061 services and connected to 203 community resources. In addition, 8 individuals obtained permanent housing. In 2020, the program served 12 people with 2,382 services and connected to 88 community resources. In addition, 2 individuals obtained permanent housing. In the first half of 2021, the program served 19 people with 2,784 services and connected to 112 community resources. In addition, 4 individuals obtained permanent housing.

INJURY AND DISEASE PREVENTION MANAGEMENT

Name of program/activity/initiative	Healthy Living with Diabetes
Description	Newly funded program in 2020. Funding will help expand the existing Healthy Living with Diabetes Program (HLDP), which aims to equip the low-income CommuniCare Health Center's patient with diabetes management skills and access to the healthy food. The expansion will include adding two new Paraprofessional Diabetes Educators (PDEs), a Registered Nurse (RN) who is also a Certified Diabetes Educator (CDE), and a Garden Coordinator to the HLDP team. PDEs will be bilingual, bicultural individuals cross trained as Comprehensive Perinatal Services Program (CPSP) providers. Coverage and coordination of diabetes-related services offered will improve the patient health with particular attention to addressing inequitable outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for our perinatal patients with diabetes through Centering Pregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach more of our vulnerable populations. Lastly, funding will also allow

	for the completion of construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the Yolo Food Bank, which will further educate patients on how they can incorporate sustainable and affordable options at home.
Goals	The goal is to equip the low-income CCHC patient with diabetes management skills and access to the healthy food.
Outcomes	In 2020, the program served 706 people with 3,874 services and connection to 2,379 community resources. In addition, provided 200 pounds of healthy food. In the first half of 2021, the program served 448 people with 2,123 services and connection to 1,491 community resources. In addition, provided 1,000 pounds of healthy food.
Name of program/activity/initiative	Street Medicine Program
Description	Newly funded program in 2020. The Yolo Street Medicine and Mobile Medical Unit Collaboration consists of partnership between SDH, County of Yolo Health and Human Services Agency, and Dignity Health. The program provides street-based medicine units. The community based provider, CommuniCare Health Center, will provide physical health, behavioral health, and social services to the target populations. In addition, funding for the Mobile Medical Unit will help purchase a vehicle (van), and a mobile medical unit.
Goals	The goal is to provide physical health, behavioral health, and social services to individuals living homeless in Yolo County; individuals and families at education, faith and migrant farm community locations who need mobile medical services; people in certain rural areas of Yolo County that need health care services to individuals living homeless in Yolo County.
Outcomes	In 2020, the program served 379 people with 3,587 services and connected to 663 community resources. In the first half of 2021, the program served 193 people with 1,654 services and connected to 347 community resources.
Name of program/activity/initiative	Vaccine Outreach
Description	This is a newly funded program in 2021. The Yolo County Children's Alliance will bring vital information and resources regarding the COVID-19 vaccine to all residents, focusing on hard-to-reach communities, living within Yolo County. These communities include non-English speaking communities, rural communities, and communities with limited or no access to the internet. YCCA will expand the communication and outreach approach to ensure a broader reach within these communities, with a goal of bringing greater awareness about the vaccine and its importance, creating better access to vaccine clinics, and increasing enrollment to the State's MyTurn vaccine clinic system.

Goals	Provide vaccine outreach and awareness to all residents, focusing on hard-to-reach communities, living within Yolo County.
Outcomes	In the first half of 2021, the program served 4,000 children and 1,400 families with 6,800 educational services.
Name of program/activity/initiative	Nourish Yolo
Description	Sutter has awarded a five-year investment to the Yolo Food Bank for the Nourish Yolo Campaign. Our investment will help prevent chronic diseases by increasing access to fresh, healthy foods in Yolo County, increase awareness around the crisis that is food insecurity and create new/expand existing programs across Yolo County to ensure more people have consistent access to the food and resources they so desperately need.
Goals	Currently, there is an unmet need of 20-30% of Yolo County residents requiring food access and nutritious food options. With the help of our funding, the food bank will be able to fully meet that need.
Outcomes	In 2019, the program served 25,645 people and distributed 2,458,957 pounds of food. In 2020, the program served 144,000 people and distributed 4,186,825 pounds of food. In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.
Name of program/activity/initiative	Nurture Yolo
Description	Newly funded program in 2021 and anticipated to be a one-time investment. Yolo Food Bank will increase storage space to prevent the damage or perish of goods to be utilized for the targeted expansion to rural communities and underserved populations that face greater inequities, including Knights Landing, Madison, Esparto, Dunnigan and Winters. In addition, the home delivery service will be expanded for senior citizens and vulnerable, homebound residents in every portion of the county, especially remote rural areas.
Goals	Increase capacity to service more individuals and families in Yolo County, including expanded services for home delivery services.
Outcomes	In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.

ACCESS TO BASIC NEEDS SUCH AS HOUSING, JOBS AND FOOD

Name of program/activity/initiative	Emergency Childcare and Wrap-Around Services for Families in Crisis
Description	Yolo Crisis Nursery (YCN) is one of only four crisis nurseries in CA and the only crisis nursery in Yolo County. They offer emergency childcare and wrap-around services to families in crisis which ensure continued stability and the well-being of young children at risk for child abuse. YCN's early intervention services focus on building successful and

	resilient children, strengthening parents, and preserving families. Their work helps to stop the cycle of child abuse and its long-term impact, contributing to a healthier community for everyone.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
Outcomes	In 2019, the program served 408 children and 331 families received services. In 2020, the program served 678 children and 515 families received 4,848 services. In the first half of 2021, 431 children and 174 families received 4,692 services.
Name of program/activity/initiative	Mobile Client Navigator and Nursery Case Management Services
Description	This is a newly funded program in 2021. As homeless and domestic violence shelters reach maximum capacity during the pandemic, the Yolo Crisis Nursery is playing an even more essential role triaging victims of violence and families facing homelessness. Sutter Health's funding will support an increase in onsite staff at the Nursery to provide emergency triage services related to the pandemic and provide wrap around services to these families, such as case management, connection to community resources, and Safe Stays at the Nursery. In addition, funding will support building greater capacity for the Mobile Client Navigator through purchasing a much-needed vehicle that will allow the Nursery to reach more high-risk families in rural areas of Yolo County and expand services to RISE, Inc. in Woodland when construction is complete. The Mobile Client Navigator collaborates with local agencies to reach families where they are during an emergency to remove access as a barrier and is available 3 days/week on site at Empower Yolo in Woodland, 1 day/week at a shelter, and 1day/ week at a library, hospital, or resource center. However, when locations are unavailable due to COVID, the Navigator is available remotely. The designated vehicle will allow for uninterrupted services for families in rural locations, such as delivery of essential supplies and transportation to the Nursery to be connected to wrap around services.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
Outcomes	In the first half of 2021, 500 children and 415 families received 915 services.
Name of program/activity/initiative	West Sacramento Family Resource Center (WSFRC)

Description	Sutter is funded the expansion of services at YCCA impacting the West Gateway Place apartments and the full-service West Sacramento Family Resource Center (WSFRC) located in a low income West Sacramento neighborhood, next to Riverbank Elementary School. Through Yolo County Children's Alliance's programs and services, immigrants, refugees, homeless and unstably housed families, and other under-resourced parents, children, seniors, and individuals in the community find a safe and nurturing space where they can get hands on personal assistance to access the resources, they need in order to improve their lives. They also find a community space that fosters social connection between and among neighbors and other community members.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
Outcomes	In 2019, the program served 1,442 children and 1,099 families with 957 services and connected to 3,144 community resources. In addition, 144 families obtained permanent housing. In 2020, the program served 1,353 children and 5,165 families with 2,361 services and connected to 4,990 community resources. In addition, 86 families obtained permanent housing. In the first half of 2021, the program served 578 children and 534 families with 707 services and connected to 3,666 community resources. In addition, 10 families obtained permanent housing.
Name of program/activity/initiative	Paul's Place
Description	As part of Getting to Zero, Sutter Health has committed to match up to $2.5 million in private donations to Paul's Place – a multi-functional housing center designed to serve the most vulnerable individuals experiencing homelessness in Davis by providing housing and support services. Working with community leaders to leverage both public and private sector resources, we can come together as a community to raise the capital necessary to finance Paul's Place.
Goals	The goal is to complete the construction of Paul's Place.
Outcomes	In 2019, no outcomes to report. In 2020, city council approved the project in June. In 2021, working toward obtaining project approval from both the city of Davis planning commission and city council.
Name of program/activity/initiative	Eviction Prevention Program
Description	The Eviction Prevention Program serves families and individuals to prevent homelessness by keeping clients housed during a short-term financial emergency. This objective is consistent with the "housing first" model supported by the US Department of Housing and Urban Development and widely used by nonprofits across America. All recipients of STEAC assistance are referred by one of the more than 20

	public and nonprofit agencies. STEAC only works with agencies and organizations that have received training regarding STEAC programs, policies, and procedures. After receiving the recommendation for service, prospective clients are screened by STEAC's staff and office volunteers using an intake form, accessing database records, reviewing support documents (income, tenant history, etc.) and following rental assistance policies. To qualify, clients must be low-income according to federal poverty guidelines, their rent cannot exceed 80% of their income, and they must prove they can be self-sufficient after they receive STEAC assistance. STEAC makes payments only to vendors, such as landlords, and never directly to clients.
Goals	The goal is to prevent homelessness by providing eviction prevention support.
Outcomes	In 2019, the program served 200 individuals and 70 families. In 2020, the program served 346 individuals and 114 families. In the first half of 2021, the program served 301 individuals and 122 families.
Name of program/activity/initiative	Permanent Supportive Housing Project
Description	Newly funded program in 2020. Sutter Health is partnering with the City of West Sacramento, Mercy Housing California, Yolo County Health and Human Services and Yolo County Housing Authority to help fund the completion of the permanent supportive housing project (PSH). Mercy Housing has developed and operates 134 affordable communities in California with more than 9,190 homes serving lower-income seniors, families, and people who have experienced homelessness. Mercy Housing will develop and manage the 85-unit PSH project with Yolo County Health and Human Services providing the on-site supportive services such as case management and related health services. Yolo County Housing Authority will be a co-developer and has awarded 60 project-based vouchers. The project will aim to expand the available housing for individuals experiencing homelessness; and improve the overall well-being of people experiencing homelessness by targeting four social determinants of health, including housing stability, physical health, behavioral health, and self-sufficiency.
Goals	The goal is to complete the construction of the permanent supportive housing project.
Outcomes	In 2020, the project is under construction and anticipated to be completed in late August/early September 2021. In the first half of 2021, the project is under construction and still anticipated to be completed in late August/early September 2021.
Name of program/activity/initiative	Employ and Empower Case Management Services
Description	Newly funded program in 2021. 3SGF will provide case management services to survivors of human trafficking or individuals at risk of exploitation between the ages of 16 and 50. Social workers will assist

	with goal setting, mental health services, childcare, obtain legal documentation, career development, job skills and education. Each client is assessed to allow for accurate case plan goals. Clients are connected to mental health resources and support at no cost. Financial assistance is provided to clients to help secure daycare until they remain consistently employed. Career development includes helping clients access documents necessary for employment, transportation education, purchasing professional clothing, promoting financial literacy skills, career goal setting, job readiness skills, job training, job placement and retention services.
Goals	The goal is to provide mental health and wrap around services to survivors or human trafficking or individuals at risk for exploitation, as well as obtain job placement.
Outcomes	In the first half of 2021, the program provided 24 services and connections to 6 community resources.
Name of program/activity/initiative	Healthy Living with Diabetes
Description	Newly funded program in 2020. Funding will help expand the existing Healthy Living with Diabetes Program (HLDP), which aims to equip the low-income CommuniCare Health Center's patient with diabetes management skills and access to the healthy food. The expansion will include adding two new Paraprofessional Diabetes Educators (PDEs), a Registered Nurse (RN) who is also a Certified Diabetes Educator (CDE), and a Garden Coordinator to the HLDP team. PDEs will be bilingual, bicultural individuals cross trained as Comprehensive Perinatal Services Program (CPSP) providers. Coverage and coordination of diabetes-related services offered will improve the patient health with particular attention to addressing inequitable outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for our perinatal patients with diabetes through Centering Pregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach more of our vulnerable populations. Lastly, funding will also allow for the completion of construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the Yolo Food Bank, which will further educate patients on how they can incorporate sustainable and affordable options at home.
Goals	The goal is to equip the low-income CCHC patient with diabetes management skills and access to the healthy food.
Outcomes	In 2020, the program served 706 people with 3,874 services and connection to 2,379 community resources. In addition, provided 200 pounds of healthy food. In the first half of 2021, the program served 448 people with 2,123 services and connection to 1,491 community resources. In addition, provided 1,000 pounds of healthy food.

Name of program/activity/initiative	School Based Mental Health Services
Description	School Based Mental Health Services targets Sacramento City Unified School District (nearly 50,000 students) and Washington Unified School District (over 8,000 students). Student outreach is conducted through education around mental health wellness to reduce stigma related to mental health and promote access to mental health services. Students are provided referrals and linkages to appropriate mental health services. The program includes Family & Youth Partnership, which is peer partner services and support groups designed to inform, educate, support, and empower parents/caregivers to be able to advocate and be fully engaged with their child/youth's educational and social well-being. Access is given to skill building and targeted behavior groups and Sutter Health's funding will cover group costs for students who do not qualify for Medi-Cal. Sutter's funding will also help provide school supplies for low-income students and Life Fund, which offers strategic, targeted assistance to at-risk youth and families by providing financial resources to meet basic needs (i.e. access to food, clothing, housing, and/or transportation) and/or provide educational or social opportunities as youth work toward completing treatment and recovery goals.
Goals	The goal is to provide provided referrals and linkages to appropriate mental health services.
Outcomes	In 2020, the program served 457 individuals with 16,497 services and connected to 199 community resources in Sacramento and Yolo counties. In the first half of 2021, the program served 593 individuals in Yolo County.
Name of program/activity/initiative	Haven House Interim Care Program
Description	In partnership with Dignity Health, Sutter Health invests in the Haven House with Yolo Community Care Continuum (YCCC). Haven House is an interim care program that offers people experiencing homelessness a safe place to recover after hospitalization. Haven House offers four respite beds for up to 29 days. During their stay, the homeless will be assisted by YCCC, who will work with them to provide connections to other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing.
Goals	The goal is to allow a safe space for people experiencing homelessness to recover after hospitalization.
Outcomes	In 2019, the program served 28 people with 1,061 services and connected to 203 community resources. In addition, 8 individuals obtained permanent housing.

	In 2020, the program served 12 people with 2,382 services and connected to 88 community resources. In addition, 2 individuals obtained permanent housing. In the first half of 2021, the program served 19 people with 2,784 services and connected to 112 community resources. In addition, 4 individuals obtained permanent housing.
Name of program/activity/initiative	Kids Farmers Market
Description	The Yolo Food Bank offers the Kids Farmers Market program to provide Yolo County preschool and elementary school children with ongoing access to fresh fruits and vegetables through a fun, interactive farmer's market-style distribution. The program provides a free weekly after school farmers' market for preschool and elementary school children at seven schools. It allows students the opportunity to use play money to "purchase" up to 10 pounds of produce from the onsite market.
Goals	The goal of this effort is for students to learn about and sample the available fruits and vegetables, and to take home the produce, recipes, and other information about healthy living.
Outcomes	In 2019, the program served students from seven schools around Yolo County, with 2,050 children and families having access to 200,000 pounds of fresh and healthy food. In 2020, the program served students from seven schools around Yolo County, with 2,434 children and families having access to 55,077 pounds of fresh and healthy food. In 2021, the food bank transitioned funding for this program to general food drives due to demand tripling in size as a result of the pandemic.
Name of program/activity/initiative	Nourish Yolo
Description	Sutter has awarded a five-year investment to the Yolo Food Bank for the Nourish Yolo Campaign. Our investment will help prevent chronic diseases by increasing access to fresh, healthy foods in Yolo County, increase awareness around the crisis that is food insecurity and create new/expand existing programs across Yolo County to ensure more people have consistent access to the food and resources they so desperately need.
Goals	Currently, there is an unmet need of 20-30% of Yolo County residents requiring food access and nutritious food options. With the help of our funding, the food bank will be able to fully meet that need.
Outcomes	In 2019, the program served 25,645 people and distributed 2,458,957 pounds of food. In 2020, the program served 144,000 people and distributed 4,186,825 pounds of food. In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.

Name of program/activity/initiative	Nurture Yolo
Description	Newly funded program in 2021 and anticipated to be a one-time investment. Yolo Food Bank will increase storage space to prevent the damage or perish of goods to be utilized for the targeted expansion to rural communities and underserved populations that face greater inequities, including Knights Landing, Madison, Esparto, Dunnigan and Winters. In addition, the home delivery service will be expanded for senior citizens and vulnerable, homebound residents in every portion of the county, especially remote rural areas.
Goals	Increase capacity to service more individuals and families in Yolo County, including expanded services for home delivery services.
Outcomes	In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.

ACTIVE LIVING AND HEALTHY EATING

Name of program/activity/initiative	Kids Farmers Market
Description	The Yolo Food Bank offers the Kids Farmers Market program to provide Yolo County preschool and elementary school children with ongoing access to fresh fruits and vegetables through a fun, interactive farmer's market-style distribution. The program provides a free weekly after school farmers' market for preschool and elementary school children at seven schools. It allows students the opportunity to use play money to "purchase" up to 10 pounds of produce from the onsite market.
Goals	The goal of this effort is for students to learn about and sample the available fruits and vegetables, and to take home the produce, recipes, and other information about healthy living.
Outcomes	In 2019, the program served students from seven schools around Yolo County, with 2,050 children and families having access to 200,000 pounds of fresh and healthy food. In 2020, the program served students from seven schools around Yolo County, with 2,434 children and families having access to 55,077 pounds of fresh and healthy food. In 2021, the food bank transitioned funding for this program to general food drives due to demand tripling in size as a result of the pandemic.
Name of program/activity/initiative	Nourish Yolo
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	people have consistent access to the food and resources they so desperately need.
Goals	Currently, there is an unmet need of 20-30% of Yolo County residents requiring food access and nutritious food options. With the help of our funding, the food bank will be able to fully meet that need.
Outcomes	In 2019, the program served 25,645 people and distributed 2,458,957 pounds of food. In 2020, the program served 144,000 people and distributed 4,186,825 pounds of food. In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.
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Goals	Increase capacity to service more individuals and families in Yolo County, including expanded services for home delivery services.
Outcomes	In the first half of 2021, the program served 99,000 people and distributed 12,000,000 pounds of food.
Name of program/activity/initiative	Healthy Living with Diabetes
Description	Newly funded program in 2020. Funding will help expand the existing Healthy Living with Diabetes Program (HLDP), which aims to equip the low-income CommuniCare Health Center's patient with diabetes management skills and access to the healthy food. The expansion will include adding two new Paraprofessional Diabetes Educators (PDEs), a Registered Nurse (RN) who is also a Certified Diabetes Educator (CDE), and a Garden Coordinator to the HLDP team. PDEs will be bilingual, bicultural individuals cross trained as Comprehensive Perinatal Services Program (CPSP) providers. Coverage and coordination of diabetes-related services offered will improve the patient health with particular attention to addressing inequitable outcomes in blood sugar management associated with poverty and ethnicity. There will be targeted efforts to increase access for our perinatal patients with diabetes through Centering Pregnancy groups and one-on-one diabetes case management at each site, in addition to implementing strategies to reach more of our vulnerable populations. Lastly, funding will also allow for the completion of construction of the garden and outdoor classroom and purchase supplementary produce from local farms and the Yolo

	Food Bank, which will further educate patients on how they can incorporate sustainable and affordable options at home.
Goals	The goal is to equip the low-income CCHC patient with diabetes management skills and access to the healthy food.
Outcomes	In 2020, the program served 706 people with 3,874 services and connection to 2,379 community resources. In addition, provided 200 pounds of healthy food. In the first half of 2021, the program served 448 people with 2,123 services and connection to 1,491 community resources. In addition, provided 1,000 pounds of healthy food.

ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES

Name of program/activity/initiative	Uncompensated Care in Yolo County
Description	With access to care, including primary, mental health and specialty care continuing to be a major priority area in the SDH HSA, we will continue to make strategic investments in our local FQHC partners to increase clinic capacity and services offered. Our relationship with CommuniCare Health Center is one of our most valued partnerships in Yolo County. CommuniCare is an FQHC offering comprehensive primary medical and dental services, perinatal services, behavioral health services, substance abuse treatment, health education and outreach services to the culturally diverse, low-income, and uninsured and Medi-Cal populations of Yolo County and eastern Solano County, including migrant and seasonal farm workers and their families.
Goals	The goal is to expand access to care.
Outcomes	In 2019, the program expanded capacity to serve 18,871 underserved adults and youth with 45,578 primary care, behavioral/mental health care, and dental and other specialty services. In 2020, the program funding ended.
Name of program/activity/initiative	Winter Shelter
Description	Newly funded program in 2020. CommuniCare Health Centers will partner with Mercy Coalition of West Sacramento to provide clinical services in the rotating homeless shelters in West Sacramento.
Goals	The goal is to provide clinical services to those in the rotating homeless shelters in West Sacramento.

Outcomes	In 2020, the program served 25 people with 124 services and connection to 78 community resources. In 2021, program funding ended.
Name of program/activity/initiative	Salud Clinic Outdoor Play Area
Description	Newly funded program in 2021. Sutter Health is funding the rebuild of the preschool's outdoor play space at the Salud Clinic in West Sacramento. They recently experienced a tragic fire that rendered the space unusable. The area is used for hands on learning and outdoor play therapy for children of patients receiving treatment through the Perinatal Day Program, which is for pregnant and parenting mothers struggling with substance use issues and is the only program of its kind in Yolo County.
Goals	The goal is to rebuild play area to allow children to experiencing hands on learning and outdoor play therapy while parents receive treatment through the Perinatal Day Program.
Outcomes	As a result of the pandemic, the space is still in the planning stages. Demolition is anticipated to begin in 2021 and then construction. There is no program data or demographics to report at this time.
Name of program/activity/initiative	Haven House Interim Care Program
Description	In partnership with Dignity Health, Sutter Health invests in the Haven House with Yolo Community Care Continuum (YCCC). Haven House is an interim care program that offers people experiencing homelessness a safe place to recover after hospitalization. Haven House offers four respite beds for up to 29 days. During their stay, the homeless will be assisted by YCCC, who will work with them to provide connections to other services. Services include health insurance enrollment, substance abuse and mental health services, and placement in permanent housing.
Goals	The goal is to allow a safe space for people experiencing homelessness to recover after hospitalization.
Outcomes	In 2019, the program served 28 people with 1,061 services and connected to 203 community resources. In addition, 8 individuals obtained permanent housing. In 2020, the program served 12 people with 2,382 services and connected to 88 community resources. In addition, 2 individuals obtained permanent housing. In the first half of 2021, the program served 19 people with 2,784 services and connected to 112 community resources. In addition, 4 individuals obtained permanent housing.
Name of program/activity/initiative	Street Medicine Program
Description	Newly funded program in 2020. The Yolo Street Medicine and Mobile Medical Unit Collaboration consists of partnership between SDH, County of Yolo Health and Human Services Agency, and Dignity Health.

	The program provides street-based medicine units. The community based provider, CommuniCare Health Center, will provide physical health, behavioral health, and social services to the target populations. In addition, funding for the Mobile Medical Unit will help purchase a vehicle (van), and a mobile medical unit.
Goals	The goal is to provide physical health, behavioral health, and social services to individuals living homeless in Yolo County; individuals and families at education, faith and migrant farm community locations who need mobile medical services; people in certain rural areas of Yolo County that need health care services to individuals living homeless in Yolo County.
Outcomes	In 2020, the program served 379 people with 3,587 services and connected to 663 community resources. In the first half of 2021, the program served 193 people with 1,654 services and connected to 347 community resources.
Name of program/activity/initiative	Yolo Cares
Description	Newly funded program in 2020. YoloCares Program is comprehensive, 24/7, 360-degree, community-based palliative care (including behavioral health services, disease management and improved access to care) to patients throughout Yolo County. YoloCares serves as the primary care physician for YoloCare patients in need and will work with partners to coordinate care. Peer-to-peer education will be offered to area physicians about the YoloCares program to help create a streamlined continuum of care and referral process between YoloCares, Yolo Adult Day Health Center, CommuniCare, and Fourth & Hope through educational workshops. The program will work to expand the knowledge of palliative care, YoloCares services, and advance care planning through YoloCares workshops for our community faith leaders by holding advance care planning workings for community partners, the general public, and faith leaders. In addition, YoloCares' one-of-a-kind, caregiver relief program, Citizens Who Care (CWC) will provide caregiver relief through professionally trained volunteers.
Goals	The goal is to provide palliative care to low-income and homeless populations, as well as provide peer to peer education for how to access palliative care for patients.
Outcomes	In 2020, the program served 243 people with 2,748 services and connected to 359 community resources. In addition, YoloCares hosted a meeting with the CommuniCare physicians to continue YoloCares and referral education. In the first half of 2021, the program served 160 people with 1,319 services and connected to 147 community resources. Due to scheduling issues, the virtual conference on palliative care is tentatively scheduled for June 2022.

ACCESS AND FUCTIONAL NEEDS

Name of program/activity/initiative	School Based Mental Health Services
Description	School Based Mental Health Services targets Sacramento City Unified School District (nearly 50,000 students) and Washington Unified School District (over 8,000 students). Student outreach is conducted through education around mental health wellness to reduce stigma related to mental health and promote access to mental health services. Students are provided referrals and linkages to appropriate mental health services. The program includes Family & Youth Partnership, which is peer partner services and support groups designed to inform, educate, support, and empower parents/caregivers to be able to advocate and be fully engaged with their child/youth's educational and social well-being. Access is given to skill building and targeted behavior groups and Sutter Health's funding will cover group costs for students who do not qualify for Medi-Cal. Sutter's funding will also help provide school supplies for low-income students and Life Fund, which offers strategic, targeted assistance to at-risk youth and families by providing financial resources to meet basic needs (i.e. access to food, clothing, housing, and/or transportation) and/or provide educational or social opportunities as youth work toward completing treatment and recovery goals.
Goals	The goal is to provide provided referrals and linkages to appropriate mental health services.
Outcomes	In 2020, the program served 457 individuals with 16,497 services and connected to 199 community resources in Sacramento and Yolo counties. In the first half of 2021, the program served 593 individuals in Yolo County.
Name of program/activity/initiative	Mobile Client Navigator and Nursery Case Management Services
Description	This is a newly funded program in 2021. As homeless and domestic violence shelters reach maximum capacity during the pandemic, the Yolo Crisis Nursery is playing an even more essential role triaging victims of violence and families facing homelessness. Sutter Health's funding will support an increase in onsite staff at the Nursery to provide emergency triage services related to the pandemic and provide wrap around services to these families, such as case management, connection to community resources, and Safe Stays at the Nursery. In addition, funding will support building greater capacity for the Mobile Client Navigator through purchasing a much-needed vehicle that will allow the Nursery to reach more high-risk families in rural areas of Yolo County and expand services to RISE, Inc. in Woodland when construction is complete. The Mobile Client Navigator collaborates with local agencies to reach families where they are during an emergency to

	remove access as a barrier and is available 3 days/week on site at Empower Yolo in Woodland, 1 day/week at a shelter, and 1day/ week at a library, hospital, or resource center. However, when locations are unavailable due to COVID, the Navigator is available remotely. The designated vehicle will allow for uninterrupted services for families in rural locations, such as delivery of essential supplies and transportation to the Nursery to be connected to wrap around services.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
Outcomes	In the first half of 2021, 500 children and 415 families received 915 services.

ACCESS TO SPECIALTY AND EXTENDED CARE

Name of program/activity/initiative	Yolo Cares
Description	Newly funded program in 2020. YoloCares Program is comprehensive, 24/7, 360-degree, community-based palliative care (including behavioral health services, disease management and improved access to care) to patients throughout Yolo County. YoloCares serves as the primary care physician for YoloCare patients in need and will work with partners to coordinate care. Peer-to-peer education will be offered to area physicians about the YoloCares program to help create a streamlined continuum of care and referral process between YoloCares, Yolo Adult Day Health Center, CommuniCare, and Fourth & Hope through educational workshops. The program will work to expand the knowledge of palliative care, YoloCares services, and advance care planning through YoloCares workshops for our community faith leaders by holding advance care planning workings for community partners, the general public, and faith leaders. In addition, YoloCares' one-of-a-kind, caregiver relief program, Citizens Who Care (CWC) will provide caregiver relief through professionally trained volunteers.
Goals	The goal is to provide palliative care to low-income and homeless populations, as well as provide peer to peer education for how to access palliative care for patients.
Outcomes	In 2020, the program served 243 people with 2,748 services and connected to 359 community resources. In addition, YoloCares hosted a meeting with the CommuniCare physicians to continue YoloCares and referral education. In the first half of 2021, the program served 160 people with 1,319 services and connected to 147 community resources. Due to scheduling issues, the virtual conference on palliative care is tentatively scheduled for June 2022.

SAFE AND VIOLENCE FREE ENVIRONMENT

Name of program/activity/initiative	Emergency Childcare and Wrap-Around Services for Families in Crisis
Description	Yolo Crisis Nursery (YCN) is one of only four crisis nurseries in CA and the only crisis nursery in Yolo County. They offer emergency childcare and wrap-around services to families in crisis which ensure continued stability and the well-being of young children at risk for child abuse. YCN's early intervention services focus on building successful and resilient children, strengthening parents, and preserving families. Their work helps to stop the cycle of child abuse and its long-term impact, contributing to a healthier community for everyone.
Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
Outcomes	In 2019, the program served 408 children and 331 families received services. In 2020, the program served 678 children and 515 families received 4,848 services. In the first half of 2021, 431 children and 174 families received 4,692 services.
Name of program/activity/initiative	Mobile Client Navigator and Nursery Case Management Services
Description	This is a newly funded program in 2021. As homeless and domestic violence shelters reach maximum capacity during the pandemic, the Yolo Crisis Nursery is playing an even more essential role triaging victims of violence and families facing homelessness. Sutter Health's funding will support an increase in onsite staff at the Nursery to provide emergency triage services related to the pandemic and provide wrap around services to these families, such as case management, connection to community resources, and Safe Stays at the Nursery. In addition, funding will support building greater capacity for the Mobile Client Navigator through purchasing a much-needed vehicle that will allow the Nursery to reach more high-risk families in rural areas of Yolo County and expand services to RISE, Inc. in Woodland when construction is complete. The Mobile Client Navigator collaborates with local agencies to reach families where they are during an emergency to remove access as a barrier and is available 3 days/week on site at Empower Yolo in Woodland, 1 day/week at a shelter, and 1day/ week at a library, hospital, or resource center. However, when locations are unavailable due to COVID, the Navigator is available remotely. The designated vehicle will allow for uninterrupted services for families in rural locations, such as delivery of essential supplies and transportation to the Nursery to be connected to wrap around services.

Goals	The goals of these programs/organizations include providing children with stable, loving environments, while wrapping the children and their families with services to help them end the cycle of violence, and live happy, healthy lives.
Outcomes	In the first half of 2021, 500 children and 415 families received 915 services.

Appendix B: Yolo County Community Health Status Survey (Community Survey)

Yolo County Health Status Survey

The purpose of this survey is to better understand your opinions about your health and the health of the Yolo County Community. The results will help Yolo County Health and Human Services Agency Community Health Branch, area hospitals (Woodland Memorial Hospital, Sutter Davis) and local community clinics (CommuniCare) support important community health initiatives and projects to improve the health of Yolo County residents. We sincerely appreciate your time as we know it is valuable. The survey should only take about 20 minutes.

In order to take the survey, we ask that you meet the following:

- ✦ You live in Yolo County
- ✦ You understand that taking this survey is voluntary
- ✦ You agree to only take the survey once

Completed surveys must be submitted by August 25

If you would like to be entered to win a $100 grocery gift card, please enter your name and e-mail address or phone number on the last page. Winners will be notified by email or phone in early August 2021.

1. **What city in Yolo County do you live?**

☐ Clarksburg ☐ Davis ☐ Dunnigan ☐ Esparto ☐ Guinda
☐ Knights Landing ☐ Madison ☐ West Sacramento ☐ Winters
☐ Woodland ☐ Yolo ☐ Other: _____

2. **What is your age?**

☐ Under 18 ☐ 19-24 ☐ 25-34 ☐ 35-44 ☐ 45-54

☐ 55-64 ☐ 65-74 ☐ 75-84 ☐ 85 or older

3. **How long have you lived in Yolo County?**
   - ☐ Less than 1 year
   - ☐ 1-5 years
   - ☐ 6-10 years
   - ☐ 11-20 years
   - ☐ Over 20 years
4. **Are you Hispanic or LatinX, or of Spanish origin? (Select all that apply)**
   - ☐ No, not of Hispanic, Latino/a, or Spanish origin
   - ☐ Yes, Mexican, Mexican American, Chicano/a
   - ☐ Yes, Salvadoran
   - ☐ Yes, Cuban
   - ☐ Yes, Guatemalan
   - ☐ Yes, Puerto Rican
   - ☐ Prefer not to say
   - ☐ Yes, Additional Hispanic, Latino/a, or Spanish origin: _____
5. **What is your race? (Select all that apply)**
   - ☐ American Indian or Alaska Native
   - ☐ Asian Indian
   - ☐ Black or African American
   - ☐ Cambodian
   - ☐ Chinese
   - ☐ Filipino
   - ☐Guamaninan or Chamorro
   - ☐ Hispanic, Latino/a, LatinX, or a Spanish origin
   - ☐ Hmong
   - ☐ Japanese
   - ☐ Korean
   - ☐ Laotian
   - ☐ Native Hawaiian
   - ☐ Samoan
   - ☐ Vietnamese
   - ☐ White
   - ☐Prefer not to say
   - ☐ Additional: _____
6. **Which describes your current employment status? (Check all that apply)**
   - ☐ Employed full-time
   - ☐ Employed part-time
   - ☐ Unemployed
   - ☐ Unemployed or partially employed due to COVID
   - ☐ Retired
   - ☐ Full-time student

☐ Part-time student
☐ Disabled
☐ Declined to state

7. **In general, would you say your overall health is:**
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

8. **Do you have a condition that substantially limits one or more physical activities?**
   <u>If no, please skip to question 10</u>
   ☐ Yes ☐ No

9. **<u>If you answered yes to question 8</u>, which activities are affected? (Select all that apply)**
   ☐ Dressing, bathing, or getting around inside your home
   ☐ Going outside the home alone to shop or visit the doctor
   ☐ Walking, climbing stairs, reaching, lifting, or carrying
   ☐ Working at a job or business
   ☐ Other: _____

10. **Have you ever been told by a doctor that you have? (Select all that apply)**
    ☐ Asthma/lung disease/COPD/emphysema
    ☐ Autoimmune disease (Rheumatoid Arthritis, Lupus, etc.)
    ☐ Cancer
    ☐ Diabetes
    ☐ Drug or alcohol problem
    ☐ Heart disease
    ☐ Hypertension (high blood pressure)
    ☐ Mental illness
    ☐ Obesity
    ☐ Physical disability
    ☐ Other: _____

11. **Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your mental health, emotions, nerves, or use of alcohol or drugs? <u>If no, please skip to question 13</u>**
    ☐ Yes ☐ No

12. **<u>If you answered yes to question 11</u>, have you seen a doctor or mental health professional (counselor, psychiatrist, or social worker) for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?**
    ☐ Yes ☐ No

13. **Did you have a doctor's visit in the past 12 months (virtually or in-person)?**
    ☐ Yes: Once ☐ Yes: 2-5 times ☐ Yes: 6 or more times
    ☐ Yes, but I do not know how many times ☐ No

14. **Would you have liked to (or felt you needed to) see a doctor more often than this?**

☐ Yes ☐ No

15. **How long does it normally take you to get to your regular doctor's office from your home?**

☐ Less than 5 minutes ☐ 5-10 minutes ☐ 10-20 minutes ☐ 20-30 minutes
☐ 30-45 minutes ☐ 45-60 minutes ☐ More than an hour

16. **How do you typically get to your medical or dental appointments? (Select all that apply)**

☐ App-based ride (Lyft/Uber/etc.)

☐ Borrow car from friend/family
☐ Bus or other transit
☐ My car
☐ Shared on-demand transit (Via, etc.)
☐ Virtually (Zoom, or other online platform)
☐ Walk and/or Bicycle
☐ Other: _____

17. **When you last contacted a medical clinic for an appointment, how quickly could you be seen by a doctor?**

☐ Days ☐ Weeks ☐ I don't know

18. **Were you satisfied with how quickly you were able to get an appointment?**

☐ Very Satisfied ☐ Satisfied ☐ Neutral ☐ Unsatisfied ☐ Very Unsatisfied

19. **How important is it to you to have regular healthcare services and medical screenings?**

☐ Extremely Important ☐ Very Important ☐ Somewhat Important ☐ Not Important

20. **Have you received healthcare services or medical screenings in the past 12 months? (Routine check-up, blood pressure screening, mammogram, etc.) <u>If yes, please skip to question 22</u>**

☐ Yes ☐ No

21. **<u>If you answered no to question 20</u>, please select all that apply.**

☐ I did/do not have any health insurance
☐ I did/do have health insurance, but it does not cover all of my costs
☐ I did not need healthcare services or medical screenings because I was not sick
☐ I did not have transportation to the medical clinic
☐ I do not trust the healthcare providers
☐ I had concerns about exposure to COVID-19 at my healthcare provider location
☐ I have to wait too long to see a doctor
☐ I was/am too busy
☐ I was unable to find adequate childcare due to COVID-19
☐ The doctor does not speak the same language as I do
☐ The medical clinic is not open all of the time, so it is difficult to get an appointment
☐ There are not enough doctors in my area, so it is difficult to get an appointment
☐ Not sure / Do Not Know
☐ Other: _____

22. Did you visit the emergency room in the past 12 months? <u>If no, please skip to question 24</u>

☐ Yes ☐ No

23. <u>If you answered yes to question 22</u>, why did you visit the emergency room? (Select all that apply)

☐ Became ill or injured before 8 a.m. or after 5 p.m. on a weekday
☐ Became ill or injured during the weekend
☐ Could not get an urgent care appointment with my doctor
☐ Do not have a regular doctor or dentist, this is my usual source of care
☐ Had a life-threatening illness or injury
☐ Needed to refill a prescription
☐ Thought it seemed more convenient than waiting for an appointment
☐ Other: _____

24. Did you become sick or injured on the job in the past 12 months? <u>If No or Not Applicable, please skip to question 26</u>

☐ Yes ☐ No ☐ Not applicable (not working)

25. <u>If you answered yes to question 24,</u> did you seek medical care for your job-related illness or injury?

☐ Yes ☐ No If No, why not? _____

26. What do you think are the three biggest health issues that most affect our community? (Choose three)

☐ Alcoholism
☐ Cancer
☐ Child abuse and neglect
☐ COVID-19
☐ Dental problems
☐ Diabetes
☐ Health problems associated with aging
☐ Heart disease
☐ Homicide
☐ Infectious diseases (e.g., hepatitis, tuberculosis, etc.)
☐ Mental health issues
☐ Motor vehicle/bicycle accidents
☐ Obesity
☐ Poor birth outcomes
☐ Respiratory illnesses/lung disease/asthma
☐ Sexual abuse
☐ Sexually transmitted diseases
☐ Stroke
☐ Substance abuse

☐ Teenage pregnancy
☐ Other (please specify): _____

27. What do you think are the three individual behaviors that are responsible for health issues in our community? (Choose three)

☐ Alcohol abuse
☐ Crime/violence
☐ Distracted driving
☐ Domestic or intimate partner violence
☐ Driving while drunk/on drugs
☐ Drug abuse
☐ Lack of exercise
☐ Life stress/lack of coping skills
☐ Not getting "shots" (vaccines) to prevent disease
☐ Suicide
☐ Teenage sex
☐ Unsafe sex
☐ Using weapons/guns
☐ Other (please specify): _____

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

☐Homelessness
☐High cost of living (rent, utilities, food, etc.)
☐ Lack of education/no high school education
☐ Lack of affordable child-care options
☐ Language barriers
☐ Limited support for mental health services
☐ No health insurance
☐ Not enough food (food insecurity)
☐ Pandemic shutdowns
☐ Poverty
☐ Racism and discrimination
☐ Social Isolation
☐ Unemployment/underemployment
☐ Other (please specify): _____

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

☐ Air pollution and/or wildfire smoke
☐ Contaminated drinking water
☐ Flooding/drainage problems

☐ Heat/hot days
☐ Lack of access to healthy foods
☐ Lack of access to places for physical activity
☐ Lace of public transportation
☐ Lack of safe walkways and bikeways
☐ Pesticide use
☐ Poor housing condition
☐ Poor neighborhood design
☐ Second-hand smoke
☐ Traffic
☐ Trash on streets and sidewalks
☐ None
☐ Other (please specify): _____

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

☐ Access to childcare
☐ Access to dental care
☐ Access to healthcare
☐ Access to healthy food
☐ Affordable housing
☐ Air quality
☐ Community involvement
☐ Elderly care
☐ Good schools
☐ Green/open spaces
☐ Job opportunities
☐ Low crime/safe neighborhoods
☐ Parks and recreation facilities
☐ Safe place to raise kids
☐ Support agencies (faith-based organizations, support groups, social worker outreach) ☐ Time for family
☐ Tolerance for diversity
☐Well-informed community about health issues
☐ None
☐ Other (please specify): _____

31. What are the top three strengths in your community that support physical & mental wellbeing of residents? (Choose three)

☐ Access to fresh, local foods (such as farmers' markets, CSA box, urban farm stand)
☐ Friendly neighbors

☐ Good paying jobs
☐ Local job opportunities
☐ Local non-profit organizations
☐ My child's (children's) school
☐ Our local park or trail
☐ Religious institution
☐ Supportive selected leaders
☐ None
☐ Other (please specify): _____

32. Who are your top three trusted leaders in the Yolo County Community? (Choose three)

☐ Child-care providers
☐ Coaches
☐ Community advocates
☐ Healthcare professionals
☐ Law enforcement officers
☐ Non-profit agency leaders
☐ Political leaders
☐ Religious leaders
☐ School administrators (Principals, Vice-Principals, Superintendents)
☐ School boards
☐ Teachers
☐ None
☐ Other (please specify): _____

33. What are your top three trusted institutions in the Yolo County Community? (Choose three)

☐ City government
☐ County government
☐ Food bank
☐ Healthcare centers/hospitals
☐ K-12 schools
☐ Large businesses
☐ Law enforcement agencies
☐ Local community organizations
☐ Non-profit organizations
☐ Neighborhood associations
☐ Religious institutions (church, mosque, temple, or other places of worship)
☐ Small local businesses
☐ State government
☐ University/community college
☐ None

☐ Other (Please specify): _____

34. What have been the top three negative impacts of the COVID-19 Pandemic on the overall health and wellbeing of the Yolo County Community? (Choose three)

☐ Businesses closing
☐ Illness related to contracting COVID-19
☐ Increased substance abuse (alcohol or other drugs)
☐ Increased domestic violence or child abuse
☐ Job loss or reduction in work hours
☐ Lack of childcare for working parents
☐ Mental health issues
☐ Mistrust of government health officials
☐ Mistrust of healthcare system
☐ Schools closing
☐ Social isolation
☐ None
☐ Other (please specify): _____

35. Have you ever felt that you were treated differently by a doctor, mental health care worker, dentist, or other healthcare provider in Yolo County due to?

- ✦ The color of your skin ☐ Yes ☐ No ☐ Not sure
- ✦ Your gender ☐ Yes ☐ No ☐ Not sure
- ✦ Your sexual orientation ☐ Yes ☐ No ☐ Not sure
- ✦ Your race ☐ Yes ☐ No ☐ Not sure
- ✦ Your national origin ☐ Yes ☐ No ☐ Not sure
- ✦ Your physical and mental ability ☐ Yes ☐ No ☐ Not sure
- ✦ Your ability to speak English ☐ Yes ☐ No ☐ Not sure

36. Have you ever felt that you were treated differently by a local government agency (City or County) or program due to?

- ✦ The color of your skin ☐ Yes ☐ No ☐ Not sure
- ✦ Your gender ☐ Yes ☐ No ☐ Not sure
- ✦ Your sexual orientation ☐ Yes ☐ No ☐ Not sure
- ✦ Your race ☐ Yes ☐ No ☐ Not sure
- ✦ Your national origin ☐ Yes ☐ No ☐ Not sure
- ✦ Your physical and mental ability ☐ Yes ☐ No ☐ Not sure
- ✦ Your ability to speak English ☐ Yes ☐ No ☐ Not sure

37. In the past 12 months have you worried that you would run out of food before you got money to buy more?

☐ Yes, sometimes ☐ Yes, often, or always ☐ No ☐ I'm not sure

38. Is there anything else you would like to share about your personal health or the health status of the Yolo County Community?

39. What language(s) do you primarily speak at home?

☐ English ☐ Spanish ☐ Russian ☐ Mandarin ☐ Cantonese ☐ Farsi
☐ Pashto ☐ Urdu ☐ Decline to Answer
☐ Other (please specify): _____

40. How many people live in your home including yourself? _____

41. What is your annual household income before taxes?

☐Less than $10,000 ☐ $10,000 to $14,999 ☐ $15,000 to $24,999
☐ $25,000 to $34,999 ☐ $35,000 to $49,999 ☐ $50,000 to $74,999
☐ $75,000 to $99,999 ☐ $100,000 to $149,999 ☐ $150,000 to $249,999
☐ 250,000 or greater ☐ Decline to state

42. What is your current gender identity?

☐ Female ☐ Male ☐ Genderqueer
☐ Transgender Female/Transwoman/MTF ☐ Transgender Male/Transman/FTM
☐ Decline to Answer ☐ Prefer to self-describe as: _____

43. What is your sexual orientation?

☐ Bisexual ☐ Gay ☐ Lesbian ☐ Queer
☐ Questioning ☐ Straight (Heterosexual) ☐ Decline to answer
☐ Prefer to self-describe as: _____

44. Do you have health insurance? If yes, what type of insurance do you have?

☐ Yes: Medi-Cal
☐ Yes: Medi-Care
☐ Yes: Military or VA
☐ Yes: Other government
☐ Yes: Private – employer or someone else's employer
☐ Yes: Private – Covered California
☐ Yes: Private – Individual Plan
☐ I do not know
☐ No, I do not have insurance

45. If you answered "I do not have insurance" to Question 44, what are your barriers to getting health insurance? (Select all that apply)

☐ Employer does not provide insurance
☐ I do not know how to get health insurance
☐ Health insurance is too expensive for me or my family ☐ Other (please specify):

46. Are you eligible for Medi-Cal or Medicare?

☐ Yes ☐ No ☐ I don't know

47. Do you have dental insurance? ☐ Yes, through Medi-Cal
☐ Yes, through private insurance
☐ Yes, through another source
☐ No
☐ I do not know

48. Have you been to the dentist in the past 12 months?

☐ Yes ☐ No

49. Do you have reliable internet at home?

☐ Yes ☐ No

THANK YOU FOR COMPLETING THE YOLO COUNTY HEALTH STATUS SURVEY

Please return the survey to the staff member or individual who provided you the survey, or please place the survey in a designated survey collection envelope if one is available. If you completed the survey at home and would like to drop it off, please use one of the Yolo County Library locations listed below. You can visit www.yolocountylibrary.org for more information about library hours and location.

Clarksburg Branch Library	*52915 Netherlands Ave, Clarksburg CA 95612*	*Tuesday 10 am – 1 pm & 2 - 5:30 pm* *Thursday 10 am – 1 pm & 2 - 5:30 pm*
Mary L Stephens - Davis Branch Library	*315 E 14th St, Davis CA 95616*	*Monday 2 - 8 pm* *Tuesday 10 am - 8 pm* *Wednesday 10 am – 6 pm* *Thursday 10 am – 6pm* *Friday 12 – 5:30 pm* *Saturday 2 – 5:30 pm*

Esparto Regional Library	*17065 Yolo Avenue, Esparto CA 95627*	*Monday 2 – 7 pm* *Tuesday 12 - 7 pm* *Wednesday 10 am – 2 pm* *Friday 10 am – 2 pm* *Saturday 10 am – 5:30 pm*
Knight's Landing Branch Library	*42351 Third Street, Knight's Landing, CA 95645*	*Tuesday 11 am – 1 pm & 2 – 7 pm* *Wednesday 10 am – 12 pm & 1 – 6 pm* *Friday 10 am – 12 pm & 1 – 5:30 pm*
Arthur F. Turner Community Library	*1212 Merkley Ave, West Sacramento CA 95691*	*Monday 1:30 - 5:30 pm* *Wednesday 10 am - 2 pm* *Thursday 12 – 7 pm* *Saturday 2 - 5:30 PM*
Winters Community Library	*708 Railroad Ave, Winters CA 95694*	*Monday 10 am - 4 pm* *Tuesday 12 pm – 7 pm* *Wednesday 10 am – 4 pm* *Thursday 3:30 – 7 pm* *Saturday 1 - 5pm*
Yolo Branch Library	*37750 Sacramento Street, Yolo CA 95697*	*Tuesday 1:30 pm – 5:30 pm* *Wednesday 3 – 7 pm* *Thursday 10 am – 12 pm & 1:30 – 5:30 pm* *Saturday 1:30 – 5:30 pm*

PLEASE FILL OUT YOUR CONTACT INFORMATION BELOW AND RETURN IT WITH YOUR SURVEY FOR A CHANCE TO WIN A $100 GROCERY GIFT CARD

Name:

Phone Number: or Email Address:

https://mysacstate-my.sharepoint.com/personal/diazh_csus_edu1/Documents/Desktop/CHI 2018/Final Yolo Main report_Feb 2019.docx?web=1