2025
Community Health Needs Assessment

A joint assessment for Sutter Davis Hospital and Woodland Memorial Hospital.

Adopted on June 25, 2025.

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*Section was written and designed by Community Health Insights

Executive Summary

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs in the community served by Woodland Memorial Hospital. The priorities identified in this report help to guide the hospitals' community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirement of the Patient Protections and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least once every 3 years. The hospitals' commitment to engaging with the community partners is in keeping with its mission. We make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Woodland Memorial Hospital conducted a joint CHNA with Sutter Davis Hospital. Community Health Insights was contracted to help conduct the CHNA; however, the majority of its efforts were concentrated on obtaining community/stakeholder input, identifying places of concern within the community, and determining preliminary priority health needs.

Our Community

A hospital's service area comprises all residents in a defined geographic area and does not exclude low-income or underserved populations. As such, Woodland Memorial Hospital is located in Yolo County and serves the entire county. For summary of the demographic composition of Yolo County, see page 9.

Assessment Process & Methods

The process and methods used by Community Health Insights to conduct this assessment are described below. The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model. 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 24 community health experts, social service providers, and medical personnel. Furthermore, 24 community residents and community service provider organizations participated in three focus groups across the service area. Finally, 18 community service providers responded to a Community Service Provider survey asking about health need identification and prioritization.

Identification of Priority Community Health Needs: The initial process used to identify and prioritize health needs conducted by Community Health Insights is described below:

> Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 11 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 the service area. These PHNs were selected as significant health needs. These significant health needs were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 11 PHNs identified in previous CHNAs.

As a result of these efforts, the following 11 health needs were identified (listed by importance): (1) Access to Basic Needs Such as Housing, Jobs, and Food; (2) Access to Mental Health and Substance Use Services; (3) Access to Quality Primary Care Health Services; (4) Increased Community Connections; (5) System Navigation; (6) Active Living and Healthy Eating; (7) Injury and Disease Prevention and Management; (8) Access to Functional Need; (9) Safe and Violence-Free Environment; (10) Access to Specialty and Extended Care; and (11) Healthy Physical Environment.

To strategically focus its community health improvement efforts, Dignity Health consolidated and prioritized the 11 health needs identified by Community Health Insights. A thematic analysis (described below) was conducted to identify shared barriers, risk factors, and potential solutions across the initial 11 needs. This process resulted in the identification of four significant health needs: Access to Care, Access to Resources, Chronic Disease Prevention & Management, and Mental Health/Substance Use.

- Access to Care
  - *Foci:* (1) Access to Quality Primary Care Health Services, (2) Access to Specialty & Extended Care, and (3) System Navigation - Health Care
- Chronic Disease Prevention & Management
  - *Foci:* (1) Active Living & Healthy Eating and (2) Injury/Disease Prevention & Management
- Mental Health & Substance Use
- Access to Resources
  - *Foci:* (1) Access to Basic Needs and (2) System Navigation - Social Supports

Resources to Address Needs

A list of available resources in Yolo County to address the four significant health needs and their foci can be found in Section VI.

Adoption, Availability & Comments

This CHNA report was adopted by the Woodland Memorial Hospital community board in June 2025. The report is widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at Dignity Health's Community Health Department. Written comments on this report can be submitted to Dignity Health's Community Health Department (3400 Data Drive, Rancho Cordova, CA 95670) or by e-mail to DignityHealthGSSA_CHNA@dignityhealth.org.

Core Demographic Composition, 2019-2023

	Yolo County	Notes
Geographic Classification Total	Rural & Suburban	
Population	217,782	
Race & Ethnicity		
Not Hispanic or Latino	66.8%	
White	*43%*	
Black or African American	*2.5%*	
American Indian and Alaska Native	*0.4%*	
Asian	*14.5%*	*Source:* American Community Survey (Table: DP05), 5-Year Estimates (2019-2023)
Native Hawaiian/Other Pacific Islander	*0.4%*	
Some Other Race	*0.5%*	
Two or More Races	*5.4%*	
Hispanic or Latino (of any race)	33.2%	
Socioeconomic Status		
Median Household Income	$88,818	Household income in the past 12 months in 2023 inflation-adjusted dollars. *Source:* American Community Survey (Table: B19013), 5-Year Estimates (2019-2023).
Poverty Among Families w/Children	9.1%	Families with related children of householders, under 18 years with an estimated poverty status in the past 12 months. Source: American Community Survey (Table: S1702), 5-Year Estimates (2019-2023)
Unemployment Rate	5.3%	*Source:* American Community Survey (Table: DP03), 5-Year Estimates (2019-2023)
Non-High School Graduates	11.5%	*Source:* American Community Survey (Table: DP02), 5-Year Estimates (2019-2023)
Limited-English Proficiency	12.8%	Population 5 years and older that speak a language other that english at home. *Source:* American Community Survey (Table: DP02), 5-Year Estimates (2019-2023)
Access to Care		
Uninsured Individuals	4.6%	*Source:* American Community Survey (Table: S2701), 5-Year Estimates (2019-2023)
Medicaid Beneficiaries	4.1%	*Source:* American Community Survey (Table: S2704), 5-Year Estimates (2019-2023)
# of Non-Dignity Health Hospitals (non-behavioral health)	1	Sutter Davis Hospital
Are federally-designated Health Professional Shortage Areas and Medically Underserved Areas or Populations present?	Yes	

SECTION I

Introduction

How does Woodland Memorial Hospital put human kindness into practice?

About Us

As the largest hospital network and one of the largest subspeciality networks in the region, Dignity Health has cared for the Greater Sacramento area for more than 125 years. Since the Sister of Mercy broke ground on Sacramento's first private hospital, Mater Misericordiae (Latin for "Mother of Mercy"). We have grown and now operate five hospitals in the Greater Sacramento Area (Mercy General Hospital, Mercy Hospital of Folsom, Mercy San Juan Medical Center, Methodist Hospital of Sacramento and Woodland Memorial Hospital) but our mission has remained unchanged.

From the care we deliver, to the community investments we make, our commitment has been and always will be to provide affordable high-quality and compassionate care that meets the needs of the region's diverse communities. Dignity Health offers comprehensive health care options, including access to doctors from Dignity Health Mercy Medical Group, Dignity Health Woodland Clinic, Dignity Health Medical Group, Dignity Health Medical Group - Sierra Nevada, and Hill Physicians Medical Group. With more than 1,500 renowned affiliated physicians and five Sacramento area full-service hospitals, we offer access to personalized, community-based care with all the benefits of being one of the largest health systems in the nation.

Our hospitals are dedicated to achieving medical excellence through a continual assessment of the needs in their respective communities and an investment in people, capacity and innovative treatments and technology. Mercy San Juan Medical Center is a regional leader in stroke care and has treated more patients than any other system or provider in the area.

Our Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all, inspired by faith, driven by innovation and powered by our humanity.

Our Values

Compassion

- Care with listening, empathy and love.
- Accompany and comfort those in need of healing.

Inclusion

- Celebrate each person's gifts and voice.
- Respect the dignity of all.

Integrity

- Inspire trust through honesty.
- Demonstrate courage in the face of inequity

Excellence

- Serve with fullest passion, creativity and stewardship.
- Exceed expectations of others and ourselves.

Collaboration

- Commit to the power of working together.
- Build and nurture meaningful relationships.

Treatments and technology. Mercy San Juan Medical Center is a regional leader in stroke care and has treated more patients than any other system or provider in the area. Likewise, Mercy General Hospital is known for its innovative and first-class cardiovascular services. Methodist Hospital of Sacramento and Mercy Hospital of Folsom have dedicated emergency department programs for OB patients. The programs ensure pregnant patients experiencing urgent medical needs are evaluated by an OB/GYN physician within 30 minutes of arrival.

Dignity Health provides outpatient services through Mercy Home Health, Hospice & Palliative Care, Dignity Health Advanced Imaging, Mercy Cancer Center, and across our physician network. Our collaborative partners work together to build bridges to health care and community resources to increase access and wellness.

A Healthier Future for All

At Dignity Health, we believe everyone has the right to be healthy. We know our health shouldn't depend on our ZIP Code, economic status or the color of our skin. Together we have a chance to create a more just health care system across the country that improves physical, social and mental health through better access and more equitable outcomes.

We envision an approach to providing health care that solves health needs proactively and






holistically and achieves more equitable health outcomes. As one of the nation's largest nonprofit health care organizations, Dignity Health is uniquely positioned to lead this work in our communities.

Community Health Programs: A community is not healthy until everyone is healthy. At Dignity Health, we are investing to create stronger communities where we live, work, learn and pray. We seek to weave better health into every part of our society so that more people and places can prosper. Because only when our health is strong can we begin to grow stronger. Dignity Health supports a range of community health programs addressing the root causes health such as access to quality care, affordable housing and safe neighborhoods.

In FY 2024, Dignity Health Invested $170,968,370 in community benefits in response to critical community needs in the Greater Sacramento Region. For more information on the resources invested by Dignity Health to improve the health and quality of life for the communities we serve, please refer to our annual report to our communities by clicking here.

SECTION II

Assessment Methods & Prioritization Results

How were significant health needs identified and prioritized by Community Health Insights and Woodland Memorial Hospital?

Introduction and Purpose

Both state and federal laws require that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years to identify and prioritize the SHNs of the communities they serve. The results of the CHNA guide the development of implementation plans aimed at addressing identified health needs. Federal regulations define a health need accordingly: "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)" (p. 78963).[2]

This report documents the processes, methods, and findings of a CHNA conducted on behalf of Woodland Memorial Hospital located at 1325 Cottonwood Street, Woodland CA 95695 . The primary service area includes all of Yolo County. The total population of the service area was 240,914.

Woodland Memorial Hospital (WMH) is an affiliate of CommonSpirit Health, a nonprofit healthcare system. The CHNA was conducted over a period of ten months, beginning in March 2024 and concluding January 2025. This CHNA report meets requirements of the Patient Protection and Affordable Care Act and California Senate Bill 697 that nonprofit hospitals conduct a CHNA at least once every three years. Primary data collection, specifically key informant interviews, were collected in collaboration with ASR, a consulting firm conducting another CHNA on behalf of Kaiser Permanente in portions of the Yolo County service area

Community Health Insights conducted the CHNA on behalf of both SDH and WMH, with participation from the Yolo County Health and Human Services Community Health Branch. CHI is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. CHI 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 SHNs in the Yolo County service area. In all, 11 SHNs were identified. Primary data were then used to prioritize these SHNs.

Prioritization was based on three 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 measure was the percentage of community service provider survey respondents that identified a health need as a top priority. Table 1 shows the value of these measures for each SHN.

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

Table 1: Health needs prioritization inputs for the Yolo County 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
Access to Basic Needs Such as Housing, Jobs, and Food	100%	39%	67%
Access to Mental/Behavioral Health and Substance Use Services	82%	18%	44%
Access to Quality Primary Care Health Services	94%	8%	28%
Increased Community Connections	76%	3%	22%
System Navigation	59%	5%	28%
Active Living and Healthy Eating	47%	7%	17%
Injury and Disease Prevention and Management	41%	8%	11%
Access to Functional Needs	59%	4%	6%
Safe and Violence-Free Environment	47%	3%	~
Access to Specialty and Extended Care	29%	3%	6%
Healthy Physical Environment	29%	~	6%

~ 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 were more frequently identified among the top priority needs.[3] The prioritization index values are shown in Figure 1, where health needs are ordered from highest priority at the top of the figure to lowest priority at the bottom.

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

These SHNs are described below. The secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each SHN ordered by their relationship to the conceptual model used to guide data collection for this report. 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).

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

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[4] 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.[5]

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Struggling to meet basic needs leads to difficult choices between essentials. ●More programs to enhance parent education and access to childcare are needed. ●Critical need for secure and affordable housing. ●Increasing homelessness, particularly in urban regions. ●High rental costs and insufficient transitional housing options. ●One in three households in Yolo County experiences food insecurity. ●Transportation challenges hinder access to food resources. ●Stress related to financial insecurity affects mental health. ●Medi-Cal (California's Medicaid) offers options, but underutilization persists. ●Insufficient job opportunities that pay a livable wage.	●Additional low-income housing options are needed. ●It is difficult to find affordable childcare. ●Many people do not make a living wage. ●Housing is unaffordable. ●Many residents struggle with food insecurity. ●Poverty is high. ●Services for homeless residents are insufficient. ●Employment opportunities are limited. ●Services are inaccessible for Spanish-speaking and immigrant residents. ● Educational attainment in the area is low.	●Hypertension Mortality ●Accidental Falls (aged over 65+) ED visits ●Frequent Mental Distress ●Frequent Physical Distress ●Poor Mental Health Days ●Poor or Fair Health ●Poor Physical Health Days ●Medically Underserved Area ●Food Environment Index ●Homeownership ●Severe Housing Cost Burden ●Households with no Vehicle Available ●Third Grade Math Level ●Income Inequality ●Median Household Income

[4] McLeod, S. 2020. Maslow's Hierarchy of Needs. Retrieved 31 Jan 2022 from http://www.simplypsychology.org/maslow.html.

[5] Robert Wood Johnson Foundation, and University of Wisconsin, 2022. Research Articles. Retrieved 31 Jan 2022 from http://www.countyhealthrankings.org/learn-others/research-articles#Rankingsrationale.

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Many individuals are ineligible for health benefits due to income limits. ●Many unhoused individuals do not possess necessary IDs or documentation to access vital services. ●Language barriers limit accessibility for immigrant and refugee communities. ●Lack of outreach and education about available resources contributes to service utilization. ●Discrimination and stigma affect access to services, especially among the unhoused. ●Initiatives aimed at mobilizing resources and engaging the community in service distribution are needed. ●Pandemic exacerbated financial strain and food insecurity in Yolo County. ●More affordable housing options and rental assistance programs are needed. ●Educational programs to enhance job skills and inform community members about available resources are needed. ●Advocacy for equitable healthcare services and increased involvement of culturally competent staff. ●Difficulty in finding rental spaces for clients needing mental health or forensic support. ● Time off work is often necessary for health-related appointments, impacting financial stability.		

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Demand for services is increasing due to financial stress, but access remains limited. ●There are alarming rates of depression, anxiety, and substance abuse, particularly in marginalized groups like the unhoused and immigrants ●There is a growing crisis in behavioral health among pre-adolescents and adolescents. ●Mental health stigma is a significant barrier, especially within immigrant and tribal communities. ●Inadequate access to services leads to a need for immediate treatment options for mental health and substance use crises. ●There is a suggestion to create a centralized facility to address community health needs comprehensively. ●Adults and adolescents in rural areas face particularly long wait times and lack adequate services. ●Enhancing access to care and conducting community education on mental health and substance use prevention is vital.	●There aren't enough mental health providers or treatment centers (e.g., psychiatric beds, therapists, support groups). ●Additional services for those who are homeless and experiencing mental/behavioral health issues are needed. ●There aren't enough services for those who are homeless and dealing with substance-abuse issues. ●It's difficult for people to navigate mental/behavioral healthcare. ●The cost for treatment is too high. ●Treatment options for those with Medi-Cal are limited. ●There aren't enough substance-abuse treatment services available (e.g., detox centers, rehabilitation centers). ●Treatment options for those with Medi-Cal are limited. ●Additional services specifically for young people, are needed (e.g., child psychologists, counselors and therapists in the schools). ●Substance-abuse is a problem (e.g., use of opiates and methamphetamine, prescription misuse).	●All Cause Cancer Mortality ●Breast Cancer Mortality (Females) ●Lung Cancer Mortality ●Prostate Cancer Mortality ●Frequent Mental Distress ●Frequent Physical Distress ●Mental Health Hospitalizations (ages 15-24) ●Mental Health or Drug-Related Hospitalizations (ages 15-24) ●Poor Mental Health Days ●Poor or Fair Health ●Poor Physical Health Days ●Medically Underserved Area ●Mental Health Care Shortage Area ●Mental Health Providers ●Excessive Drinking ●Adult Smoking ●Severe Housing Cost Burden ●Income Inequality

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Increased mental health resources are essential. ● Increased mental health resources are essential.	●Awareness of mental health issues is low. ●There is a lack of infrastructure to support acute mental health crises. ●Substance-abuse is an issue among youth in particular. ●The stigma around seeking mental health treatment keeps people out of care. ●Substance-abuse treatment services are available, but people do not know about them. ●Mental/behavioral health services are available, but people do not know about them. ● The use of nicotine delivery products such as e-cigarettes and tobacco is a problem.	

3. 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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●There is a need for a more robust network of care that includes better coordination between healthcare organizations and community partners, especially in rural areas.	●There aren't enough primary care providers. ●Patients seeking primary care overwhelm local	●All Cause Cancer Mortality ●Breast Cancer Mortality (Females) ●Lung Cancer Mortality

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●There are insufficient healthcare providers, leading to long wait times for appointments and emergency services. ●The healthcare system is overwhelmed, resulting in many individuals relying on emergency care due to the lack of primary care providers. ●Patients experience significant challenges with communication and navigation within the healthcare system, including poor telephone services and difficult billing processes. ●Navigating health insurance is complicated, especially for those not using Federally Qualified Health Centers (FQHCs). ●Patients often face tough choices regarding time off work and financial burdens related to health choices, leading to the underutilization of available benefits. ●Many health issues stem from social determinants outside of healthcare services, such as housing and food security, necessitating better integration of services to address these basic needs. ●A new clinic, Capay Valley Health and Community Center, has improved local access to essential medical services, reducing the travel burden for patients in rural areas. ●Patients face long waits for care, the risk of being turned away at hospitals due to insurance issues, and culturally inappropriate treatments, showing a need for more culturally competent care ●Systemic improvements in healthcare access, provider availability, service integration, and community support	emergency departments. ●Too few providers accept Medi-Cal. ●Wait-times for appointments are excessively long. ●It's difficult to obtain appointments outside of regular business hours. ●Out-of-pocket costs are too high. ●Quality health insurance is unaffordable. ●Primary care services are available, but they are difficult to navigate. ●Specific services are unavailable (e.g., 24-hour pharmacies, urgent care, telemedicine). ● The quality of care is low (e.g., providers lack cultural or linguistic competence).	●Prostate Cancer Mortality ●Alzheimer's Disease Mortality ●Behavioral Chronic Disease model for over 50% of the population ●Hypertension Mortality ●Diabetes Mortality ●Stroke Mortality ●Breast Cancer Prevalence ●Lung Cancer Prevalence ●Frequent Mental Distress ●Frequent Physical Distress ●Poor Mental Health Days ●Poor or Fair Health ●Poor Physical Health Days ●Mammography Screening ●Medically Underserved Area ●Prenatal Care (1st Trimester) ●Income Inequality

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
are needed to address the complex and interrelated needs of patients ● Lack of cohesion among different service providers leads to inadequate patient support; entities often work in silos.		

4. 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." [6] Assuring that community members connect with each other through community opportunities like programs, services, and civic engagement is important to foster a healthy community. Further, 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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Navigating healthcare systems is complex and often poses barriers. ●There is an urgent need for enhanced collaborations and cohesive pathways among healthcare providers. ●Emphasis on developing partnerships with local organizations. ●Greater coordination is required among healthcare organizations, particularly for referrals and follow-ups.	●Health and social-service providers operate in silos; cross-sector connections needed. ●City and county leaders need to work together. ●There isn't enough funding for social services. ●Building community connections doesn't seem like a priority. ●People in the community face discrimination from local service providers.	●Behavioral Chronic Disease model for over 50% of the population ●Hypertension Mortality ●Diabetes Mortality ●Stroke Mortality ●Frequent Mental Distress ●Frequent Physical Distress ●Mental Health Hospitalizations (ages 15-24) ●Mental Health or Drug-Related Hospitalizations (ages 15-24) ●Poor Mental Health Days

[6] Robert Wood Johnson Foundation. 2016. Building a Culture of Health: Sense of Community. Retrieved 31 Jan 2022 from https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●There is a growing need to strengthen networks of healthcare in rural areas. ●No Wrong Door Approach: Patients should be able to find help easily, regardless of where they enter the system. ●Post-COVID-era isolation has led to a need for more community engagement opportunities. ●Lack of affordable summer programs leaves children with limited options for engagement. ●There is a need for programs aimed at young citizens to foster educational aspirations. ●Encourage community organizations to act collectively, addressing specific needs and streamlining resources. ●Increased support needed for cognitively impaired individuals living in isolation. ● A siloed approach in healthcare delivery results in duplication of services and inefficiencies.	●Relations between law enforcement and the community need to be improved. ● The community needs to invest more in the local public schools.	●Poor or Fair Health ●Poor Physical Health Days ●Medically Underserved Area ●Mental Health Care Shortage Area ●Mental Health Providers ●Excessive Drinking ●Physical Inactivity ●Households with no Vehicle Available ●Income Inequality

5. System Navigation

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

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Need for stronger partnerships among organizations to address community needs. ●Individuals struggle with navigating fragmented social and healthcare systems, which complicates access to the care they need. ●Improved coordination with healthcare organizations is crucial, particularly to enhance rural healthcare networks. ●There is a significant delay for patients in securing appointments and completing lab work. ●Many individuals earn too much to qualify for Medi-Cal but cannot afford Covered California, resulting in service gaps. ●There is a lack of awareness among community members about available resources and how to access them. ●Proposed solutions include hiring more caseworkers and utilizing Promotoras to disseminate information actively. ●Unhoused individuals often receive housing assistance without adequate follow-up for substance abuse treatments or mental health evaluations.	●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. ●It is difficult to navigate multiple, different health care systems. ●More navigators are needed to connect people to services. ●People have trouble understanding their insurance benefits. ●People may not be aware of the services they are eligible for. ●Medical and insurance paperwork can be overwhelming. ●Medical terminology is confusing. ● There aren't enough bilingual navigators.	●All Cause Cancer Mortality ●Breast Cancer Mortality (Females) ●Lung Cancer Mortality ●Prostate Cancer Mortality ●Behavioral Chronic Disease model for over 50% of the population ●Hypertension Mortality ●Diabetes Mortality ●Stroke Mortality ●Frequent Mental Distress ●Poor Mental Health Days ●Poor or Fair Health ●Dentists ●Mammography Screening ●Medically Underserved Area ●Mental Health Care Shortage Area ●Mental Health Providers ●Prenatal Care (1st Trimester)

[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.

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Transportation services are often unavailable, limiting access to necessary resources. ●Services offered are often not culturally or linguistically appropriate, particularly for diverse communities (e.g., Russian, Hispanic/Latino, Black, Afghan). ●Low retention rates in services that fail to meet cultural needs. ●Poor telephone services, long wait times, and difficulty in navigating patient portals hinder effective communication with medical providers. ●Accessibility issues arise from a transition to electronic e-health services, creating difficulties for populations lacking technology skills or resources. ● Lack of cohesive patient-centered care leads to services not aligning with individual patient needs.		

6. 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 experience 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.

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Some individuals lack access to food altogether, while others have limited access to healthy food options. ●Food banks generally do not provide ready-to-eat meals. ●Many fresh or canned items given through food assistance programs require preparation, which poses challenges for those without access to cooking facilities (e.g., stoves, microwaves, refrigerators). ●Transportation barriers further complicate food access. ●There is a notable absence of soup kitchens or centralized locations offering ready-made meals in the County. ●Limited availability of grocery and department stores, particularly those providing healthy options. ●The increase in food service accessibility post-COVID has highlighted the needs of specific populations, particularly Latino farmworkers, who face obstacles related to cost of living and inflation affecting their ability to purchase nutritious foods. ●Many local parks suffer from poor maintenance, including worn-out equipment and unkempt lawns filled with trash and animal waste. ●There aren't enough parks to serve the community effectively. ●Limited affordable recreational activities are available (expensive gyms and swimming lessons). ●Community members often feel forced to choose between necessary goods and recreational opportunities.	●Fresh, unprocessed foods are unaffordable. ●Nutrition education programs are needed. ●Food insecurity is an issue. ●Students need healthier food options in schools. ●Homelessness in parks or other public spaces deters their use. ●Recreational opportunities are unaffordable (e.g., gym memberships, recreational activity programming). ●The built environment doesn't support physical activity (e.g., neighborhoods aren't walk-able, roads aren't bike-friendly, parks are inaccessible). ● There are food deserts where fresh, unprocessed foods are not available.	● All Cause Cancer Mortality ●Breast Cancer Mortality (Females) ●Lung Cancer Mortality ●Prostate Cancer Mortality ●Behavioral Chronic Disease model for over 50% of the population ●Hypertension Mortality ●Diabetes Mortality ●Stroke Mortality ●Breast Cancer Prevalence ●Frequent Mental Distress ●Frequent Physical Distress ●Poor Mental Health Days ●Poor or Fair Health ●Poor Physical Health Days ●Food Environment Index ●Physical Inactivity ●Severe Housing Cost Burden ●Income Inequality

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Available healthy eating programs do not adequately address cultural dietary practices and are mostly offered online and in English, limiting accessibility for some community members. ● School lunches are predominantly high in fats and carbohydrates, further contributing to health issues in children.		

7. 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.

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●There is a need for increased focus on preventative care and chronic disease management. ●Highlights the significant management of chronic conditions like hypertension, diabetes, and obesity. ●Indicates a lack of education on prevention. ●Many individuals must choose between essential needs (food, medicine, rent) due to income restrictions. ●Medi-Cal offers extensive services, yet many individuals	●Health education in the schools needs to be improved. ●Nutrition education opportunities are needed. ●Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision). ●Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, the elderly, LGBTQ individuals, immigrants).	●All Cause Cancer Mortality ●Breast Cancer Mortality (Females) ●Lung Cancer Mortality ●Prostate Cancer Mortality ●Alzheimer's Disease Mortality ●Behavioral Chronic Disease model for over 50% of the population ●Hypertension Mortality ●Diabetes Mortality ●Stroke Mortality

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
only opt for traditional medical insurance, neglecting beneficial services like dietician support. ●The community faces high rates of diabetes, obesity, and cardiovascular diseases. ●Youth are particularly affected by obesity, as they lack education in healthy food choices. ●Emphasizes the need for early childhood education and support for parents, particularly in childcare. ●Calls for the hiring of more case workers and the use of community health workers (Promotoras) to improve individual engagement and education. ●Suggests implementing nutritional classes in schools to educate young people on healthy eating from an early age. ●Stress on the importance of teaching life skills to combat loneliness and foster connections in the community. ●Limited resources and funding for community health prevention programs, worsened by the COVID-19 pandemic. ●Introduce preventative and chronic disease management education early in schools. ● Encourage involvement and self-responsibility among patients regarding their health and care decisions.	●There isn't really a focus on prevention. ●There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease). ● Preventive health services for women are needed (e.g., breast and cervical cancer screening).	●Accidental Falls (aged over 65+) ED visits ●Frequent Mental Distress ●Frequent Physical Distress ●Mental Health Hospitalizations (ages 15-24) ●Mental Health or Drug-Related Hospitalizations (ages 15-24) ●Poor Mental Health Days ●Poor or Fair Health ●Prenatal Care (1st Trimester) ●Excessive Drinking ●Physical Inactivity ●Adult Smoking ●Motor Vehicle Crash Death ●Third Grade Math Level ●Income Inequality

8. Access to Functional Needs

Functional needs refer to needs related to adequate transportation access and conditions that 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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Individuals in rural areas struggle to access essential services due to inadequate transportation options. ●Transportation can be costly, particularly for those on fixed incomes, such as those receiving Supplemental Security Income (SSI). ●There are insufficient shuttle services to help elderly individuals reach appointments or stores. ●In Woodland, there is a major need for improved bike and scooter-friendly infrastructure, as many individuals feel unsafe riding. ●There's a need to enhance transportation services to enable youth to gather for activities. ●The existing public transportation services are inadequate, complicating access to necessary destinations like Woodland and Winters. ● Spanish-speaking unhoused individuals reportedly do not seek services due to language barriers that hinder their access to transportation and resources.	●Medical transport is limited or unreliable. ●The distance between service providers is inconvenient for those using public transportation. ● Using public transportation to reach providers can take a very long time.	●Accidental Falls (aged over 65+) ED visits ●Frequent Mental Distress ●Frequent Physical Distress ●Poor or Fair Health ●Households with no Vehicle Available ●Income Inequality

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. Additionally, research has shown that individuals exposed to violence in their homes,

communities, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior. [8]

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 and focus group participants: Key Informant and Focus Group Responses	The following indicators performed worse in the service area when compared to state averages:
●People feel unsafe around unhoused individuals, often struggling with mental health issues, which can lead to violent encounters. ●Notably increase in gang violence among youth in the community. ●IPV incidents rose significantly, especially during the pandemic, with overwhelmed shelters. ●Limited access to mental health and support services for IPV victims. ●Lack of adequate lighting and infrastructure in areas of the County makes areas unsafe for activities like cycling or walking. Poor road conditions contribute to traffic accidents ●Unhoused individuals frequently experience violence and theft, causing shelters to struggle with safety for their residents. ●Some residents, including Muslims in the area, live in fear due to heightened violence and global events. ●Care providers face significant risks, experiencing aggressive behavior and violence from individuals struggling with addiction, leading to burnout and a need for formal protections. ●There is a need for a centralized hub to provide holistic health and community support services addressing both mental health and domestic violence survivor needs.	●Hypertension Mortality ●Frequent Mental Distress ●Frequent Physical Distress ●Mental Health Hospitalizations (ages 15-24) ●Mental Health or Drug-Related Hospitalizations (ages 15-24) ●Poor Mental Health Days ●Poor or Fair Health ●Physical Inactivity ●Severe Housing Cost Burden ●Motor Vehicle Crash Death ● Income Inequality

10. 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.

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

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Lack of sufficient healthcare providers necessitates exploring alternative care models. ●There is a considerable lack of optometrists, forcing community members to travel out of their counties, especially for those on Medi-Cal. ●Specialty services are limited, often requiring patients to travel 30-40 minutes for necessary appointments. ●Long wait times persist for appointments, particularly for specialty care referrals. ●Shortage of affordable long-term and skilled nursing facilities to accommodate community needs. ●Lack of available long-term rehabilitation facilities that address behavioral health and substance use issues. ●Uninsured individuals face significant challenges accessing specialty care. ●Specialty services often refuse those without the "right" insurance, exacerbating healthcare inequalities. ● The healthcare system is described as complicated, leading to insufficient use of available resources.	●More extended care options for the aging population are needed (e.g. skilled nursing homes, in-home care). ●Not all specialty care is covered by insurance. ● Out-of-pocket costs for specialty and extended care are too high.	●All Cause Cancer Mortality ●Breast Cancer Mortality (Females) ●Lung Cancer Mortality ●Prostate Cancer Mortality ●Alzheimer's Disease Mortality ●Behavioral Chronic Disease model for over 50% of the population ●Hypertension Mortality ●Diabetes Mortality ●Stroke Mortality ●Lung Cancer Prevalence ●Frequent Mental Distress ●Frequent Physical Distress ●Poor Mental Health Days ●Poor or Fair Health ●Poor Physical Health Days ●Income Inequality

11. Healthy Physical Environment

Individual health is determined by several factors, and some models show that one's living environment, including the physical (natural and built) and sociocultural environment, has more impact on individual health than one's lifestyle, heredity, or access to medical services.[9]

[9] Blum, H. L. 1983. Planning for Health. New York: Human Sciences Press

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 survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
●Extreme weather conditions contribute to residents experiencing homelessness. ●Concerns include pollution, climate change, and access to clean water. ●Poor air quality is a significant problem, primarily due to dust from farm plowing. ●A high number of potholes are present, which can damage car tires. ● Large geographical distances create additional transportation difficulties.	●Agricultural activity harms the air quality. ●Low-income housing is substandard. ●The air quality contributes to high rates of asthma. ● Water quality is poor.	●Hypertension Mortality ●Breast Cancer Prevalence ●Lung Cancer Prevalence ●Frequent Mental Distress ●Frequent Physical Distress ●Poor or Fair Health ●Adult Smoking ●Air Pollution - Particulate Matter ●Drinking Water Violations ●Drought Frequency ●Projected Difference in Extreme Heat Days ●Projected Difference in Extreme Precipitation Days ●Severe Housing Cost Burden ●Income Inequality

Methods Overview

Conceptual and Process Models

The data used to conduct the CHNA 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 analytic stages were developed. For a detailed review of methods, see the technical section.

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 strategies. Woodland Memorial Hospital (WMH) requested written comments from the public on its 2022 CHNA and most recently adopted Implementation Strategy through DignityHealthGSSA_CHNA@dignityhealth.org

At the time of the development of this CHNA report, WMH had not received written comments. However, input from the broader community was incorporated in the 2025 CHNA through key informant interviews, focus groups, and the community service provider survey. WMH will continue to use its website as a tool to solicit

[10] Robert Wood Johnson Foundation, and University of Wisconsin, 2024. County Health Rankings Model. Retrieved 18 July 2024 from https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods.

public comments and ensure that these comments are considered as community input in the development of future CHNAs.

Data Used in the CHNA

Data collected and analyzed included both primary or qualitative data and secondary or quantitative data. Primary data included 13 interviews with 24 community health experts, three focus groups conducted with a total of 24 community residents or community-facing service providers, and 18 responses to the community 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 sub-county levels was used to identify portions of the hospital service area with greater concentrations of disadvantaged populations and poor health outcomes. A set of county-level indicators was collected from various sources to help identify and prioritize SHNs. Additionally, socioeconomic indicators were collected to help describe the overall social conditions within the service area. 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, 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 related to issues such as climate, air and water quality, transit and mobility resources, and housing affordability. In all, 104 different health-outcome and health factor indicators were collected for the CHNA.

Data Analysis

Primary and secondary data were analyzed to identify and prioritize the SHNs within the Yolo County service area. This included identifying 12 PHNs in these communities. These PHNs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the hospital's service area. After these were identified, health needs were prioritized based on an analysis of primary data sources that described the PHN as a SHN.

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

The definition of the community served by the hospital was the primary service area of Yolo County. 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.

The total population of the service area for 2023 was 242,067. The service area is shown in Figure 2.

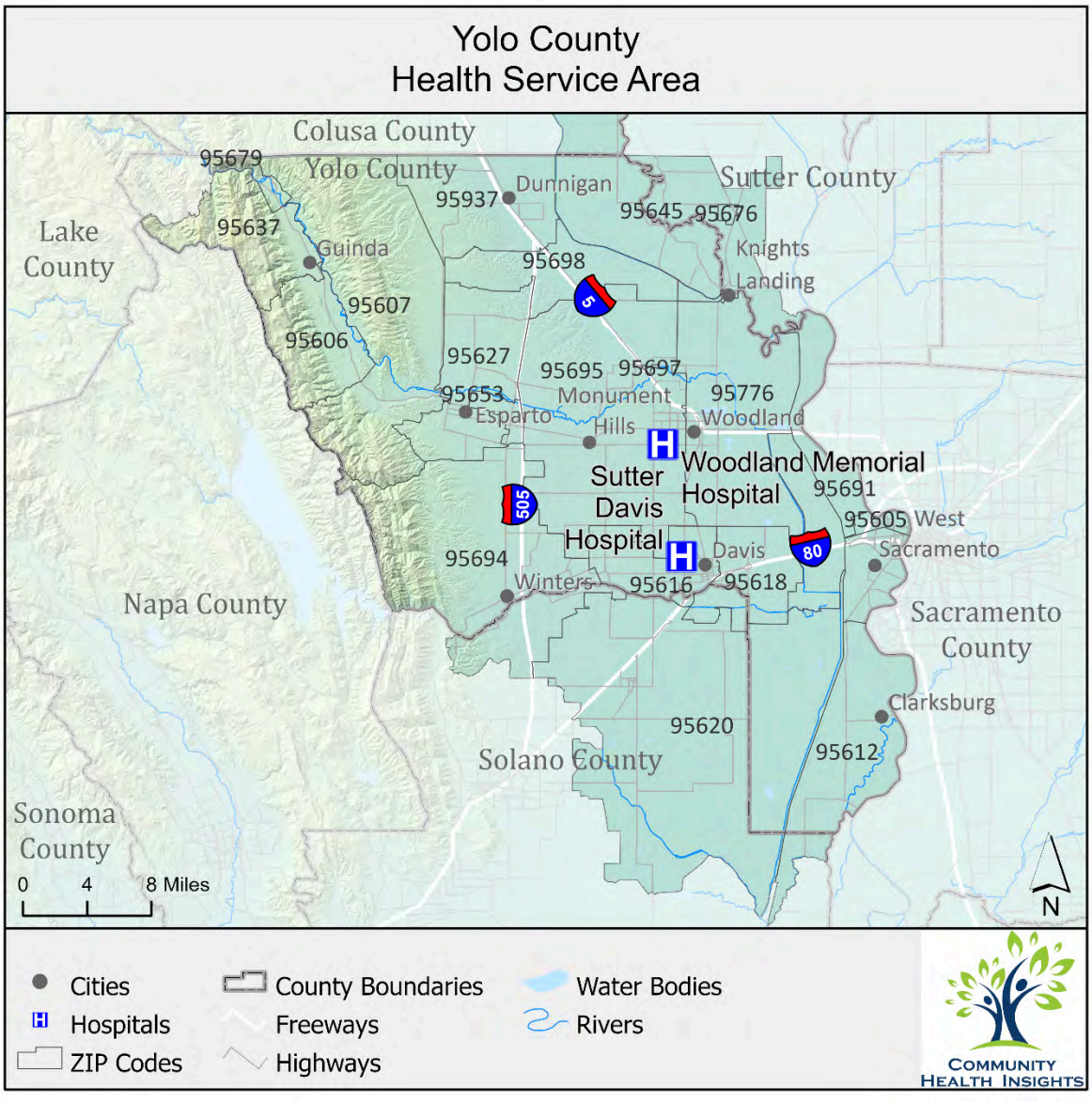


Figure 2: Community served is Yolo County.

Population characteristics for each ZIP Code in the service area 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 it is primarily located in is highlighted.

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

ZIP Code	Total Population	% Hispanic\Latinx or Non-White	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95620	22,367	100	34.7	$100,224	8.6	3.5	3.8	15.1	31.1	13.1
95676	91	100	28.3	$58,438	63.7	0	23.1	23.4	43.5	0
95605	14,711	100	32.4	$71,361	14.3	4.9	8.9	20.8	39.3	12.6
95606	230	100	66.3	~	24.3	0	0	1.4	63	16.5
95607	271	100	51.1	$143,529	0	0	5.9	0	10.6	21.8
95612	1,519	100	43.4	$87,031	0	10.2	8.8	25.9	37.7	8.6
95616	51,863	99.8	23.4	$74,758	30.2	6.8	3.2	2.6	47.2	8.1
95618	27,007	99.8	31.8	$112,454	20.9	4.3	4	5.3	36.2	9.3
95627	3,935	100	31.3	$104,265	13	2.1	6.3	14.7	23.7	10.3
95637	374	100	64.5	$134,663	34.5	0	7.8	0	22.6	13.1
95645	1,363	100	41	$66,184	17.7	9.6	5.9	34	45.5	13.6
95653	682	100	40.5	~	48.7	0	7.5	45.2	50.7	19.1
95679	113	100	55.3	~	0	0	8.8	0	0	23
95691	39,894	100	35.4	$100,822	13	5.3	3.5	11.4	33.9	10.2
95694	10,156	99.8	39.1	$107,415	8.5	1.7	8.2	13.9	27.4	8.9
95695	38,787	100	37.6	$78,875	9.3	5.5	6.3	15	38.3	14.6
95697	264	100	15.4	~	90.2	0	0	40	68.3	11.4
95698	255	100	60.8	~	13.7	16.5	0	16.5	22.7	7.8
95776	27,189	100	34.7	$104,020	6	4.9	3.8	16.2	29.2	11.1
95937	996	100	43.7	$46,650	5.5	6.8	5.3	24.2	35.5	32.5
All Service Area ZIP codes in	217,782[11]	99.9	32.3	$88,818	16.3	5.3	4.6	11.6	37.8	10.8

Yolo County[a]										
California	39,242,785	99.7	37.6	$96,334	12	6.4	6.9	15.4	40.1	11.3

Source: 2023 American Community Survey 5-year estimates; U.S. Census Bureau.
~ Data Not Available
[a]Total population reported here consists of population in all ZIP codes that fall within the county, though they might also cross other county lines.

Health Equity

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]

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 US, and many parts of the world, inequities are most apparent when comparing various racial and ethnic groups to one another. Using these comparisons between racial and ethnic populations, it's clear that health inequities persist across communities, including Yolo County.

This section of the report shows inequities in health outcomes, comparing these between race and ethnic groups. These differences inform better planning for more focused interventions.

Health Outcomes - The Results of Inequity

The Table 3 below displays disparities among race and ethnic groups for the HSA for life expectancy, mortality, and low birthweight.

[12] Robert Wood Johnson Foundation. 2017. What is Health Equity? And What Difference Does a Definition Make?. Health Equity Issue Brief #1. Retrieved 18 July 2024 from https://buildhealthyplaces.org/content/uploads/2017/05/health_equity_brief_041217.pdf.
[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.

Table 3: Health outcomes comparing race and ethnicity in the Yolo County service area.

Health Outcomes	Description	Asian	Black	Hispanic	White	Overall County
Child Mortality	Number of deaths among residents under age 18 per 100,000 population.	~	~	32.3	19.2	24.1
Life Expectancy	Average number of years people are expected to live.	87.6	76.4	80.8	79.9	80.6
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	7.6%	8.9%	6%	5.4%	6.1%
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	141.7	450.5	280.1	302.9	280.6
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	2,221.1	8,123.5	5,393	5,530.2	5,138.9

~ Data Not Available (Note: Data were not available for American Indian/Alaskan Native and Native Hawaiian/Pacific Islander populations) Data sources included in the technical section of the report.

Health outcome data by race and ethnic groups shows Black residents have the lowest life expectancy, highest percentage of low birthweight babies, highest age-adjusted premature mortality, and highest rate of premature death (YPLL). Secondarily, Asian residents have the second highest percentage of low birth weight babies, while Whites have the second highest rates of premature age-adjusted mortality and premature death (YPPL). Hispanics have high rates of child mortality and premature death (YPLL).

Health Factors - Inequities in the Service Area

Inequalities can be seen in data that help describe health factors in the HSA, such as education attainment and income. These health factors are displayed in the Table 4, Table 5, and Table 6 below and are compared across race and ethnic groups.

Table 4: Injury related health factors comparing race and ethnicity in the Yolo County service area.

Health Factors	Description	Asian	Black	Hispanic	White	Overall County
Juvenile Felony Arrests	Felony juvenile arrests per 1,000 juveniles	~	9.7	1.5	0.7	1.2
Firearm Fatalities	Number of deaths due to firearms per 100,000 population.	~	~	5.7	6.8	5.3
Injury Mortality[a]	Number of deaths due to injury per 100,000 population.	12.5	69.5	44.4	63.5	48.7
Motor Vehicle Crash Deaths	Number of motor vehicle crash deaths per 100,000 population.	5.5	~	13.1	11.3	10.8
Homicides[b]	Number of deaths due to homicide per 100,000 population.	~	~	3.3	2.3	2.6

Health Factors	Description	Asian	Black	Hispanic	White	Overall County
Suicides[c]	Number of deaths due to suicide per 100,000 population (age-adjusted).	~	~	7.2	12.6	9.4
Drug Overdose Deaths[d]	Number of drug poisoning deaths per 100,000 population.	~	~	11.3	19.8	14

~ Data Not Available. (Note: Data were not available for American Indian/Alaskan Native and Native Hawaiian/Pacific Islander populations))
Unless otherwise noted, data sources included in the technical section of the report.
[a]From County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2017-2021
[b]From County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2015-2021
[c]From County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2017-2021
[d]From County Health Rankings: National Center for Health Statistics - Mortality Files; Census Population Estimates Program, 2019-2021

Table 5: Education and income related health factors comparing race and ethnicity in the Yolo County service area.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall County
High School Completion[a]	'Percentage of adults ages 25 and over with at least a high school diploma or equivalent.'	85.7%	91.6%	91.8%	71.6%	95.8%	87.9%
Math Scores	Average grade level performance for 3rd graders on math standardized tests.	~	3.2	2.1	2.3	3	2.7
Reading Scores	Average grade level performance for 3rd graders on English Language Arts standardized tests.	~	~	2.3	2.5	3.3	2.9
Some College[a]	Percentage of adults ages 25 and over with some post-secondary education.	56.4%	80%	66%	47.1%	80.6%	69.9%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$57,993	$77,050	$41,900	$68,958	$99,621	$82,359
Children in Poverty	Percentage of people under age 18 in poverty.	8.1%	14.6%	22.9%	19.2%	7.3%	14.5%

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall County
Uninsured Population[b]	Percentage of the civilian non-institutionalized population without health insurance.	10.7%	4.7%	4.3%	7.6%	2.7%	4.7%
Homelessness Rate	Number of homeless individuals per 100,000 population.	3,624.1	53.1	2,009.7	328.6	403.4	339.4

Table 6: Clinical related health factors comparing race and ethnicity in the Yolo County service area.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall County
Preventable Hospital Stays[a]	Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	~	610	1,446	2,151	1,827	1,809
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening.	31%	27%	26%	29%	39%	35%
Teen Births	Number of births per 1,000 female population ages 15-19.	35.5	~	9.3	12.4	2.7	5.8

~ Data Not Available. (Note: Data were not available for Native Hawaiian/Pacific Islander populations)
Unless otherwise noted, data sources included in the technical section of the report.
[a]From County Health Rankings: Mapping Medicare Disparities Tool, 2021

Health factor data by race and ethnic groups shows that Black residents have high rates of injury mortality and juvenile felony arrests. Rates for Blacks show the highest percentage of children in poverty and lowest median income. Additionally, Black residents, have the lowest math and reading scores, and the percentage of those attending college is also lower than most other groups and the overall county percentage. Data for the Black community also shows the lowest percentage of mammogram screening compared to any other group and an elevated teen birth rate. Hispanics have the highest motor vehicle crash death rate and a higher homicide rate than Whites. Hispanics also have the highest rate of preventable hospital stays, a low mammogram screening percentage and a high teen birth rate.

Data for American Indian\Alaska Native residents shows clear inequities. These residents have the highest homelessness rate (more than 10 times the overall county rate), the second lowest median income, the highest rate of teen births (more than six times the overall county rate), and the highest percentage of uninsured. Data for Hispanic residents showed a higher homicide rate than the overall county rate (and White residents).

Population Groups Experiencing Disparities

The figure below describes populations in the Yolo County service area identified through qualitative data analysis that were identified as experiencing health disparities. Interview participants were asked, "What specific groups of community members experience health issues the most?" 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 3 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.

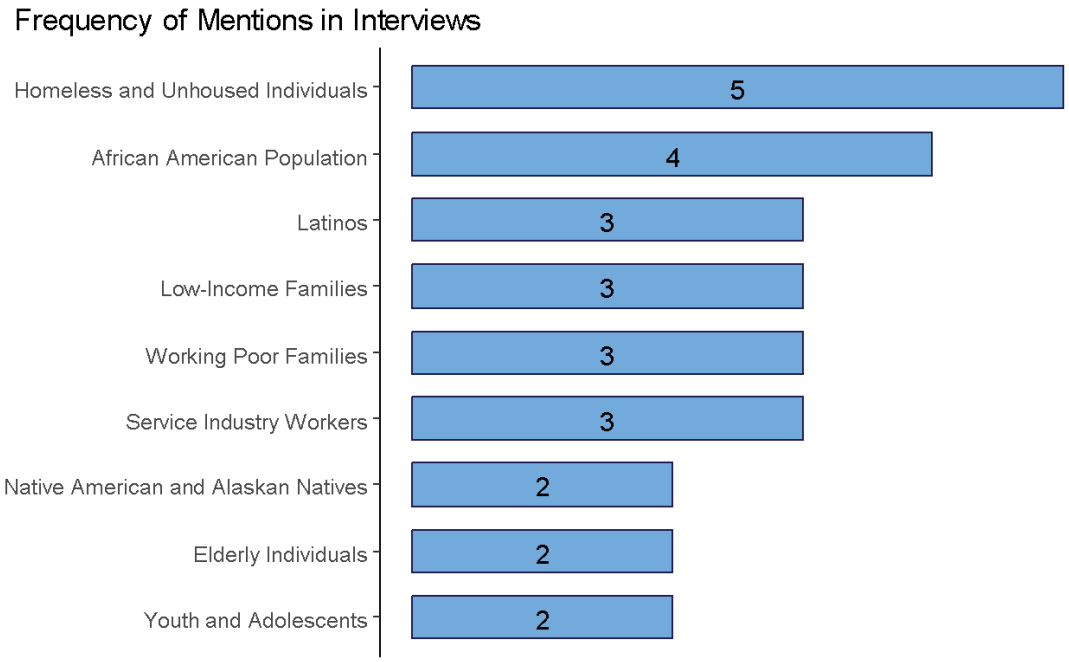


Figure 3: Populations experiencing disparities in the Yolo County service area.

The Impact of Climate Change on Health Needs

For this CHNA, key informants and community members were asked: "In the past three years has anyone in the community you serve been impacted by any of the following climate hazard events: extreme heat, wildfire, drought, extreme rainfall, and/or other (e.g., air/water quality, loss of power, insect infestations)? If so, describe the event and its impact." Below is a summary of the data organized by the type of climate issue mentioned.

1. Extreme weather events
    - Increased frequency of heatwaves, droughts, and occasional flooding.
    - Addressing air quality issues arising from seasonal wildfires in the region.
2. Agricultural adaptation related to climate change
    - Agriculture Vulnerability: The impact of changing climate conditions on crops and farm operations.
    - Water Resource Management: Practices to manage water availability for irrigation in light of droughts.
    - Sustainable Farming Practices: Implementation of regenerative agriculture and climate-resilient crops
    - Monitoring and regulation of air pollutants, especially related to agriculture and transportation.
    - Temperature Rise: An increase in average temperatures affecting agricultural cycles.

3. Water Resources and Management
    - Groundwater Sustainability: Challenges related to over-extraction of groundwater sources.
    - Aquifer Recharge: Efforts to enhance recharge of local aquifers, especially amid declining water levels.
    - Flood Management: Plans and infrastructure to manage localized flooding events.
4. Biodiversity and Habitat Preservation
    - Habitat Loss: Impacts of development and agriculture on local habitats and wildlife has been negatively impacted by climate events.
    - Conservation Efforts: Initiatives to protect native species and ecosystems, such as the Sacramento Valley are needed.
5. Urban Development and Infrastructure
    - Smart Growth Initiatives: Sustainable urban planning to minimize climate impact and enhance resilience.
    - Energy Efficiency in Buildings: Programs to upgrade existing buildings and develop new ones to be energy efficient.
6. Climate Justice and Equity
    - Impact on Vulnerable Communities: Assessment of how climate-related issues disproportionately affect low-income and marginalized groups.
    - Access to Resources: Ensuring equitable access to climate adaptation resources, including funding and technical assistance.

Community Vulnerability Indices

Vulnerability indices provide information that describe and compare the sociodemographic characteristics of communities. For this CHNA report three indices are used: 1) the California Healthy Places Index (HPI)[13] 2) the Center for Disease Control and Prevention's Social Vulnerability Index, (SVI)[14] and 3) the Vizient Vulnerability Index (VVI).[15] Though each is somewhat distinct from the other, all three indices aggregate and combine social and demographic data from reliable sources that have known relationships to life expectancy and other health outcomes. For each index, the values of multiple indicators are combined to create a score that is assigned to a particular census tract or county that denotes the community's vulnerability to poor health outcomes. These scores are divided into quartiles (only for the HPI) or quintiles and represented by color gradation maps, also referred to a "heat maps." These maps offer a visual representation of communities in the service area where poorer health outcomes are more likely to be present.

Figure 4 displays the California Healthy Places Index (HPI)[14] values for the Yolo County service area. The HPI is an index based on 23 health-related measures for communities across California. These 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 between 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.

[14] Public Health Alliance of Southern California. 2024. California Health Places Index (HPI): About the HPI. Retrieved 18 July 2024 from https://www.healthyplacesindex.org/about-hpi.

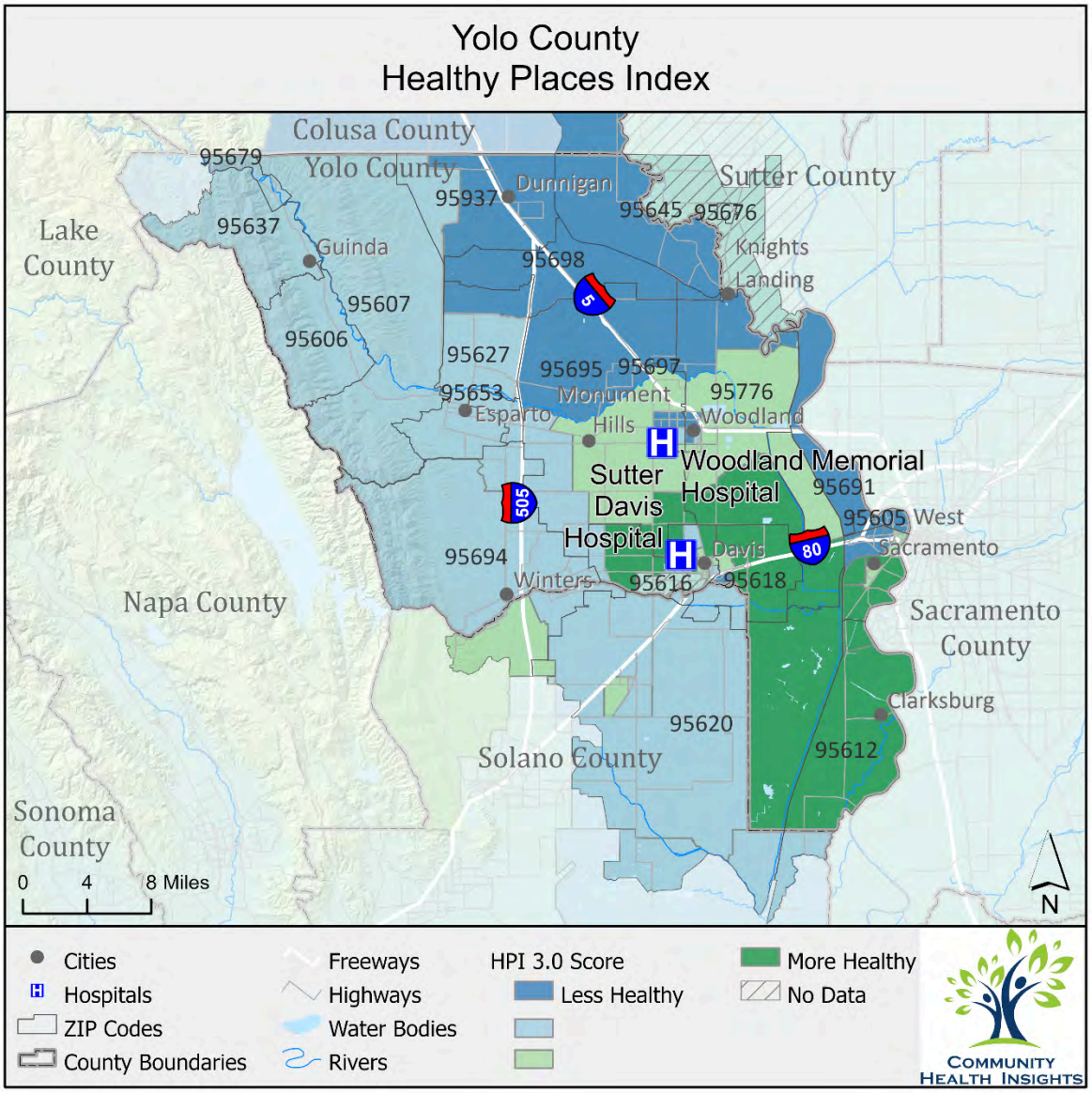


Figure 4: Healthy Places Index for Yolo County.

Areas with the darkest blue shading in Figure 4 have the lowest overall HPI scores, indicating factors leading to less healthy neighborhoods. Figure 4 displays that the central Woodland, communities in the northern portion of the county, and the northeastern portion of Yolo County along the river have the poorest HPI scores. Apart from these areas, rural areas of Yolo County along the western border also have less healthy HPI values. There are likely to be a higher concentration of residents in these locations experiencing health disparities.

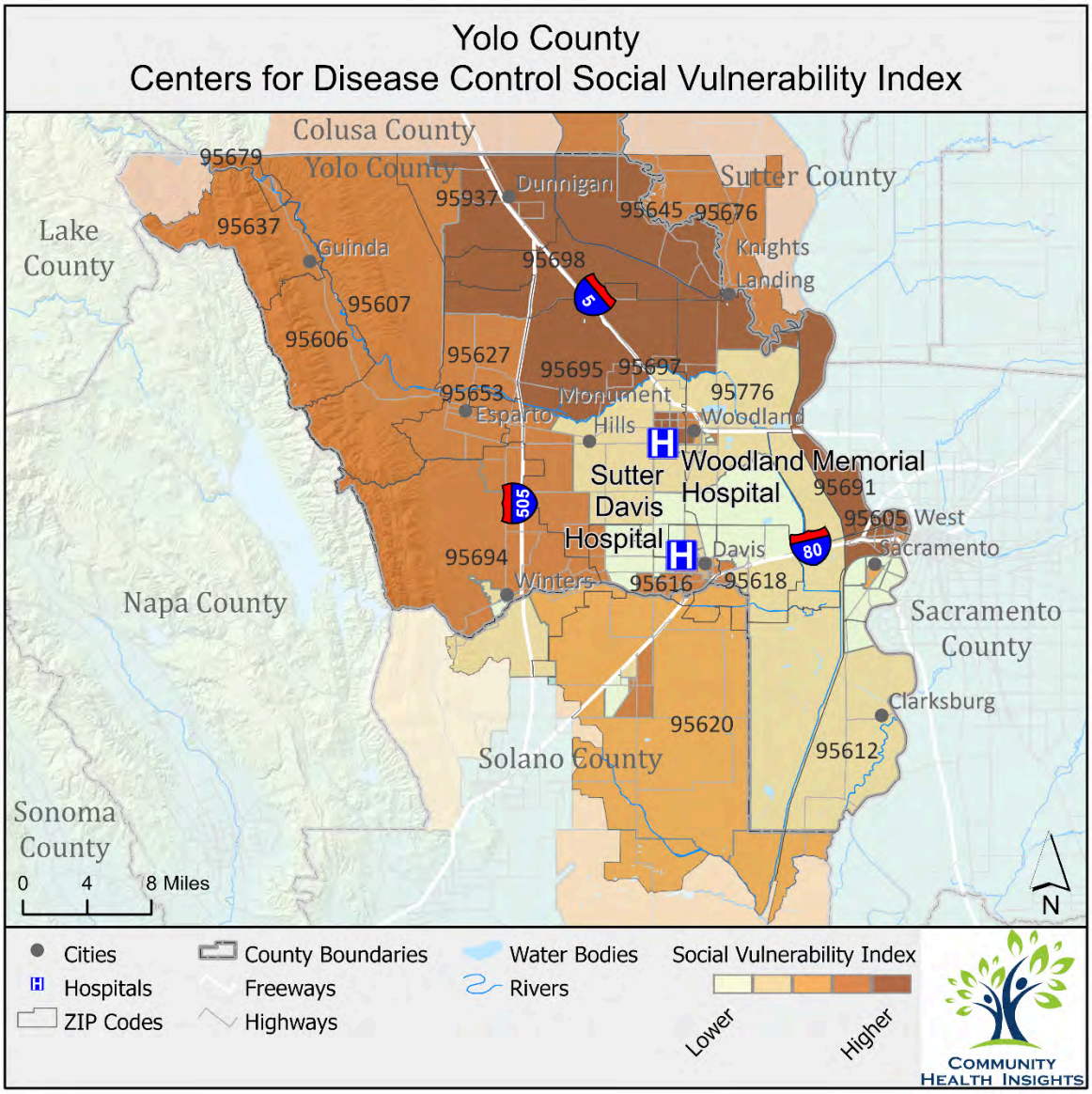


Figure 5: CDC Social Vulnerability Index for Yolo County.

Areas with the darkest shading in Figure 5 have the highest SVI scores, indicating a concentration of factors in the local population contributing to higher vulnerability. Similar patterns are seen here as were highlighted using the HPI.

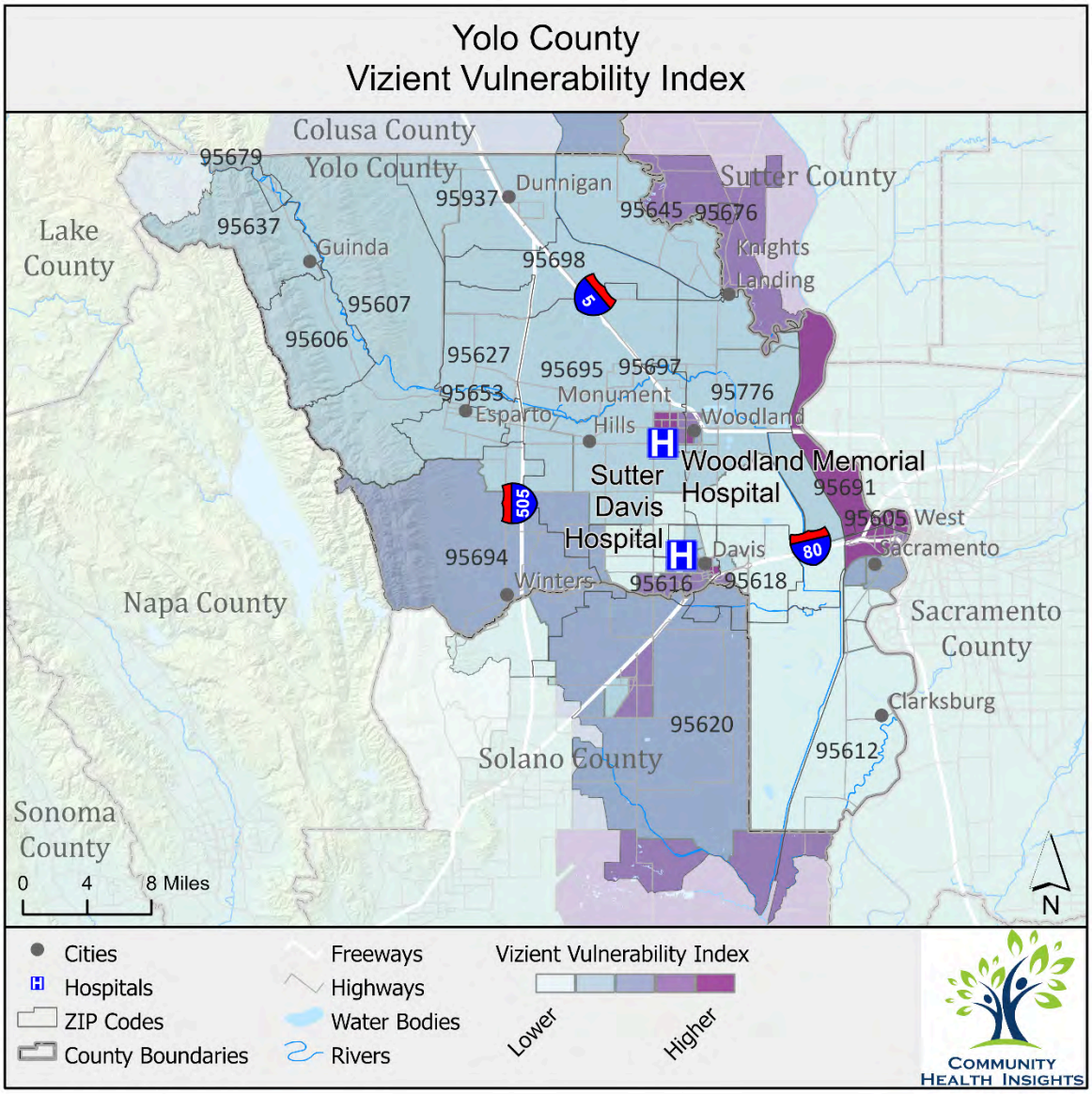


Figure 6: Vizient Vulnerability Index for Yolo County.

Aeras with the darkest shading in Figure 6 have the highest Vizient Vulnerability Index (VVI) scores, indicating a higher vulnerability rating for the areas. The VVI shows additional detail of areas around Knights Landing, Woodland and portions of eastern Yolo County along the river as specifically vulnerable. Patterns for all three indices presented show similar patterns.

Communities of Concern

Communities of Concern are geographic areas within the service area 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 service area has been assessed more broadly, they allow for a focus on those portions of the region 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 8 ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 7, with the census population provided for each, and are displayed in Figure 7.

Table 7: Identified Communities of Concern for the Yolo County service area.

ZIP Code	Community\Area	Population
Primary Communities of Concern		
95605	West Sacramento	14,711
95691	West Sacramento	39,894
95695	Woodland	38,787
95776	Woodland	27,189
Secondary Communities of Concern		
95627	Esparto	3,935
95645	Knights Landing	1,363
95653	Madison	682
95937	Dunnigan	996
Total Population in Communities of Concern		*127,557*
Total Population in Yolo County		*242,067*
Percentage of Service Area Population in Community of Concern		*52.7%*

Source: 2023 American Community Survey 5-year estimates; U.S. Census Bureau.

Figure 7 displays the ZIP Codes highlighted in pink that are Communities of Concern for the Yolo County service area.

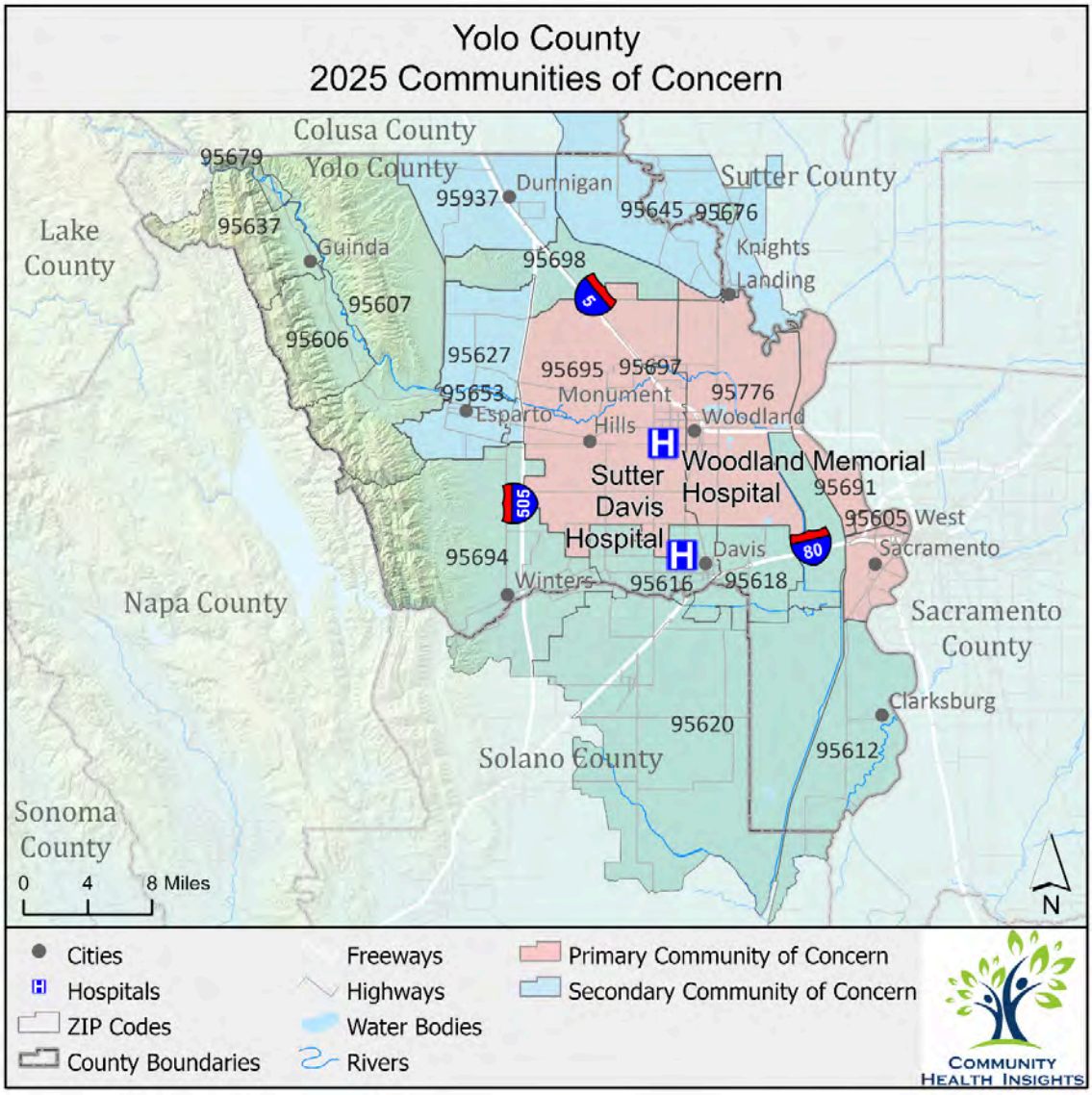


Figure 7: Yolo County Communities of Concern.

Resources Potentially Available to Meet the Significant Health Needs

In all, 399 resources were identified in the Yolo County service area that were potentially available to meet the identified SHNs. These resources were provided by a total of 126 social service, nonprofit, and governmental organizations, agencies, and programs identified in the CHNA. The identification method included starting with the list of resources from the 2022 Yolo County CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2025 CHNA report. Examination of the resources showed the following number of resources for each SHN as shown in Table 8.

Table 8: 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	83
Access to Mental/Behavioral Health and Substance Use Services	48
Access to Quality Primary Care Health Services	43
Increased Community Connections	58
System Navigation	30
Active Living and Healthy Eating	32
Injury and Disease Prevention and Management	21
Access to Functional Needs	13
Safe and Violence-Free Environment	41
Access to Specialty and Extended Care	20
Healthy Physical Environment	10
Total Resources	*399*

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

Conclusion

CHNAs play an important role in helping nonprofit hospitals and other community organizations determine where to focus community benefit and health improvement efforts, including focusing efforts in geographic locations and on specific populations experiencing inequities leading to health disparities. Data in the CHNA report can help provide nonprofit hospitals and community service providers with content to work in collaboration to engage in meaningful community work.

Please send any feedback about this CHNA report to DignityHealthGSSA_CHNA@dignityhealth.org with “CHNA Comments” in the subject line. Feedback received will be incorporated into the next CHNA cycle.

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

SECTION III

2022-2024 Community Health Improvement Plan

An evaluation of Woodland Memorial Hospital's actions taken since 2022 to improve the health of our community.

Evaluation of 2022-2024 Community Health Improvement Plan

The 2022 CHNA and 2022-2024 Community Health Improvement Plan (CHIP) priorities were the following:

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
6. System Navigation
7. Access to Specialty and Extended Care
8. Increased Community Connections
9. Safe and Violence-Free Environment

This report evaluates the impact of Dignity Health's 2022-2024 CHIP through identification of how we responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Access to Basic Needs			
Homeless Recuperative Care Program (Haven House)			
Fiscal Year(s)	2022	2023	2024
Program Description	This program, located in Woodland, focuses on providing a safe place for homeless individuals to recuperate after hospital discharge and getting them linked to wraparound services and resources. During their stay at Haven House, they get assistance with additional services including health insurance enrollment, finding a medical home, substance use and mental health services and placement in permanent housing.		
Secondary Health Needs Addressed	• Access to Basic Needs	• Access to Behavioral Health	• System Navigation
Outcomes	83 persons served with a total of 383 bed nights, which otherwise would have been spent in the hospital.		

Access to Behavioral Health			
Baby & Me Program			
Fiscal Year(s)	2022	2023	2024
Program Description	Free postpartum and family support group for primary caregivers of infants from 0 to 9 months. Led by a Dignity Health educator, the group aims to empower parents, minimize postpartum depression, create friendships, and act as a safety net for individuals navigating the first months of a child's life. This program addresses a variety of priority health needs in addition to behavioral health services.		
Secondary Health Needs Addressed	◦ Access to Behavioral Health	• Injury/Disease Prevention & Management	• System Navigation
Outcomes	529 persons served in the program.		

Injury/Disease Prevention & Management			
Healthier Living Program			
Fiscal Year(s)	2022	2023	2024
Program Description	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes.		
Secondary Health Needs Addressed	• Access to Basic Needs	• Increased Community Connections	
Outcomes	417 persons served		

Access to Quality Primary Care Health Services			
Patient Navigation Program			
Fiscal Year(s)	2022	2023	2024
Program Description	The Patient Navigator Program represents a unique collaboration between Woodland Memorial and Empower Yolo, a community-based nonprofit organization, and community clinics in the region. Patient Navigators assist patients who rely on emergency departments for non-urgent needs. The navigators help patients by connecting them to a primary care medical home and assisting them with scheduling a follow up appointment along with any other barriers that may create obstacles with accessing care.		
Secondary Health Needs Addressed	• Access to Basic Needs	• Injury/Disease Prevention & Management	• System Navigation
Outcomes	2,292 persons served with assistance to connect them to primary care medical homes, community resources education, and referrals.		

Injury/Disease Prevention & Management			
Healthier Living Program			
Fiscal Year(s)	2022	2023	2024
Program Description	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes.		
Secondary Health Needs Addressed	• Access to Basic Needs	• Increased Community Connections	
Outcomes	417 persons served		

System Navigation			
Oncology Nurse Navigator			
Fiscal Year(s)	2022	2023	2024
Program Description	The Oncology Nurse Navigation program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The Oncology navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit of their diagnosis and treatment options. The Navigation program also provides referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.		
Secondary Health Needs Addressed	◦ Access to Speciality & Extended Care	• Injury/Disease Prevention & Management	• System Navigation
Outcomes	775 persons served		

Access to Speciality & Extended Care			
Yolo Adults Day Health Center			
Fiscal Year(s)	2022	2023	2024
Program Description	The hospital is the primary provider in Yolo County that addresses specialty health care and support needs of the elderly and disabled populations through the Adult Day Health Center. The Center offers an interdisciplinary program of medical, psycho-social and rehabilitation services for adults at high risk of needing a higher level of care due to health, functional and cognitive losses. The Center specializes in high touch chronic disease management with the added components of caregiver respite, transportation, nutrition, education, and socialization.		
Secondary Health Needs Addressed	• Access to Behavioral Health	• Injury/Disease Prevention & Management	• System Navigation
	• Access to Quality Primary Care	• Access to Speciality & Extended Care	• Increased Community Connections
Outcomes	855 persons served		

Collaboration

During FY 22-24, Woodland Memorial Hospital (WMH) utilized collaborative strategies to assess current strengths, weaknesses and gaps, and engaged non-traditional partners in community health programs to increase access to expanded services and increase the continuum of care beyond hospitals walls for its patients and communities they serve.

Collaborative programs and partnerships across these various initiatives include:

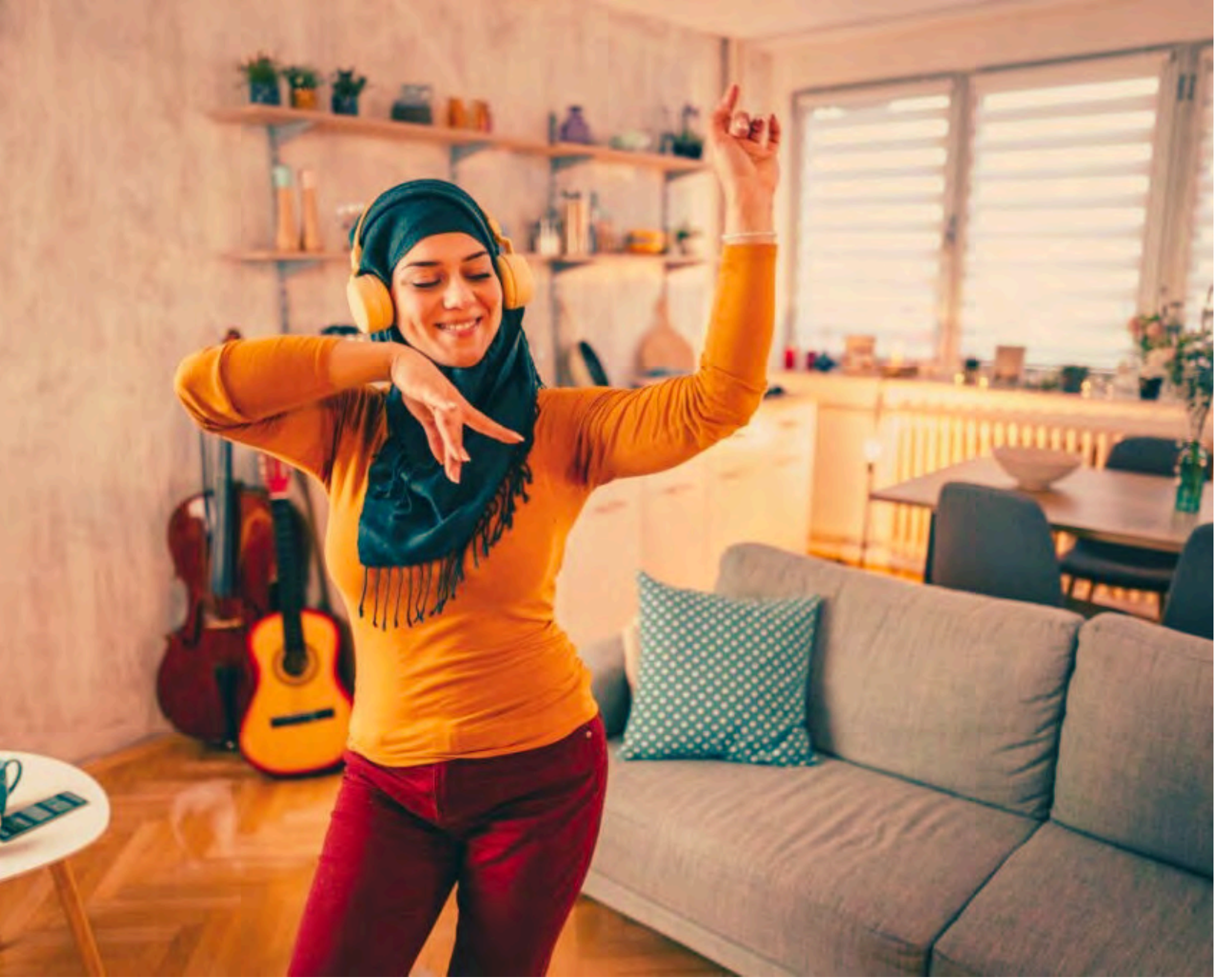
- Yolo Food Bank
- Nutrition Education and Counseling
- Inpatient Mental Health Services
- Cristo Rey
- CommuniCare
- Yolo Crisis Nursery
- Migrant Center Visits
- Community Based Violence Prevention
- Baby & Me
- East Beamer Project
- 1801 West Capitol Avenue Project
- Crisis Now Model
- Federally Qualified Health Center Capacity Building

Community Grants

The theme for WMH's Community Grants program focuses on collaboration with an emphasis on responding to significant health needs identified in the 2022 CHNA. The goal of the program is to develop strategic partnerships between community-based organizations that link services directly to WMH; leveraging resources that address priority health issues, and utilize creative strategies that have a direct, positive and lasting impact on the health of disadvantaged individuals and families in our community.

To be eligible for funding, organizations must work in collaboration with a minimum of three community partners. Program/Project responds to two or more of the priority health needs identified in the 2022 CHNA. In Fiscal Year 2022 through Fiscal Year 2024, WMH collectively awarded six grants totaling $293,574. The table below highlights the grantees.

Lead Grant Recipient	Priority Health Need(s) Addressed	Project Name	Award Year (FY)		
			2022	2023	2024
International Rescue Committee, Inc.	• Access to Basic Needs • Active Living Healthy Eating	Growing Healthy Together	$33K	-	-
Mercy Coalition of West Sacramento	• Access to Basic Needs • Access to Behavioral Health • Injury/Disease Prevention & Management • Increased Community Connections	Restorative Community Program	$65K	-	-
Boys & Girls Clubs of Greater Sacramento	• Active Living & Healthy Eating • Increased Community Connections	Triple Play: A Game Plan for Woodland Youth-Mind, Body & Soul	-	$47K	-
Sacramento District Dental Society Foundation	• System Navigation • Access to Speciality & Extended Care	Improved Overall Health Through Oral Health Care	-	$53K	-
Thriving Pink	• Injury/Disease Prevention & Management • System Navigation	Thriving Pink ProspeROSA: A Collaborative Breast Cancer Outreach, Education and Program Model	-	-	$64K
Yolo Public Defenders' Community Assistance & Re-Entry Support	• Access to Mental/Behavioral Health & Substance-Use Services • Access to Basic Needs • Increased Community Connections	Resilient Futures Fund	-	-	$30K



SECTION IV

Technical Section

2025 CHNA Technical Section

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

Results of 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 performance was worse in the county than in the state. The associated figures show rates for the county compared to the California state rates.

Length of Life *Table 9: County length of life indicators compared to state benchmarks.*

Indicators	Description	Yolo	California	
Early Life				
Infant Mortality	Number of infant deaths (within 1 year) per 1,000 live births.	3.7	4.2	
Average Age at Death	Average age of mortality, all sexes and ages	73.8	72.5	
Child Mortality	Number of deaths among residents under age 18 per 100,000 population.	24.1	37.7	
Life Expectancy	Average number of years people are expected to live.	80.6	79.9	
Preterm Births (<37 weeks)	Percentage of live births	9.0%	9.1%	
Overall				
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	280.6	318.5	
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	5,138.9	6,373.2	
Premature Mortality (under 65 years)	Percentage of deaths	24.0%	28.2%	
Cancer, Liver, and Kidney Disease				
All Cause Cancer Mortality	Age-adjusted Rate (per 100,000 residents)	142.0	122.1	
Breast Cancer Mortality (Females)	Age-adjusted Rate (per 100,000 female residents)	22.5	17.3	
Cancer Mortality	Number of deaths due to cancer per 100,000 population.	139.3	152.0	
Kidney Disease Mortality	Number of deaths due to kidney disease per 100,000 population.	5.9	11.2	

Indicators	Description	Yolo	California	
Liver Disease Mortality	Number of deaths due to liver disease per 100,000 population.	15.4	15.7	
Lung Cancer Mortality	Age-adjusted Rate (per 100,000 residents)	26.4	20.6	
Prostate Cancer Mortality	Age-adjusted Rate (per 100,000 male residents)	32.0	17.9	
Intentional and Unintentional Injuries				
Suicide Mortality	Number of deaths due to suicide per 100,000 population.	8.7	11.0	
Unintentional Injuries Mortality	Number of deaths due to unintentional injuries per 100,000 population.	39.5	46.0	
Other				
Alzheimer's Disease Mortality	Number of deaths due to Alzheimer's disease per 100,000 population.	47.3	44.0	
Influenza and Pneumonia Mortality	Number of deaths due to influenza and pneumonia per 100,000 population.	10.6	14.5	
Behavioral Chronic Disease model for over 50% of the population	Age-adjusted Rate (per 100,000 residents)	364.9	358.0	
Chronic Lower Respiratory Disease Mortality	Number of deaths due to chronic lower respiratory disease per 100,000 population.	28.7	32.1	
Heart Disease Mortality	Number of deaths due to heart disease per 100,000 population.	125.1	164.4	
Hypertension Mortality	Number of deaths due to hypertension per 100,000 population.	17.4	15.5	
Diabetes Mortality	Age-adjusted Rate (per 100,000 residents)	25.2	15.2	
Stroke Mortality	Age-adjusted Rate (per 100,000 residents)	42.5	37.4	
Indicators	Description	Yolo	California	
Cancer				
Breast Cancer Prevalence	Female in situ breast cancers per 100,000 female population (age-adjusted).	132.0	122.4	

Indicators	Description	Yolo	California	
Colorectal Cancer Prevalence	Colon and rectum cancers per 100,000 population (age-adjusted).	32.5	33.9	
Lung Cancer Prevalence	Lung and bronchus cancers per 100,000 population (age-adjusted).	42.2	38.0	
Prostate Cancer Prevalence	Prostate cancers per 100,000 male population (age-adjusted).	84.6	96.8	
Chronic Disease				
Diabetes Prevalence	Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted).	10.1%	10.8%	
Disability	Percentage of the total civilian noninstitutionalized population with a disability	10.4%	11.0%	
HIV Prevalence	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	170.3	411.4	
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	6.1%	7.1%	
Falls				
Accidental Falls (aged over 65+) ED visits	Crude Rate (per 100,000 residents)	5,976.6	4,711.7	
Accidental Falls (aged over 65+) Hospitalizations	Crude Rate (per 100,000 residents)	1,577.9	1,773.6	
Mental Health				
Drug-Related Hospitalizations	Age-adjusted Rate (per 100,000 residents)	55.9	1,631.7	
Drug-Related Hospitalizations (ages 15-24)	Age-adjusted Rate (per 100,000 residents)	1.0	5.0	
Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	15.5%	14.6%	
Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	10.8%	9.5%	

Indicators	Description	Yolo	California	
Mental Health Hospitalizations	Age-adjusted Rate (per 100,000 residents)	446.8	2,007.2	
Mental Health Hospitalizations (ages 15-24)	Age-adjusted Rate (per 100,000 residents)	94.5	86.4	
Mental Health or Drug-Related Hospitalizations	Age-adjusted Rate (per 100,000 residents)	502.7	3,638.9	
Mental Health or Drug-Related Hospitalizations (ages 15-24)	Age-adjusted Rate (per 100,000 residents)	95.5	91.4	
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	5.1	4.7	
Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	16.2%	15.8%	
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	3.6	3.1	
Self-Inflicted Injury Hospitalizations (ages 15-24)	Crude Rate (per 100,000 residents)	77.9	103.6	
Other				
Asthma ED Rates	Emergency department visits due to asthma per 10,000 (age-adjusted).	216.0	237.0	
Asthma ED Rates for Children	Emergency department visits due to asthma among ages 5-17 per 10,000 population ages 5-17 (age-adjusted).	146.0	239.0	

Quality of Life

Table 10: County quality of life indicators compared to state benchmarks.

Indicators	Description	Yolo	California	
Cancer				
Breast Cancer Prevalence	Female in situ breast cancers per 100,000 female population (age-adjusted).	132.0	122.4	
Colorectal Cancer Prevalence	Colon and rectum cancers per 100,000 population (age-adjusted).	32.5	33.9	

Indicators	Description	Yolo	California	
Lung Cancer Prevalence	Lung and bronchus cancers per 100,000 population (age-adjusted).	42.2	38.0	
Prostate Cancer Prevalence	Prostate cancers per 100,000 male population (age-adjusted).	84.6	96.8	
Chronic Disease				
Diabetes Prevalence	Percentage of adults aged 20 and above with diagnosed diabetes (age-adjusted).	10.1%	10.8%	
Disability	Percentage of the total civilian noninstitutionalized population with a disability	10.4%	11.0%	
HIV Prevalence	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	170.3	411.4	
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	6.1%	7.1%	
Falls				
Accidental Falls (aged over 65+) ED visits	Crude Rate (per 100,000 residents)	5,976.6	4,711.7	
Accidental Falls (aged over 65+) Hospitalizations	Crude Rate (per 100,000 residents)	1,577.9	1,773.6	
Mental Health				
Drug-Related Hospitalizations	Age-adjusted Rate (per 100,000 residents)	55.9	1,631.7	
Drug-Related Hospitalizations (ages 15-24)	Age-adjusted Rate (per 100,000 residents)	1.0	5.0	
Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	15.5%	14.6%	
Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	10.8%	9.5%	
Mental Health Hospitalizations	Age-adjusted Rate (per 100,000 residents)	446.8	2,007.2	

Indicators	Description	Yolo	California	
Mental Health Hospitalizations (ages 15-24)	Age-adjusted Rate (per 100,000 residents)	94.5	86.4	
Mental Health or Drug-Related Hospitalizations	Age-adjusted Rate (per 100,000 residents)	502.7	3,638.9	
Mental Health or Drug-Related Hospitalizations (ages 15-24)	Age-adjusted Rate (per 100,000 residents)	95.5	91.4	
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	5.1	4.7	
Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	16.2%	15.8%	
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	3.6	3.1	
Self-Inflicted Injury Hospitalizations (ages 15-24)	Crude Rate (per 100,000 residents)	77.9	103.6	
Other				
Asthma ED Rates	Emergency department visits due to asthma per 10,000 (age-adjusted).	216.0	237.0	
Asthma ED Rates for Children	Emergency department visits due to asthma among ages 5-17 per 10,000 population ages 5-17 (age-adjusted).	146.0	239.0	

Health Behavior

Table 11: County health behavior indicators compared to state benchmarks.

Indicators	Description	Yolo	California	
Drug Induced Death	Drug induced deaths per 100,000 (age-adjusted).	14.3	21.4	
Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	17.9 %	17.2%	
Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity.	95.7 %	94.2%	
Adult Obesity	Percentage of the adult population (age 18 and older) that reports a body mass index (BMI)	27.8 %	27.8%	

Indicators	Description	Yolo	California	
	greater than or equal to 30 kg/m2 (age-adjusted).			
Food Environment Index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	8.5	8.6	
Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	2.9%	3.2%	
Physical Inactivity	Percentage of adults age 18 and over reporting no leisure-time physical activity (age-adjusted).	20.3 %	19.9%	
Exclusively Breastfeeding	Percentage of live births	84.4 %	68.8%	
Chlamydia Incidence	Number of newly diagnosed chlamydia cases per 100,000 population.	409.2	488.2	
Teen Birth Rate	Number of births per 1,000 female population ages 15-19.	5.8	12.7	
Adult Smoking	Percentage of adults who are current smokers (age-adjusted).	11.4 %	8.8%	

Clinical Care

Table 12: County clinical care indicators compared to state benchmarks.

Indicators	Description	Yolo	California	
Dental Care Shortage Area	Presence of a dental care health professional shortage area within the county.	No		
Dentists	Dentists per 100,000 population.	62.1	92.9	
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening.	35.0 %	36.0%	
Medically Underserved Area	Presence of a medically underserved area within the county.	Yes		
Mental Health Care Shortage Area	Presence of a mental health professional shortage area within the county.	Yes		
Mental Health Providers	Mental health providers per 100,000 population.	432.7	449.8	
Primary Care Providers	Primary care physicians per 100,000 population + other primary care providers per 100,000 population.	191.9	167.6	

Indicators	Description	Yolo	California	
Primary Care Shortage Area	Presence of a primary care health professional shortage area within the county.	No		
Psychiatry Providers	Psychiatry providers per 100,000 population.	19.4	14.0	
Specialty Care Providers	Specialty care providers (non-primary care physicians) per 100,000 population.	221.0	202.7	
Prenatal Care (1st Trimester)	Percentage of live births	73.8 %	86.3%	
Preventable Hospitalization	Preventable hospitalizations per 100,000 (age-sex-poverty adjusted rate)	621.1	972.0	

Socio-Economic and Demographic Factors

Table 13: County socio-economic and demographic factors indicators compared to state benchmarks.

Indicators	Description	Yolo	California	
Community Safety				
Firearm Fatalities Rate	Number of deaths due to firearms per 100,000 population.	5.3	8.2	
Homicide Rate	Number of deaths due to homicide per 100,000 population.	2.6	5.2	
Juvenile Arrest Rate	Felony juvenile arrests per 1,000 juveniles	1.2	1.5	
Motor Vehicle Crash Death	Number of motor vehicle crash deaths per 100,000 population.	10.8	10.4	
Education				
Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	4.7%	6.6%	
High School Completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	87.9%	84.4%	
Some College	Percentage of adults ages 25-44 with some post-secondary education.	71.9%	67.6%	
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests.	2.7	2.7	

Indicators	Description	Yolo	California	
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests.	2.9	2.9	
Employment				
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	4.0%	4.2%	
Family and Social Support				
Children in Single-Parent Households	Percentage of children that live in a household headed by a single parent.	21.0%	22.4%	
Residential Segregation (Black/White)	Index of dissimilarity where higher values indicate greater residential segregation between Black and white county residents.	46.8	58.0	
Social Associations	Number of membership associations per 10,000 population.	6.7	6.0	
Income				
Children Eligible for Free Lunch	Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.	54.0%	57.8%	
Children in Poverty	Percentage of people under age 18 in poverty.	14.5%	15.3%	
Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	5.8	5.2	
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$82,359.0	$91,517.0	
Uninsured Population under 65	Percentage of adults under age 65 without health insurance.	7.7%	9.8%	

Physical Environment

Table 14: County physical environment indicators compared to state benchmarks.

Indicators	Description	Yolo	California	
Air and Water Quality				

Indicators	Description	Yolo	California	
Air Pollution - Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	7.7	7.1	
Drinking Water Violations	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	Yes		
Pollution Burden Percent	Percentage of population living in a census tract with a CalEnviroscreen 4.0 pollution burden score percentile of 50 or greater	38.4 %	50.6%	
Climate				
Drought Frequency	Percentage of weeks a county was shown as in a moderate or more severe drought by the United States Drought Monitor from 2000-2021.	40.6 %	40.0%	
Projected Difference in Extreme Heat Days	Projected difference in extreme heat days as compared to the historical period, 2016-2045, RCP 8.5 emissions scenario, 99th percentile temperature threshold.	8.0	7.9	
Projected Difference in Extreme Precipitation Days	Projected difference in extreme precipitation days as compared to the historical period, 2016-2045, RCP 8.5 emissions scenario, 99th percentile precipitation threshold.	1.0	0.3	
Wildfire Probability	Mean annual probability of wildfire burning in 30 meter grid cells within the location.	0.0%	0.2%	
Housing				
Homelessness Rate	Number of homeless individuals per 100,000 population.	339.4	460.9	
Homeownership	Percentage of owner-occupied housing units.	52.2 %	55.6%	
Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing.	20.5 %	19.7%	

Indicators	Description	Yolo	California	
Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	23.0 %	25.7%	
Transit				
Access to Public Transit	Percentage of population living near a fixed public transportation stop	77.2 %	71.1%	
Households with no Vehicle Available	Percentage of occupied housing units that have no vehicles available.	7.8%	6.9%	
Long Commute - Driving Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	31.1 %	41.6%	

Community Service Provider Survey Results

Table 15: Community service provider survey results for Yolo County service area.

Community Service Provider Survey Snapshot | Yolo County (N=16)	
Health Needs	**Percentage Reporting**
Most Frequently Reported	
Access to Basic Needs	87.5
Access to Mental/Behavioral Health and Substance-Abuse Services	75.0
System Navigation	75.0
Access to Specialty and Extended Care	68.8
Top 3 Priority *(Most Frequently Reported Characteristics)*	
Access to Basic Needs	80.0
Additional low-income housing options are needed. *Many people do not make a living wage.* *It is difficult to find affordable childcare.* *Housing is unaffordable.*	
Access to Mental/Behavioral Health and Substance-Abuse Services	53.3
There aren't enough mental health providers or treatment centers (e.g., psychiatric beds, therapists, support groups). *There aren't enough services for those who are homeless and experiencing mental/behavioral health and/or substance-abuse issues.* *There aren't enough substance-abuse treatment services available (e.g., detox centers, rehabilitation centers).* *The cost for treatment is too high.* *Treatment options for those with Medi-Cal are limited.*	
Access to Quality Primary Care Health Services	33.3
There aren't enough primary care providers. *Too few providers accept Medi-Cal.* *Patients seeking primary care overwhelm local emergency departments.* *Wait-times for appointments are excessively long.*	

CHNA Methods and Processes

Two related models were foundational in this CHNA. The first is a conceptual model that expresses the theoretical understanding of community health used in the analysis. This understanding is important because it provides the framework underpinning 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 8. This model organizes populations' individual health-related characteristics in terms of how they relate to up- or down-stream health and health-disparities factors. In this model, health outcomes (quality and length of life) are understood to result from the influence of health factors that describe interrelated individual, environmental, and community characteristics. These health factors are influenced by underlying policies and programs.

Figure 8: 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 express in general how these upstream health factors lead to the downstream health outcomes. It also suggests that poor health outcomes within the service area 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 used in the assessment, each conceptual model category was reviewed to identify potential indicators that could be used to fully represent the category. The results of this discussion were then used to guide secondary data collection.

Process Model

Figure 9 outlines the data collection and analysis stages of this process. The project began by confirming the HSA for Yolo County for which the CHNA would be conducted. Primary data collection included key informant interviews and focus-groups with community health experts and residents as well as a community service provider survey. 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 SHNs for the HSA. SHNs were 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 9: CHNA process model for Yolo County CHNA.

Primary Data Collection and Processing

Primary Data Collection

Primary data collection with key informants included two phases. Phase one began by identifying potential professionals to interview. This was done in collaboration with Applied Survey Research (ASR), a consulting firm working on behalf of Kaiser Permanente in the Yolo County service area. The intention was to reduce the burden on the community regarding oversampling, and coordinate efforts where possible. Data was shared once all interviews were completed.

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 service area, including input from the relevant Public Health Department. Data from these area-wide informants, coupled with socio-demographic data, was 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 explain what vulnerable populations existed in the county. As needed for a visual aid, key informants were provided a map of the HSA 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 16 contains a listing of community health experts, or key informants, that contributed input to the CHNA. 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.

Table 16: Key informant list.

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Woodland Memorial Hospital	04/12/2024	3	Acute Care Hospital: Healthcare services	Countywide; Special focus on LatinX Spanish Speaking Community
Sutter Davis Hospital	04/09/2024	4	Acute Care Hospital: Healthcare services	Low-income residents of Yolo County; uninsured and underinsured
Yolo County Public Health Staff	04/22/2024	1	Public Health	Residents of Yolo County
Yolo County Public Health Leadership	06/04/2024	4	Public Health	Residents of Yolo County
Winters Health	04/15/2024	1	FQHC: Healthcare services	Rural, Hispanic, migrant communities

Organization	Date	Number of Participants	Area of Expertise	Populations Served
CommuniCare	05/09/2024	2	FQHC: Healthcare services	Low income, underserved
Yolo Food Bank	04/22/2024	1	Food insecurity	Seniors, low income families
Fourth and Hope	04/24/2024	1	Food, shelter, social services	Homeless
Woodland Joint Unified School District	07/26/2021	3	Education	School aged children; Hispanic
Yolo County Children's Alliance	05/16/2024	1	Child abuse prevention, policy and advocacy	Children and families of Yolo County
Rural Innovations in Social Economics (RISE)	04/29/2024	1	Food, clothing, referrals, after school programs	Low income, Hispanic, migrant community
Empower Yolo	05/17/2024	1	Crisis intervention, counseling, legal assistance, social services resources	Victims of domestic violence, sexual assault, sex trafficking
Yocha DeHe Wintun Nation	10/02/2024	1	Case management, health education, resources, referrals	Tribal citizens

Focus Group Results

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

Table 17 contains a listing of community resident 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 population represented for focus group members.

Table 17: Focus group list.

Hosting Organization	Date	Number of Participants	Population Represented
Fourth and Hope	07/16/2024	9	Unhoused in Woodland
Yolo County Children's Alliance	08/12/2024	6	West Sacramento residents, working poor
Yolo Healthy Aging Alliance	09/03/2024	9	Seniors

Primary Data Processing

Key informant and focus group data were analyzed using qualitative analytic software. Content analysis included thematic coding to PHN 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 SHNs.

Community Service Provider Survey

A web-based survey was administered to community service providers (CSPs) who delivered health and social services to community residents of the HSA. A list of CSPs who have worked with the nonprofit hospitals included in this report was used as an initial sampling frame. An email recruitment message was sent to these CSPs detailing the survey aims and inviting them to participate. Participants we also encouraged to forward the recruitment message to other CSPs in their networks. The survey was designed and distributed using an online survey platform and was available for approximately two weeks. Eighteen respondents completed the survey. Survey respondents were asked if they would like the organizations they represented to be acknowledged in the report. The organizations represented by those respondents who requested acknowledgement are as follows. We thank all respondents for their participation in this process:

The Sacramento Environmental Justice Coalition (Sac-EJC.org), Sierra Sacramento Valley Medical Society, Society for the Blind, Yolo Community Care Continuum, Mercy Coalition of West Sacramento, Meals on Wheels Yolo County, First 5 Yolo Children and Families Commission, RISE, Inc, CommuniCare+OLE, Short Term Emergency Aid Committee, YCCC/Haven House ICP, Yolo Food Bank; UC Davis Community Advisory Board

After providing contextual information including the county they served and their affiliated organization(s), survey respondents were shown a list of previously identified PHNs and asked to indicate 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, respondents who provided service in multiple counties were given the opportunity to provide feedback for each county in which they worked.

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 used to summarize responses for health needs. This information was used along with other data sources to identify and rank SHNs in the community, and to describe how the health needs are expressed.

Secondary Data Collection and Processing

We use “secondary data” to 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 within the Yolo County HSA. This section details the data sources and processing steps used to obtain the secondary data used in each of these steps and prepare 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),[16] derived from health factor indicators available at the US Census tract level, and mortality data from the California Department of Public Health (CDPH),[17] health outcome indicators available at the ZIP Code level. The CDPH mortality data reports the number of deaths that occurred in each ZIP Code from 2018-2022 due to each of the causes listed in Table 18.

Table 18: 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
Diabetes mellitus	E10-E14
Assault (homicide)	U01-U02, X85-Y09, Y87.1
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 needed to be 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 include 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 us to identify 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.

[16] Public Health Alliance of Southern California. 2024. Access the latest HPI data. Data files for individual indicators and HPI score. Retrieved 20 Feb 2024 from https://api.healthyplacesindex.org/documentation.
[17] California Department of Public Health. 2024. California Comprehensive Master Death File (Static), 2018-2022.

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 patients into the analysis, the point location (latitude and longitude) of all ZIP Codes in California[18] were compared to 2020 ZCTA boundaries.[19] 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.

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.[20] 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-number 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.

Because the EBR were created for all ZCTAs in the state, ZCTAs with small populations that may have unstable high rates had their rates “shrunk” to more closely match the overall indicator rate 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 adjusted to more closely match the state norm. While this may not entirely resolve the small-number 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 2020 American Community Survey 5-year Estimates table B01001 and retrieved using the tidycensus[21] R package. Data for 2020 were used because this represented the central year of the 2018-2022 range of years for which CDPH data were collected. The population data for 2020 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.

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[21] Walker, K. Herman, M. 2024. *tidycensus: Load US Census Boundary and Attribute Data as ‘tidyverse’ and ‘sf’-Ready Data Frames*. R package version 1.6.5, https://walker-data.com/tidycensus/.

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 SHNs. The selection of these indicators was guided by the previously identified conceptual model. Table 19 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 19: 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	2015-2021
		Life Expectancy	Child Mortality	County Health Rankings	2018-2021
			Life Expectancy	County Health Rankings	2019-2021
			Premature Age-Adjusted Mortality	County Health Rankings	2019-2021
			Premature Death	County Health Rankings	2019-2021
		Mortality	Cancer Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Kidney Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Liver Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Suicide Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Unintentional Injuries Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Alzheimer's Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Influenza and Pneumonia Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Chronic Lower Respiratory Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Heart Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
			Hypertension Mortality	CDPH California Vital Data (Cal-ViDa)	2018 - 2022
	Quality of Life	Morbidity	Breast Cancer Prevalence	California Cancer Registry	2016 - 2020

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Colorectal Cancer Prevalence	California Cancer Registry	2016 - 2020
			Lung Cancer Prevalence	California Cancer Registry	2016 - 2020
			Prostate Cancer Prevalence	California Cancer Registry	2016 - 2020
			Diabetes Prevalence	County Health Rankings	2021
			Disability	2022 American Community Survey 5 year estimate variable S1810_C03_001E	2018 - 2022
			HIV Prevalence	County Health Rankings	2021
			Low Birthweight	County Health Rankings	2016-2022
			Frequent Mental Distress	County Health Rankings	2021
			Frequent Physical Distress	County Health Rankings	2021
			Poor Mental Health Days	County Health Rankings	2021
			Poor or Fair Health	County Health Rankings	2021
			Poor Physical Health Days	County Health Rankings	2021
			Asthma ED Rates	Tracking California	2020
			Asthma ED Rates for Children	Tracking California	2020
Health Factors	Clinical Care	Access to Care	Dental Care Shortage Area	U.S. Heath Resources and Services Administration	2024
			Dentists	County Health Rankings	2022
			Mammography Screening	County Health Rankings	2021
			Medically Underserved Area	U.S. Heath Resources and Services Administration	2024
			Mental Health Care Shortage Area	U.S. Heath Resources and Services Administration	2024
			Mental Health Providers	County Health Rankings	2023
			Primary Care Providers	County Health Rankings	2021; 2023
			Primary Care Shortage Area	U.S. Heath Resources and Services Administration	2024

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Psychiatry Providers	Area Health Resource File	2021
			Specialty Care Providers	Area Health Resource File	2021
		Quality Care	Preventable Hospitalization	Department of Health Care Access and Information Rates of Preventable Hospitalizations for Selected Medical Conditions by County	2022
	Health Behavior	Alcohol and Drug Use	Drug Induced Death	CDPH 2023 County Health Status Profiles	2019 - 2021
			Excessive Drinking	County Health Rankings	2021
		Diet and Exercise	Access to Exercise Opportunities	County Health Rankings	2023, 2022 & 2020
			Adult Obesity	County Health Rankings	2021
			Food Environment Index	County Health Rankings	2019 & 2021
			Limited Access to Healthy Foods	County Health Rankings	2019
			Physical Inactivity	County Health Rankings	2021
		Sexual Activity	Chlamydia Incidence	County Health Rankings	2021
			Teen Birth Rate	County Health Rankings	2016-2022
		Tobacco Use	Adult Smoking	County Health Rankings	2021
	Physical Environment	Air and Water Quality	Air Pollution - Particulate Matter	County Health Rankings	2019
			Drinking Water Violations	County Health Rankings	2022
			Pollution Burden Percent	California Office of Environmental Health Hazard Assessment	2021
		Climate	Drought Frequency	Centers for Disease Control and Prevention Environmental Public Health Tracking	2021
			Projected Difference in Extreme Heat Days	Centers for Disease Control and Prevention Environmental Public Health Tracking	2016

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Projected Difference in Extreme Precipitation Days	Centers for Disease Control and Prevention Environmental Public Health Tracking	2016
			Wildfire Probability	US Forest Service Research Data Archive	2020
		Housing and Transit	Homelessness Rate	US Dept. of Housing and Urban Development 2020 Annual Homeless Assessment Report	2023
			Homeownership	County Health Rankings	2018-2022
			Severe Housing Cost Burden	County Health Rankings	2018-2022
			Severe Housing Problems	County Health Rankings	2016-2020
			Access to Public Transit	US Department of Transportation Bureau of Transportation Statistics National Transportation Atlas Database: National Transit Map Stops; US Census Bureau	2024; 2020
			Households with no Vehicle Available	2022 American Community Survey 5-year estimate variable DP04_0058PE	2018 - 2022
			Long Commute - Driving Alone	County Health Rankings	2018-2022
	Socio-Economic and Demographic Factors	Community Safety	Firearm Fatalities Rate	County Health Rankings	2017-2021
			Homicide Rate	County Health Rankings	2015-2021
			Juvenile Arrest Rate	Criminal Justice Data: Arrests, OpenJustice, California Department of Justice	2018 - 2022
			Motor Vehicle Crash Death	County Health Rankings	2015-2021
		Education	Disconnected Youth	County Health Rankings	2018-2022
			High School Completion	County Health Rankings	2018-2022
			Some College	County Health Rankings	2018-2022
			Third Grade Math Level	County Health Rankings	2018

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Third Grade Reading Level	County Health Rankings	2018
		Employment	Unemployment	County Health Rankings	2022
		Family and Social Support	Children in Single-Parent Households	County Health Rankings	2018-2022
			Residential Segregation (Black/White)	County Health Rankings	2018-2022
			Social Associations	County Health Rankings	2021
		Income	Children Eligible for Free Lunch	County Health Rankings	2021-2022
			Children in Poverty	County Health Rankings	2022 & 2018-2022
			Income Inequality	County Health Rankings	2018-2022
			Median Household Income	County Health Rankings	2022 & 2018-2022
			Uninsured Population under 65	County Health Rankings	2021

Additional variables included in the analysis were provided by the Yolo County Health & Human Services Agency. These indicators, along with their sources and years they were measured, are included in Table 20 below.

Table 20: Indicators used in health need identification from Yolo County Health & Human Services Agency.

Conceptual Model Alignment			Indicator	Data Source	Time Period
Health Outcomes	Length of Life	Life Expectancy	Average Age at Death	Yolo County Health and Human Services - Public Health Branch. 2023. California Integrated Vital Records System./ Centers for Disease Control and Prevention, National Center for Health Statistics. 2021 National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database. http://wonder.cdc.gov/ucdicd10-expanded.html. Accessed August 20, 2024.	2021

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Preterm Births (<37 weeks)	Yolo County Health and Human Services - Public Health Branch. 2023. California Integrated Vital Records System./ California Department of Public Health. 2024. Birth and fetal death data. https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Births.aspx Accessed August 23, 2024.	2022
			Premature Mortality (under 65 years)	Yolo County Health and Human Services - Public Health Branch. 2023. California Integrated Vital Records System./ Centers for Disease Control and Prevention, National Center for Health Statistics. 2021 National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database. http://wonder.cdc.gov/ucdicd10-expanded.html. Accessed August 20, 2024.	2021
		Mortality	All Cause Cancer Mortality	Yolo County Health and Human Services - Public Health Branch. 2023. California Integrated Vital Records System./ Centers for Disease Control and Prevention, National Center for Health Statistics. 2021 National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database. http://wonder.cdc.gov/ucdicd10-expanded.html. Accessed August 20, 2024.	2021
			Breast Cancer Mortality (Females)	Yolo County Health and Human Services - Public Health Branch. 2023. California Integrated Vital Records System./ Centers for Disease Control and Prevention, National Center for Health Statistics. 2021 National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database. http://wonder.cdc.gov/ucdicd10-expanded.html. Accessed August 20, 2024.	2021

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Lung Cancer Mortality	Yolo County Health and Human Services - Public Health Branch. 2023. California Integrated Vital Records System./ Centers for Disease Control and Prevention, National Center for Health Statistics. 2021 National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database. http://wonder.cdc.gov/ucdicd10-expanded.html. Accessed August 20, 2024.	2021
			Prostate Cancer Mortality	Yolo County Health and Human Services - Public Health Branch. 2023. California Integrated Vital Records System./ Centers for Disease Control and Prevention, National Center for Health Statistics. 2021 National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database. http://wonder.cdc.gov/ucdicd10-expanded.html. Accessed August 20, 2024.	2021
			Behavioral Chronic Disease model for over 50% of the population	Yolo County Health and Human Services - Public Health Branch. 2023. California Integrated Vital Records System./ Centers for Disease Control and Prevention, National Center for Health Statistics. 2021 National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database. http://wonder.cdc.gov/ucdicd10-expanded.html. Accessed August 20, 2024.	2021
			Diabetes Mortality	Yolo County Health and Human Services - Public Health Branch. 2023. California Integrated Vital Records System./ Centers for Disease Control and Prevention, National Center for Health Statistics. 2021 National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database. http://wonder.cdc.gov/ucdicd10-expanded.html. Accessed August 20, 2024.	2021

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Stroke Mortality	Yolo County Health and Human Services - Public Health Branch. 2023. California Integrated Vital Records System./ Centers for Disease Control and Prevention, National Center for Health Statistics. 2021 National Vital Statistics System, Mortality 2018-2021 on CDC WONDER Online Database. http://wonder.cdc.gov/ucdicd10-expanded.html. Accessed August 20, 2024.	2021
	Quality of Life	Morbidity	Accidental Falls (aged over 65+) ED visits	California Department of Public Health. 2023. Epicenter: California injury data online. https://skylab4.cdph.ca.gov/epicenter/ Accessed August 23, 2024./ California Department of Public Health. 2023. Epicenter: California injury data online. https://skylab4.cdph.ca.gov/epicenter/ Accessed August 23, 2024.	2022
			Accidental Falls (aged over 65+) Hospitalizations	California Department of Public Health. 2023. Epicenter: California injury data online. https://skylab4.cdph.ca.gov/epicenter/ Accessed August 23, 2024./ California Department of Public Health. 2023. Epicenter: California injury data online. https://skylab4.cdph.ca.gov/epicenter/ Accessed August 23, 2024.	2022
			Drug-Related Hospitalizations	California Department of Health Care Access and Information. 2023. Patient Discharge Data./ California Department of Health Care Access and Information. 2024. HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022. https://hcai.ca.gov/visualizations/inpatient-hospitalizations-and-emergency-department-visits-for-patients-with-a-behavioral-health-diagnosis-in-california-patient-demographics/. Accessed August 23, 2024.	2021
			Drug-Related Hospitalizations (ages 15-24)	California Department of Health Care Access and Information. 2023. Patient Discharge Data./	2022

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Mental Health Hospitalizations	California Department of Health Care Access and Information. 2023. Patient Discharge Data./ California Department of Health Care Access and Information. 2024. HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022. https://hcai.ca.gov/visualizations/inpatient-hospitalizations-and-emergency-department-visits-for-patients-with-a-behavioral-health-diagnosis-in-california-patient-demographics/. Accessed August 23, 2024.	2021
			Mental Health Hospitalizations (ages 15-24)	California Department of Health Care Access and Information. 2023. Patient Discharge Data./	2022
			Mental Health or Drug-Related Hospitalizations	California Department of Health Care Access and Information. 2023. Patient Discharge Data./ California Department of Health Care Access and Information. 2024. HCAI – Patient Discharge Data, Emergency Department Data – Hospital Encounters for Behavioral Health, 2021 – 2022. https://hcai.ca.gov/visualizations/inpatient-hospitalizations-and-emergency-department-visits-for-patients-with-a-behavioral-health-diagnosis-in-california-patient-demographics/. Accessed August 23, 2024.	2021
			Mental Health or Drug-Related Hospitalizations (ages 15-24)	California Department of Health Care Access and Information. 2023. Patient Discharge Data./	2022
			Self-Inflicted Injury Hospitalizations (ages 15-24)	California Department of Public Health. 2023. Epicenter: California injury data online. https://skylab4.cdph.ca.gov/epicenter/ Accessed August 23, 2024./ California Department of Public Health. 2023. Epicenter: California injury data online. https://skylab4.cdph.ca.gov/epicenter/ Accessed August 23, 2024.	2022

Conceptual Model Alignment			Indicator	Data Source	Time Period
Health Factors	Clinical Care	Access to Care	Prenatal Care (1st Trimester)	Yolo County Health and Human Services - Public Health Branch. 2023. California Integrated Vital Records System./ California Department of Public Health. 2024. Birth and fetal death data. https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Births.aspx Accessed August 23, 2024.	2022
	Health Behavior	Diet and Exercise	Exclusively Breastfeeding	California Department of Public Health. 2024. Breastfeeding initiation data. https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Breastfeeding-Initiation.aspx. Accessed August 23, 2024./ California Department of Public Health. 2024. Breastfeeding initiation data. https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Breastfeeding-Initiation.aspx. Accessed August 23, 2024.	2022

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 2024 County Health Rankings[22] dataset. This was the most common source of data, with 49 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 service area. State-level indicators were collected to be used as benchmarks for comparison purposes. All variables included in the CHR dataset were obtained from other data providers. The original data providers for each CHR variable are given in Table 21.

Table 21: Sources and time periods for indicators obtained from County Health Rankings.

CHR Indicator	Time Period	Data Source
Infant Mortality	2015-2021	National Center for Health Statistics - Natality and Mortality Files
Child Mortality	2018-2021	National Center for Health Statistics - Mortality Files; Census Population Estimates Program
Life Expectancy	2019-2021	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program

[22] University of Wisconsin Population Health Institute. 2024. 2024 California Data; 2024 Oregon Data. Retrieved 21 Mar 2024 from https://www.countyhealthrankings.org/health-data.

CHR Indicator	Time Period	Data Source
Premature Age-Adjusted Mortality	2019-2021	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program
Premature Death	2019-2021	National Center for Health Statistics - Natality and Mortality Files; Census Population Estimates Program
Diabetes Prevalence	2021	Behavioral Risk Factor Surveillance System
HIV Prevalence	2021	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Low Birthweight	2016-2022	National Center for Health Statistics - Natality Files
Frequent Mental Distress	2021	Behavioral Risk Factor Surveillance System
Frequent Physical Distress	2021	Behavioral Risk Factor Surveillance System
Poor Mental Health Days	2021	Behavioral Risk Factor Surveillance System
Poor or Fair Health	2021	Behavioral Risk Factor Surveillance System
Poor Physical Health Days	2021	Behavioral Risk Factor Surveillance System
Dentists	2022	Area Health Resource File/National Provider Identifier Downloadable File
Mammography Screening	2021	Mapping Medicare Disparities Tool
Mental Health Providers	2023	CMS, National Provider Identification
Primary Care Providers	2021; 2023	Area Health Resource File/American Medical Association; CMS, National Provider Identification
Excessive Drinking	2021	Behavioral Risk Factor Surveillance System
Access to Exercise Opportunities	2023, 2022 & 2020	ArcGIS Business Analyst and ArcGIS Online; YMCA; US Census TIGER/Line Shapefiles
Adult Obesity	2021	Behavioral Risk Factor Surveillance System
Food Environment Index	2019 & 2021	USDA Food Environment Atlas; Map the Meal Gap from Feeding America
Limited Access to Healthy Foods	2019	USDA Food Environment Atlas
Physical Inactivity	2021	Behavioral Risk Factor Surveillance System
Chlamydia Incidence	2021	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Teen Birth Rate	2016-2022	National Center for Health Statistics - Natality Files; Census Population Estimates Program
Adult Smoking	2021	Behavioral Risk Factor Surveillance System
Air Pollution - Particulate Matter	2019	Environmental Public Health Tracking Network
Drinking Water Violations	2022	Safe Drinking Water Information System
Homeownership	2018-2022	American Community Survey, 5-year estimates
Severe Housing Cost Burden	2018-2022	American Community Survey, 5-year estimates
Severe Housing Problems	2016-2020	Comprehensive Housing Affordability Strategy (CHAS) data
Long Commute - Driving Alone	2018-2022	American Community Survey, 5-year estimates
Firearm Fatalities Rate	2017-2021	National Center for Health Statistics - Mortality Files; Census Population Estimates Program

CHR Indicator	Time Period	Data Source
Homicide Rate	2015-2021	National Center for Health Statistics - Mortality Files; Census Population Estimates Program
Motor Vehicle Crash Death	2015-2021	National Center for Health Statistics - Mortality Files; Census Population Estimates Program
Disconnected Youth	2018-2022	American Community Survey, 5-year estimates
High School Completion	2018-2022	American Community Survey, 5-year estimates
Some College	2018-2022	American Community Survey, 5-year estimates
Third Grade Math Level	2018	Stanford Education Data Archive
Third Grade Reading Level	2018	Stanford Education Data Archive
Unemployment	2022	Bureau of Labor Statistics
Children in Single-Parent Households	2018-2022	American Community Survey, 5-year estimates
Residential Segregation (Black/White)	2018-2022	American Community Survey, 5-year estimates
Social Associations	2021	County Business Patterns
Children Eligible for Free Lunch	2021-2022	National Center for Education Statistics
Children in Poverty	2022 & 2018-2022	Small Area Income and Poverty Estimates; American Community Survey, 5-year estimates
Income Inequality	2018-2022	American Community Survey, 5-year estimates
Median Household Income	2022 & 2018-2022	Small Area Income and Poverty Estimates; American Community Survey, 5-year estimates
Uninsured Population under 65	2021	Small Area Health Insurance Estimates

The provider rates for the primary care physicians and other primary care providers 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 state[23] and county[24] level for the years 2018-2022. Empirically bayes smoothed rates (EBRs) were calculated for each mortality indicator using the total county population figure reported in the 2020 American Community Survey 5-year Estimates table B01001 and retrieved using the tidycensus R package. Data for 2020 were used because this represented the central year of the 2018-2022 range of years for which CDPH data were collected. The population data for 2020 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.

[23] State of California, Department of Public Health. 2024. California Vital Data (Cal-ViDa), Death Query. Retrieved 20 Feb 2024 from https://cal-vida.cdph.ca.gov/.

[24] California Department of Public Health. 2024. 2014-2022 Final Deaths by Year by County. Data File. Retrieved 20 Feb 2024 from https://data.chhs.ca.gov/dataset/58619b69-b3cb-41a7-8bfc-fc3a524a9dd4/resource/579cc04a-52d6-4c4c-b2df-ad901c9049b7/download/20231206_deaths_final_2014_2022_county_year_sup.csv.

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, we applied the state by-cause mortality rate 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 2020 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.

Drug-Induced Deaths Data

Drug-induced death rates were obtained from Table 19 of the 2021 County Health Status Profiles[25] 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[26] (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. The indicator reports whether a given county was either partially or entirely covered by a shortage area.

[25] California Department of Public Health, Research and Analytics Branch. 2024. County Health Status Profiles 2023: CHSP 2023 Tables 1-29 (Excel). Datafile. Retrieved 20 Feb 2023 from https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP2023_Table1-29_20230214.xlsx.
[26] US Health Resources & Services Administration. 2024. Area Health resource Files; Health Professional Shortage Areas (HPSA). Datafiles. Retrieved on 29 Apr 2024 from https://data.hrsa.gov/data/download.

Psychiatry and Specialty Care Providers

The 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 the 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 2021. This number was then divided by the 2021 total population given in the 2021 American Community Survey 5-year Estimates table B01001 and retrieved using the tidycensus R package and then multiplied by 100,000 to give the total number of specialty care physicians per 100,000 residents.

The total 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 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[27] includes 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 2016 to 2020, 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 the individual county in the group.

Tracking California

Data on 2020 emergency department visits rates due to Asthma for all ages as well as children aged 5 to 17 were obtained from Tracking California.[28] These data reported 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.

US Census Bureau

Data from the US 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 2022 American Community Survey 5-year Estimates dataset using the tidycensus R package.

[27] California Cancer Registry. 2024. CAL*Explorer Application. Datafiles. Retrieved on 25 Mar 2024 from https://www.cancer-rates.info/ca/.
[28] Tracking California, Public Health Institute. 2024. Asthma Related Emergency Department & Hospitalization data. Retrieved on 25 Mar 2024 from www.trackingcalifornia.org/asthma/query.

California Office of Environmental Health Hazard Assessment

Data used to calculate the pollution burden percent indicator were obtained from the CalEnviroscreen 4.0[29] 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 4.0 Pollution Burden score in the 50th percentile or higher.

California Department of Health Care Access and Information

Data on preventable hospitalizations were obtained from the California Department of Health Care Access and Information.[30] 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.[31] 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 2018-2022 by the total population under 18 as reported in Table B01001 in the 2020 American Community Survey 5-year Estimates program. Population data from 2020 were used as this was the central year of the period over which juvenile felony arrest data were obtained. Population figures from 2020 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 2020 American Community Survey 5-year Estimates Tables B01001H, B01001B, and B01001I, respectively. All census population data were retrieved using the tidycensus R package.

US Department of Housing and Urban Development

Data from the US Department of Housing and Urban Development[32] were used to calculate homelessness rates for the counties and state. This data reported 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 matched to counties. 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 were totaled and then divided by the total county population to calculate the rate. When a single CoC covered multiple counties, the CoC PIT estimate was divided by the total of all county included populations, and the resulting rate was applied to each individual county.

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[29] California Office of Environmental Health Hazard Assessment. 2023. CalEnviroScreen 3.0. Datafile. Retrieved on 6 Apr 2024 from https://oehha.ca.gov/calenviroscreen/report/calenviroscreen-40.

[30] California Department of Health Care Access and Information. 2023. Rates of Preventable Hospitalizations for Selected Medical Conditions by County (LGHC Indicator). Data files for Statewide and County. Retrieved 25 Mar 2024 from https://data.chhs.ca.gov/dataset/rates-of-preventable-hospitalizations-for-selected-medical-conditions-by-county/resource/7c7aed93-3643-43b8-92fc-324bf8fc13f2.

[31] California Department of Justice, OpenJustice. 2024. Criminal Justice Data: Arrests. Datafile. Retrieved 25 Mar 2024 from https://data-openjustice.doj.ca.gov/sites/default/files/dataset/2023-06/OnlineArrestData1980-2022.csv.

[32] US Department of Housing and Urban Development. 2023. PIT and HIC Data Since 2007: 2007 - 2023 PIT Estimates by CoC. Datafile. Retrieved on 17 Apr 2024 from https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/.

Population data came from the total population value reported in Table B03002 from the 2022 American Community Survey 5-year Estimates dataset retrieved using the tidycensus R package. Derived rates report cases per 100,000.

Proximity to Transit Stops

The proximity to transit stops variable 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. Census block level population data from the 2020 decennial census was obtained from table P1 using the tidycensus R package. Transit stop data were obtained from the US Department of Transportation's National Transpiration Atlas Database.[33]

The sf[34] library in R was 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 buffer of the stops 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 identify Communities of Concern. These Communities of Concern could potentially include geographic regions or specific sub-populations, either of which were found to be bearing disproportionate health burdens. This information was used to focus the remaining interview and focus-group collection efforts on those areas and sub-populations. Next, the resulting data, along with the results from the community service provider survey, were combined with secondary health need identification data to identify SHNs within the service area. Finally, primary data were used to prioritize those identified SHNs. 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, 2025 Communities of Concern were identified through a process that drew upon both primary and secondary data. Three main secondary data sources were used in this analysis: Communities of Concern identified in the 2022 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 HSA. The following secondary data selection criteria were used to identify preliminary Communities of Concern.

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[33] US Department of Transportation Bureau of Transportation Statistics. 2024. National Transportation Atlas Database: National Transit Map Stops. Datafile. Retrieved on 22 Mar 2024 from https://geodata.bts.gov/datasets/usdot::national-transit-map-stops/explore?location=41.726443%2C-123.965217%2C10.90 .

[34] 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.

2022 Community of Concern

A ZCTA was included if it was included in the 2022 CHNA Community of Concern list for the HSA. This was done to allow greater continuity between CHNA rounds and reflects the work of the hospital systems oriented to serve these disadvantaged communities.

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 HSA. These census tracts represent areas with demographic, physical environment, economic, and other characteristics consistently related to poor health outcomes.

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, CLRD, Alzheimer's disease, unintentional injuries, diabetes, homicides, 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 HSA was counted. Those ZCTAs whose counted values exceeded the 80th percentile for all of the ZCTAs in the HSA met the Community of Concern mortality selection criteria.

Integration of Secondary Criteria

Any ZCTA that met any of the three selection criteria (2022 Community of Concern, HPI, and Mortality) was reviewed for inclusion as a 2025 Community of Concern, with greater weight given to those ZCTAs meeting multiple 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 list then 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 2025 Community of Concern. An additional round of expert review was then applied to determine if, based on any primary or secondary data consideration, any final adjustments should be made to this list. The resulting set of ZCTAs was then used as the final 2025 Communities of Concern.

Significant Health Need Identification

The general methods through which 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 PHNs from which SHNs could be selected. This was done by reviewing the health needs identified during prior CHNAs 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 22.

Figure 11: Significant health need identification process.

Table 22: 2025 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 Table 23 through Table 34. 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 23: 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).	Life Expectancy
The cost for mental/behavioral health treatment is too high.	Preterm Births (<37 weeks)
Treatment options in the area for those with Medi-Cal are limited.	Premature Age-Adjusted Mortality
Awareness of mental health issues among community members is low.	Premature Death
Additional services specifically for youth are needed (e.g., child psychologists, counselors and therapists in the schools).	Premature Mortality (under 65 years)
The stigma around seeking mental health treatment keeps people out of care.	All Cause Cancer Mortality
Additional services for those who are homeless and dealing with mental/behavioral health issues are needed.	Breast Cancer Mortality (Females)
The area lacks the infrastructure to support acute mental health crises.	Liver Disease Mortality
Mental/behavioral health services are available in the area, but people do not know about them.	Lung Cancer Mortality
It's difficult for people to navigate for mental/behavioral healthcare.	Prostate Cancer Mortality
	Suicide Mortality
	Drug-Related Hospitalizations
	Drug-Related Hospitalizations (ages 15-24)
	Frequent Mental Distress
	Frequent Physical Distress
	Mental Health Hospitalizations

Primary Themes	Secondary Indicators
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 is 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.	Mental Health Hospitalizations (ages 15-24) Mental Health or Drug-Related Hospitalizations Mental Health or Drug-Related Hospitalizations (ages 15-24) Poor Mental Health Days Poor or Fair Health Poor Physical Health Days Self-Inflicted Injury Hospitalizations (ages 15-24) Medically Underserved Area Mental Health Care Shortage Area Mental Health Providers Primary Care Shortage Area Psychiatry Providers Drug Induced Death Excessive Drinking Adult Smoking Homelessness Rate Severe Housing Cost Burden Firearm Fatalities Rate Juvenile Arrest Rate Disconnected Youth Residential Segregation (Black/White) Social Associations Income Inequality

Access to Quality Primary Care Health Services

Table 24: 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	Infant Mortality Average Age at Death Child Mortality Life Expectancy Preterm Births (<37 weeks) Premature Age-Adjusted Mortality Premature Death Premature Mortality (under 65 years) All Cause Cancer Mortality Breast Cancer Mortality (Females) Cancer Mortality

Primary Themes	Secondary Indicators
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 difficult for many people to navigate.	Kidney Disease Mortality Liver Disease Mortality Lung Cancer Mortality Prostate Cancer Mortality Alzheimer's Disease Mortality Influenza and Pneumonia Mortality Behavioral Chronic Disease model for over 50% of the population Chronic Lower Respiratory Disease Mortality Heart Disease Mortality Hypertension Mortality Diabetes Mortality Stroke Mortality Breast Cancer Prevalence Colorectal Cancer Prevalence Lung Cancer Prevalence Prostate Cancer Prevalence Diabetes Prevalence Low Birthweight Frequent Mental Distress Frequent Physical Distress Poor Mental Health Days Poor or Fair Health Poor Physical Health Days Asthma ED Rates Asthma ED Rates for Children Mammography Screening Medically Underserved Area Primary Care Providers Primary Care Shortage Area Prenatal Care (1st Trimester) Preventable Hospitalization Homelessness Rate Residential Segregation (Black/White) Income Inequality Uninsured Population under 65

Active Living and Healthy Eating

Table 25: 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.	Life Expectancy Premature Age-Adjusted Mortality

Primary Themes	Secondary Indicators
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 walk-able, roads aren't bike-friendly, or parks are inaccessible). The community needs nutrition education programs. Homelessness in parks or other public spaces deters 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 option in the area are limited.	Premature Death Premature Mortality (under 65 years) All Cause Cancer Mortality Breast Cancer Mortality (Females) Cancer Mortality Kidney Disease Mortality Lung Cancer Mortality Prostate Cancer Mortality Behavioral Chronic Disease model for over 50% of the population Heart Disease Mortality Hypertension Mortality Diabetes Mortality Stroke Mortality Breast Cancer Prevalence Colorectal Cancer Prevalence Prostate Cancer Prevalence Diabetes Prevalence Frequent Mental Distress Frequent Physical Distress Poor Mental Health Days Poor or Fair Health Poor Physical Health Days Asthma ED Rates Asthma ED Rates for Children Access to Exercise Opportunities Adult Obesity Food Environment Index Limited Access to Healthy Foods Physical Inactivity Exclusively Breastfeeding Homelessness Rate Severe Housing Cost Burden Access to Public Transit Long Commute - Driving Alone Residential Segregation (Black/White) Income Inequality

Safe and Violence-Free Environment

Table 26: 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 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 Premature Mortality (under 65 years) Hypertension Mortality Drug-Related Hospitalizations Drug-Related Hospitalizations (ages 15-24) Frequent Mental Distress Frequent Physical Distress Mental Health Hospitalizations Mental Health Hospitalizations (ages 15-24) Mental Health or Drug-Related Hospitalizations Mental Health or Drug-Related Hospitalizations (ages 15-24) Poor Mental Health Days Poor or Fair Health Self-Inflicted Injury Hospitalizations (ages 15-24) Access to Exercise Opportunities Physical Inactivity Homelessness Rate Severe Housing Cost Burden Severe Housing Problems Firearm Fatalities Rate Homicide Rate Juvenile Arrest Rate Motor Vehicle Crash Death Disconnected Youth Social Associations Income Inequality

Access to Dental Care and Preventive Services

Table 27: 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.	Frequent Mental Distress Frequent Physical Distress Poor or Fair Health Poor Physical Health Days

Primary Themes	Secondary Indicators
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.	Dental Care Shortage Area Dentists Homelessness Rate Residential Segregation (Black/White) Income Inequality

Healthy Physical Environment

Table 28: 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 Average Age at Death Life Expectancy Premature Age-Adjusted Mortality Premature Death Premature Mortality (under 65 years) Cancer Mortality Chronic Lower Respiratory Disease Mortality Hypertension Mortality Breast Cancer Prevalence Colorectal Cancer Prevalence Lung Cancer Prevalence Prostate Cancer Prevalence Frequent Mental Distress Frequent Physical Distress Poor or Fair Health Asthma ED Rates Asthma ED Rates for Children Adult Smoking Air Pollution - Particulate Matter Drinking Water Violations Pollution Burden Percent Drought Frequency Projected Difference in Extreme Heat Days Projected Difference in Extreme Precipitation Days Wildfire Probability Homelessness Rate Severe Housing Cost Burden Long Commute - Driving Alone Income Inequality

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

Table 29: 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. Many residents struggle with food insecurity. It is difficult to find affordable childcare. Educational attainment in the area is low.	Infant Mortality Average Age at Death Child Mortality Life Expectancy Premature Age-Adjusted Mortality Premature Death Premature Mortality (under 65 years) Hypertension Mortality Diabetes Prevalence Low Birthweight Accidental Falls (aged over 65+) ED visits Accidental Falls (aged over 65+) Hospitalizations Frequent Mental Distress Frequent Physical Distress Poor Mental Health Days Poor or Fair Health Poor Physical Health Days Asthma ED Rates Asthma ED Rates for Children Medically Underserved Area Drug Induced Death Adult Obesity Food Environment Index Limited Access to Healthy Foods Homelessness Rate Homeownership Severe Housing Cost Burden Severe Housing Problems Households with no Vehicle Available Long Commute - Driving Alone Disconnected Youth High School Completion Some College Third Grade Math Level Third Grade Reading Level Unemployment Children in Single-Parent Households Residential Segregation (Black/White) Social Associations Children Eligible for Free Lunch Children in Poverty Income Inequality

Primary Themes	Secondary Indicators
	Median Household Income Uninsured Population under 65

Access to Functional Needs

Table 30: 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. 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 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).	Disability Accidental Falls (aged over 65+) ED visits Accidental Falls (aged over 65+) Hospitalizations Frequent Mental Distress Frequent Physical Distress Poor or Fair Health Adult Obesity Homelessness Rate Access to Public Transit Households with no Vehicle Available Long Commute - Driving Alone Income Inequality

Access to Specialty and Extended Care

Table 31: 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 Average Age at Death Life Expectancy Preterm Births (<37 weeks) Premature Age-Adjusted Mortality Premature Death Premature Mortality (under 65 years) All Cause Cancer Mortality Breast Cancer Mortality (Females) Cancer Mortality Kidney Disease Mortality Liver Disease Mortality Lung Cancer Mortality Prostate Cancer Mortality Alzheimer's Disease Mortality Behavioral Chronic Disease model for

Primary Themes	Secondary Indicators
	over 50% of the population Chronic Lower Respiratory Disease Mortality Heart Disease Mortality Hypertension Mortality Diabetes Mortality Stroke Mortality Lung Cancer Prevalence Diabetes Prevalence Frequent Mental Distress Frequent Physical Distress Poor Mental Health Days Poor or Fair Health Poor Physical Health Days Asthma ED Rates Asthma ED Rates for Children Psychiatry Providers Specialty Care Providers Preventable Hospitalization Drug Induced Death Homelessness Rate Residential Segregation (Black/White) Income Inequality

Injury and Disease Prevention and Management

Table 32: 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 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 Average Age at Death Child Mortality All Cause Cancer Mortality Breast Cancer Mortality (Females) Kidney Disease Mortality Liver Disease Mortality Lung Cancer Mortality Prostate Cancer Mortality Suicide Mortality Unintentional Injuries Mortality Alzheimer's Disease Mortality Behavioral Chronic Disease model for over 50% of the population

Primary Themes	Secondary Indicators
	Chronic Lower Respiratory Disease Mortality Heart Disease Mortality Hypertension Mortality Diabetes Mortality Stroke Mortality Diabetes Prevalence HIV Prevalence Low Birthweight Accidental Falls (aged over 65+) ED visits Accidental Falls (aged over 65+) Hospitalizations Drug-Related Hospitalizations Drug-Related Hospitalizations (ages 15-24) Frequent Mental Distress Frequent Physical Distress Mental Health Hospitalizations Mental Health Hospitalizations (ages 15-24) Mental Health or Drug-Related Hospitalizations Mental Health or Drug-Related Hospitalizations (ages 15-24) Poor Mental Health Days Poor or Fair Health Self-Inflicted Injury Hospitalizations (ages 15-24) Asthma ED Rates Asthma ED Rates for Children Prenatal Care (1st Trimester) Drug Induced Death Excessive Drinking Adult Obesity Physical Inactivity Exclusively Breastfeeding Chlamydia Incidence Teen Birth Rate Adult Smoking Homelessness Rate Firearm Fatalities Rate Juvenile Arrest Rate Motor Vehicle Crash Death Disconnected Youth Third Grade Math Level

Primary Themes	Secondary Indicators
	Third Grade Reading Level Income Inequality

Increased Community Connections

Table 33: 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 Average Age at Death Child Mortality Life Expectancy Premature Age-Adjusted Mortality Premature Death Premature Mortality (under 65 years) Suicide Mortality Unintentional Injuries Mortality Behavioral Chronic Disease model for over 50% of the population Heart Disease Mortality Hypertension Mortality Diabetes Mortality Stroke Mortality Diabetes Prevalence Low Birthweight Drug-Related Hospitalizations Drug-Related Hospitalizations (ages 15-24) Frequent Mental Distress Frequent Physical Distress Mental Health Hospitalizations Mental Health Hospitalizations (ages 15-24) Mental Health or Drug-Related Hospitalizations Mental Health or Drug-Related Hospitalizations (ages 15-24) Poor Mental Health Days Poor or Fair Health Poor Physical Health Days Self-Inflicted Injury Hospitalizations (ages 15-24) Medically Underserved Area Mental Health Care Shortage Area Mental Health Providers Primary Care Providers Primary Care Shortage Area

Primary Themes	Secondary Indicators
	Psychiatry Providers Specialty Care Providers Preventable Hospitalization Drug Induced Death Excessive Drinking Access to Exercise Opportunities Physical Inactivity Teen Birth Rate Homelessness Rate Access to Public Transit Households with no Vehicle Available Long Commute - Driving Alone Firearm Fatalities Rate Homicide Rate Juvenile Arrest Rate Disconnected Youth High School Completion Some College Unemployment Children in Single-Parent Households Residential Segregation (Black/White) Social Associations Income Inequality

System Navigation

Table 34: 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 health care systems. The area needs more navigators to help to get people connected to services. People have trouble understanding their insurance 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. Medical terminology is confusing. Some people just don't know where to start in order to access care or benefits.	Infant Mortality Child Mortality Life Expectancy Preterm Births (<37 weeks) Premature Age-Adjusted Mortality Premature Death All Cause Cancer Mortality Breast Cancer Mortality (Females) Cancer Mortality Kidney Disease Mortality Liver Disease Mortality Lung Cancer Mortality Prostate Cancer Mortality Influenza and Pneumonia Mortality Behavioral Chronic Disease model for over 50% of the population

Primary Themes	Secondary Indicators
	Chronic Lower Respiratory Disease Mortality Heart Disease Mortality Hypertension Mortality Diabetes Mortality Stroke Mortality Frequent Mental Distress Poor Mental Health Days Poor or Fair Health Asthma ED Rates Asthma ED Rates for Children Dental Care Shortage Area Dentists Mammography Screening Medically Underserved Area Mental Health Care Shortage Area Mental Health Providers Primary Care Providers Primary Care Shortage Area Psychiatry Providers Specialty Care Providers Prenatal Care (1st Trimester) Preventable Hospitalization Uninsured Population under 65

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 35 lists each secondary indicator and describes the comparison made to the benchmark to determine if it was problematic.

Table 35: Benchmark comparisons to show indicator performance.

Indicator	Benchmark Comparison Indicating Poor Performance
Infant Mortality	Higher
Average Age at Death	Lower
Child Mortality	Higher
Life Expectancy	Lower
Preterm Births (<37 weeks)	Higher
Premature Age-Adjusted Mortality	Higher
Premature Death	Higher
Premature Mortality (under 65 years)	Higher

Indicator	Benchmark Comparison Indicating Poor Performance
All Cause Cancer Mortality	Higher
Breast Cancer Mortality (Females)	Higher
Cancer Mortality	Higher
Kidney Disease Mortality	Higher
Liver Disease Mortality	Higher
Lung Cancer Mortality	Higher
Prostate Cancer Mortality	Higher
Suicide Mortality	Higher
Unintentional Injuries Mortality	Higher
Alzheimer's Disease Mortality	Higher
Influenza and Pneumonia Mortality	Higher
Behavioral Chronic Disease model for over 50% of the population	Higher
Chronic Lower Respiratory Disease Mortality	Higher
Heart Disease Mortality	Higher
Hypertension Mortality	Higher
Diabetes Mortality	Higher
Stroke Mortality	Higher
Breast Cancer Prevalence	Higher
Colorectal Cancer Prevalence	Higher
Lung Cancer Prevalence	Higher
Prostate Cancer Prevalence	Higher
Diabetes Prevalence	Higher
Disability	Higher
HIV Prevalence	Higher
Low Birthweight	Higher
Accidental Falls (aged over 65+) ED visits	Higher
Accidental Falls (aged over 65+) Hospitalizations	Higher
Drug-Related Hospitalizations	Higher
Drug-Related Hospitalizations (ages 15-24)	Higher
Frequent Mental Distress	Higher
Frequent Physical Distress	Higher
Mental Health Hospitalizations	Higher
Mental Health Hospitalizations (ages 15-24)	Higher
Mental Health or Drug-Related Hospitalizations	Higher
Mental Health or Drug-Related Hospitalizations (ages 15-24)	Higher
Poor Mental Health Days	Higher
Poor or Fair Health	Higher
Poor Physical Health Days	Higher
Self-Inflicted Injury Hospitalizations (ages 15-24)	Higher
Asthma ED Rates	Higher
Asthma ED Rates for Children	Higher

Indicator	Benchmark Comparison Indicating Poor Performance
Dental Care Shortage Area	Present
Dentists	Lower
Mammography Screening	Lower
Medically Underserved Area	Present
Mental Health Care Shortage Area	Present
Mental Health Providers	Lower
Primary Care Providers	Lower
Primary Care Shortage Area	Present
Psychiatry Providers	Lower
Specialty Care Providers	Lower
Prenatal Care (1st Trimester)	Lower
Preventable Hospitalization	Higher
Drug Induced Death	Higher
Excessive Drinking	Higher
Access to Exercise Opportunities	Lower
Adult Obesity	Higher
Food Environment Index	Lower
Limited Access to Healthy Foods	Higher
Physical Inactivity	Higher
Exclusively Breastfeeding	Lower
Chlamydia Incidence	Higher
Teen Birth Rate	Higher
Adult Smoking	Higher
Air Pollution - Particulate Matter	Higher
Drinking Water Violations	Present
Pollution Burden Percent	Higher
Drought Frequency	Higher
Projected Difference in Extreme Heat Days	Higher
Projected Difference in Extreme Precipitation Days	Higher
Wildfire Probability	Higher
Homelessness Rate	Higher
Homeownership	Lower
Severe Housing Cost Burden	Higher
Severe Housing Problems	Higher
Access to Public Transit	Lower
Households with no Vehicle Available	Higher
Long Commute - Driving Alone	Higher
Firearm Fatalities Rate	Higher
Homicide Rate	Higher
Juvenile Arrest Rate	Higher
Motor Vehicle Crash Death	Higher
Disconnected Youth	Higher
High School Completion	Lower

Indicator	Benchmark Comparison Indicating Poor Performance
Some College	Lower
Third Grade Math Level	Lower
Third Grade Reading Level	Lower
Unemployment	Higher
Children in Single-Parent Households	Higher
Residential Segregation (Black/White)	Higher
Social Associations	Lower
Children Eligible for Free Lunch	Higher
Children in Poverty	Higher
Income Inequality	Higher
Median Household Income	Lower
Uninsured Population under 65	Higher

Identification of preliminary secondary SHNs was then based on the percentage of all secondary indicators associated with a given PHN that were identified as performing poorly within the HSA. Identification of preliminary SHNs interview and focus group health needs were similarly based on the percentage of events in which themes associated with each given PHN were mentioned as priority health needs. Finally, preliminary survey SHN identification was based on the percentage of survey respondents selecting a particular health need as one of the top health needs in the HSA.

For this report, a PHN was selected as a preliminary quantitative SHN if 40% of the associated quantitative indicators were identified as performing poorly; as a preliminary qualitative SHN if it was identified by 50% or more of the primary sources as performing poorly; and as a preliminary community service provider survey SHN if it was identified by at least 40% of survey respondents. Finally, a PHN was selected as a SHN if it was included as a preliminary SHN in two of these categories and/or if expert opinion warranted its inclusion.

Health Need Prioritization

The final step in the analysis was to prioritize the identified SHNs. SHN prioritization was based solely on primary data to honor and reflect the voice of the community. Key informants and focus-group participants were asked to identify the three most SHNs in their communities. These responses were associated with one or more of the PHNs. This, along with the responses across the rest of the interviews and focus groups, was used to derive two measures for each SHN.

First, the total percentage of all primary data sources that mentioned themes associated with a SHN at any point was calculated. This number was taken to represent how broadly a given SHN was recognized within the community. Next, the percentage of times a theme associated with a SHN 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 percentage of each health need was selected as one of the top three health needs by survey respondents was also included.

These three measures were then re-scaled so that the SHN with the maximum value for each measure equaled one, and all other SHNs had values appropriately proportional to the maximum value. The re-scaled 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 36: Resources available to meet health needs.

Organization Information			Significant Health Needs (SHNs)											Other Health Needs
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Mental/ Behavioral Health and Substance Use Services	Access to Quality Primary Care Health Services	Increased Community Connections	System Navigation	Active Living and Healthy Eating	Injury and Disease Prevention and Management	Access to Functional Needs	Safe and Violence-Free Environment	Access to Specialty and Extended Care	Healthy Physical Environment	Access to Dental Care and Preventive Services
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								
ApexCare	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	
Cal Aggie Christian Association	95616	www.cahouse.org	x			x							x	

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California Accountable Communities for Health Initiative (CACHI)	95605	cachi.org	x		x				x					
Calvary Baptist Church	95695	www.calvarywoodland.org	x			x								
Calvary Chapel of Woodland	95776	www.ccwoodland.org	x			x								
Calvary Chapel of Zamora	95698	(530) 476-3582	x			x					x			
Capay Valley	95627	www.capayvalleyvision.net	x					x		x	x			
Capay Valley Health and Community Center	95627	healthycapayvalley.org		x	x		x		x			x		x
Catholic Charities	95695	www.ccyoso.org	x			x				x				
Center For Land-Based Learning	95776	www.landbasedlearning.org						x					x	
Children's Home Society of California – Woodland	95695	www.chs-ca.org	x			x	x							
Church on The Rock	95695	www.cotrwoodland.org	x			x								
Citizens Who Care	95695	www.findhelp.org/provider/citizens-who-care-inc--davis-ca/6551345896620032?postal=95616				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								
Countryside Community Church	95627	www.espartocountrysidechurch.org	x			x							x	
Davis Community Church	95616	dccpres.org												

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Davis Community Meals and Housing	95616	daviscommunitymeals.org	x			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		
Davis Senior Housing	95616	www.cityofdavis.org/city-hall/parks-and-community-services/senior-services/information-assistance	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	(707) 678-2113	x											
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						
Fourth and Hope	95776	fourthandhope.org	x								x			
Gender Health Center	95817	genderhealthcenter.org	x	x	x		x				x			

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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								
Head Start – Yolo County Office of Education	95605, 95616, 95627, 95695	www.ycoe.org/Divisions/Educational-Services/Early-Childhood-Education/Early-Head-StartHead-StartState-Preschool/index.html	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								
Keaton's Child Cancer Alliance	95661	childcancer.org				x			x					
Knights Landing One Health Center	95645	knightslandingonehealth.com			x		x							
Legal Services of Northern California – Health Rights	95814	lsnc.net/office/lsnc-health-program	x											
Lilliput Children's Services (New name Wayfinder Family Services)	95695	www.wayfinderfamily.org	x											
Madison Migrant Center (Child Development Centers)	95834	cdicdc.org						x			x			

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Meals on Wheels Yolo County	95776	mowyolo.org	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							
New Season Community Development Corporation	95627	www.newseasoncdc.com				x					x		x	
Northern California Children's Therapy Center	95695	www.ctchelpskids.org			x		x					x		
Northern Valley Indian Health	95695	www.nvih.org/locations/woodland		x	x				x		x	x		x
Outa Sight Group	95695	www.outasightgroup.com	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			
Salvation Army	95695	www.salvationarmyusa.org	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			

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Short Term Emergency Aide Committee (STEAC)	95616	steac.org	x			x								
Shriner's Hospital for Children – Northern California	95817	www.shrinerschildrens.org/locations/northern-california			x		x		x			x		
Slavic American Chamber of Commerce	95816	www.slavicamericanchamber.org	x			x					x			
Slavic Assistance Center	95825	www.slavicassistance.org	x											
Soroptimist International of Woodland	95776	www.soroptimistofwoodland.org	x			x								
Spero Medical Pregnancy Support Group	95695	sperodonor.org/services-referrals/client-services/	x	x		x	x							
St. John's Retirement Village	95695	www.stjohnsretirementvillage.org	x	x	x			x			x	x		
St. Luke's Episcopal Church	95695	stlukeswoodland.org	x			x								
St. Lukes Episcopal Church	95695	stlukeswoodland.org/about	x			x								
St. Vincent de Paul Sacramento Council	95816	www.svdp-sacramento.org	x			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					

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The Californian Assisted Living and Dementia Care	95695	thecalifornian.net	x	x	x			x			x	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										
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									
Wayfinder Family Services	95695	www.wayfinderfamily.org	x											
West Sacramento Community Center	95691	www.cityofwestsacramento.org/residents				x		x						
Wind Youth Services	95817	www.windyouthservices.org	x	x							x			
Winter's Healthcare Foundation	95694	www.wintershealth.org		x	x		x	x	x					x

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Woodland Community Care Car	95776	www.communitycarecar.org								x				
Woodland Community College Foundation	95776	wcc.yccd.edu/foundation	x											
Woodland Community College Student Health Center	95776	wcc.yccd.edu/student/health-center		x	x									
Woodland Community Senior Center	95776	cityofwoodland.org/351/Seniors	x		x	x		x				x		
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/what-would-woodland-do	x	x	x									
YMCA of Superior California	95695	www.ymcasuperiorcal.org				x		x			x			
Yocha Dehe Wintun Nation	95606	yochadehe.gov				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 Cares	95618	yolocares.org										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			

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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			
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		

Limits and Information Gaps

Study limitations for this CHNA included obtaining secondary quantitative data specific to population subgroups and assuring 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.

Finally, though this CHNA was conducted with an equity focus, data that point to differences among population subgroups that are more “upstream” focused are not as available as those data that detail the resulting health disparities. Having a clearer picture of early-in-life opportunity differences experienced among various populations that result in later-in-life disparities can help direct community health improvement efforts for maximum impact.

Your voice matters!

To request a printed copy free of charge and to provide comments about this Community Health Needs assessments, email DignityHealthGSSA_CHNA@dignityhealth.org.

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