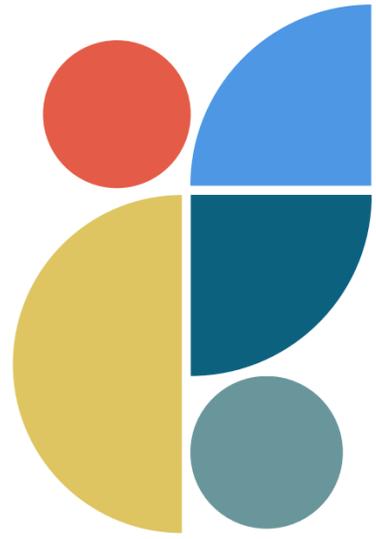


# Healthy Yolo

*Looking upstream to address Yolo County's  
Significant Health Needs: reducing health disparities  
through the Social Determinants of Health*

**June 5, 2024**

Speaker: Rebeca Tryon, MS  
HHSA Program Manager  
Yolo County HHSA Public Health Branch  
[rebecca.tryon@yolocounty.org](mailto:rebecca.tryon@yolocounty.org)



# Learning Agenda and Objectives

- **Discuss the role of County Public Health in addressing health outcomes**
- **Understand the influence of the Social Determinants of Health on Health Outcomes and Disparities**
- **Learn how the collective impact approach is being applied in Yolo County to improve health outcomes**

# OUR AGENCY

Yolo County Health & Human Services Agency



## 5 Branches

### Public Health

Director: Brian Vaughn



**73 Staff**

**28 Programs**

### Health Equity

Health in All Policies

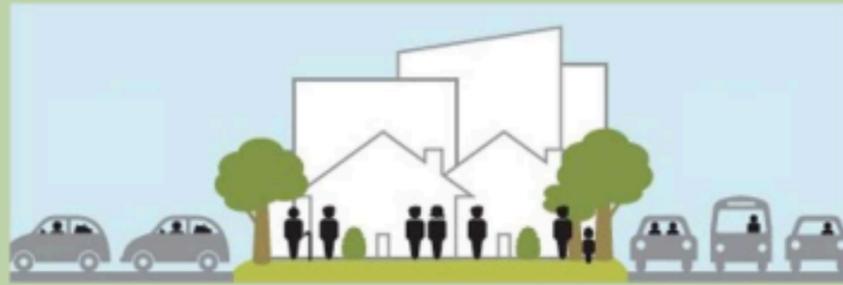
Farmworker Equity Initiatives

CHA/CHIP/Healthy Yolo

**Healthy Communities Initiative**



# A Tale of Two Neighborhoods



## SOUTHEAST DAVIS (Neighborhood 1)

Life Expectancy: 84.4 years

**9%** living in poverty

Extensive parks and green space

**77%** at least bachelor's degree

**\$63,750** median personal income

**74%** management occupations

**64%** housing occupied by owner

**5%** of population is African American

**17%** of population is foreign-born



## WEST CAP – WEST SACRAMENTO (Neighborhood 2)

Life Expectancy: 69.2 years

**41%** living in poverty

Limited parks and green space

**10%** at least bachelor's degree

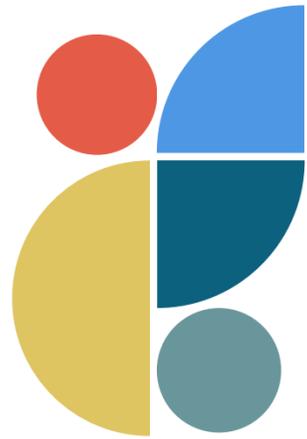
**\$24,425** median personal income

**27%** management occupations

**24%** housing occupied by owner

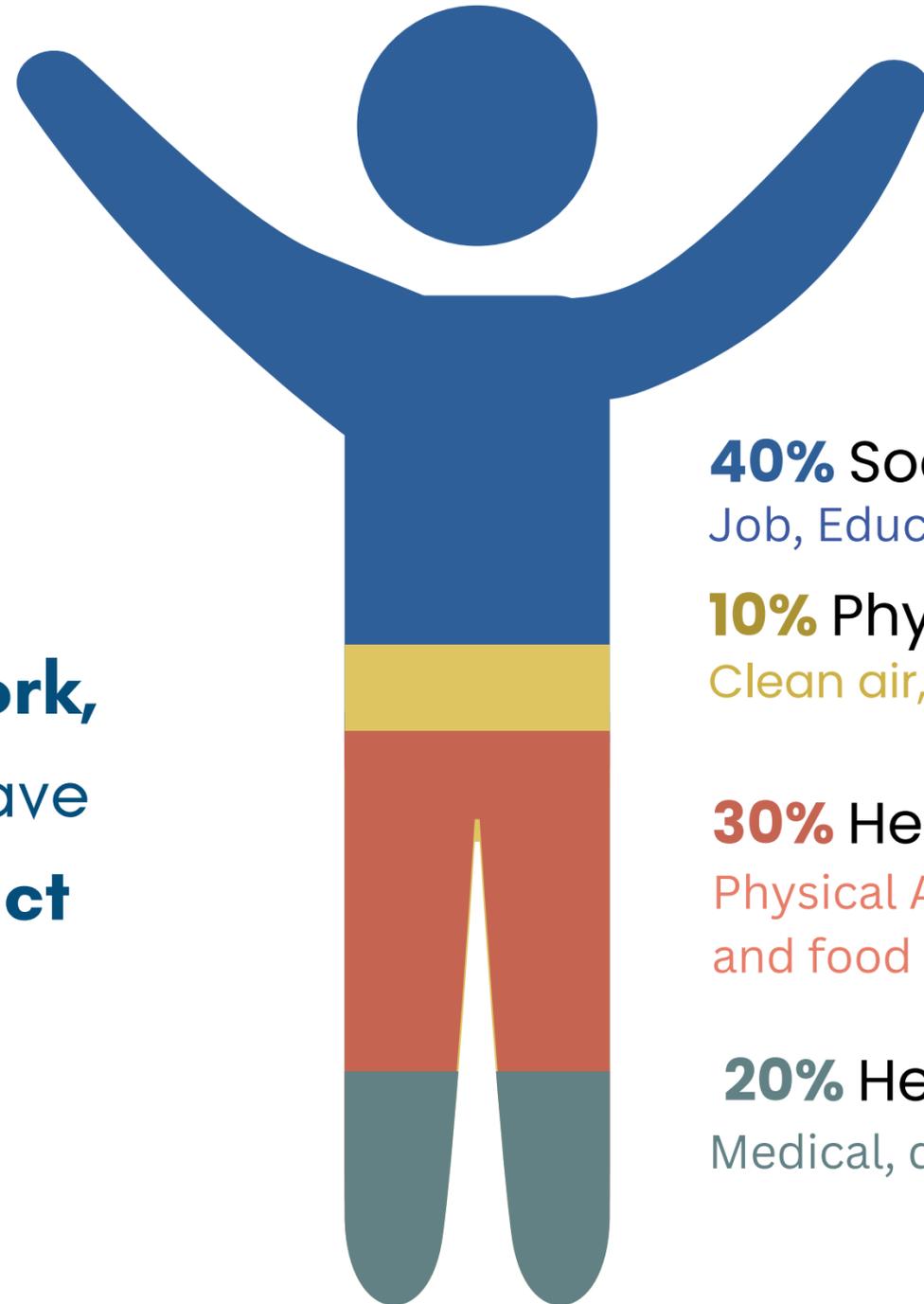
**12%** of population is African American

**27%** of population is foreign-born



# The Social Determinants of Health

**Where we live, work, learn, and play** have the **biggest impact** on our health & wellbeing.

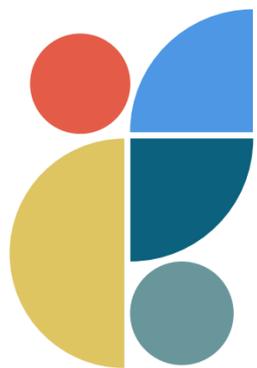


**40%** Socioeconomics Factors  
Job, Education, income, etc.

**10%** Physical Environment  
Clean air, safe housing, green space, etc.

**30%** Health Behaviors  
Physical Activity, Substance use, Nutrition and food behaviors, etc.

**20%** Healthcare  
Medical, dental, behavioral healthcare



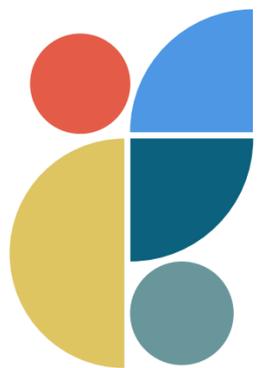
# Health Disparities

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

Health disparities result from multiple factors, including

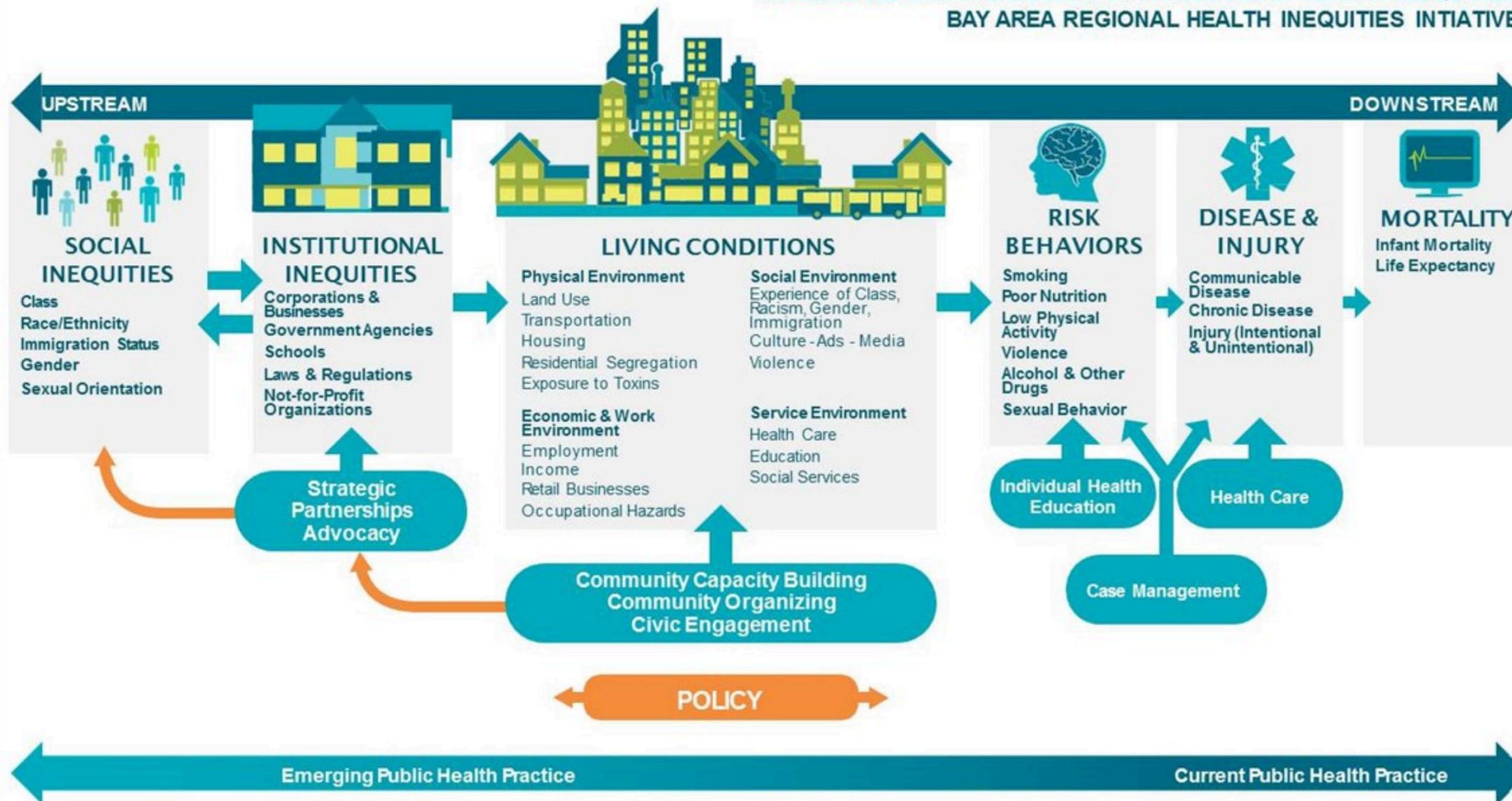
- Poverty
- Environmental threats
- Inadequate access to health care
- Individual and behavioral factors
- Educational inequalities





# THE BARHII FRAMEWORK

A PUBLIC HEALTH FRAMEWORK FOR REDUCING HEALTH INEQUITIES  
BAY AREA REGIONAL HEALTH INEQUITIES INITIATIVE





# Addressing Upstream Causes of Health Disparities has the biggest long-term impact



## UPSTREAM: Community Change

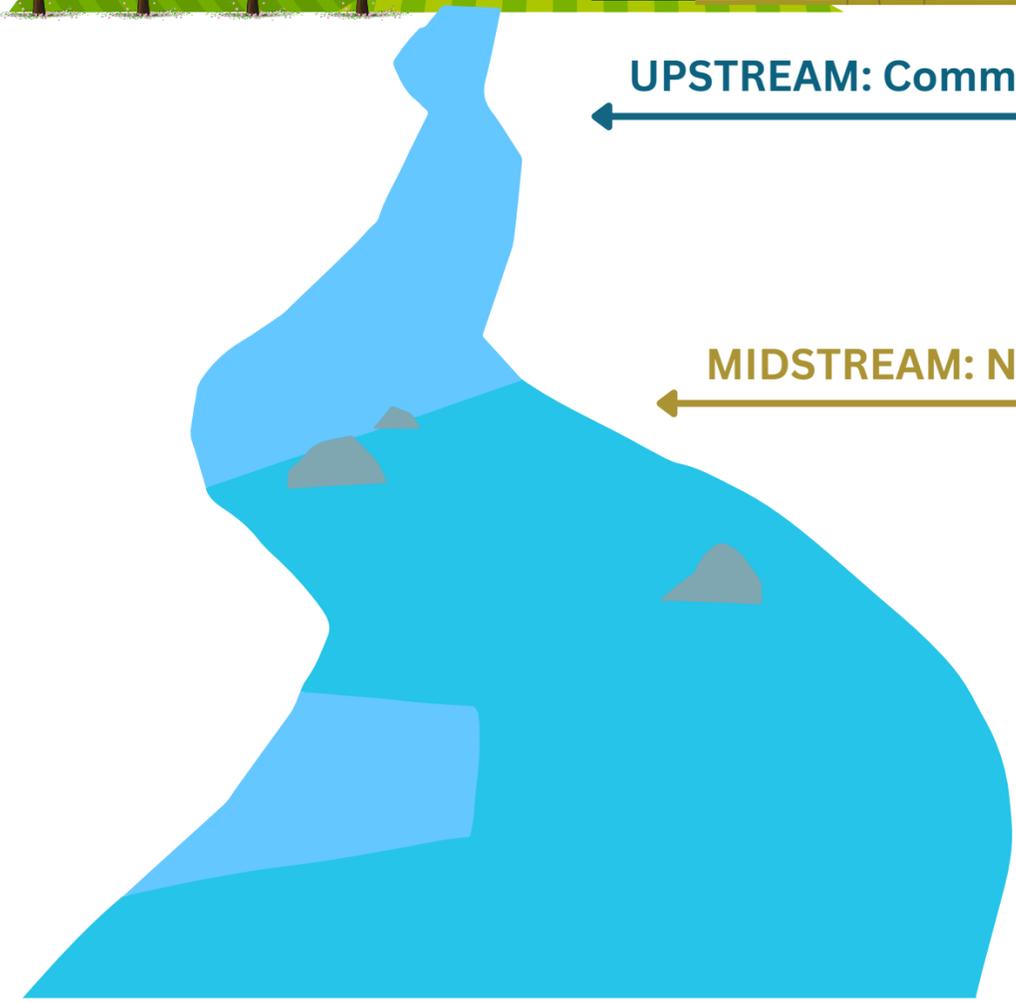
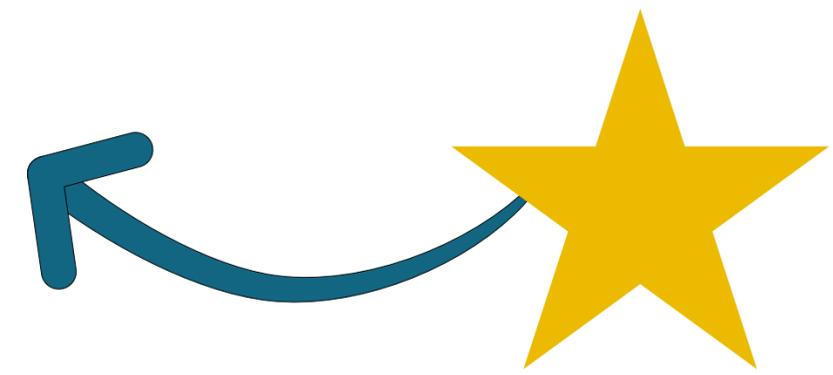
**UPSTREAM:** policies, laws and system change to create the conditions for communities to thrive

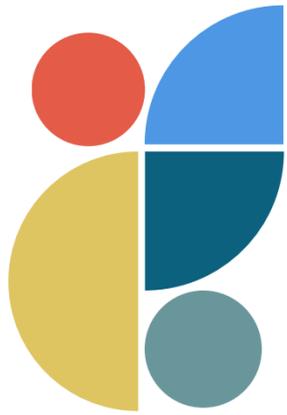
## MIDSTREAM: Neighborhood Change

**MIDSTREAM:** system coordination, neighborhood or agency level change; targeted at specific groups or services

## DOWNSTREAM: Individual Change

**DOWNSTREAM:** Individual or small group level changes; programs or services for individuals





# Public Health Leads Upstream Equity Workin Yolo County

- **Community Health Assessment**
- **Community Health Improvement Plan**
  - Every 3-5 years
- **Public Health Strategists role**
- **Health in all Policies (HiaP) training**



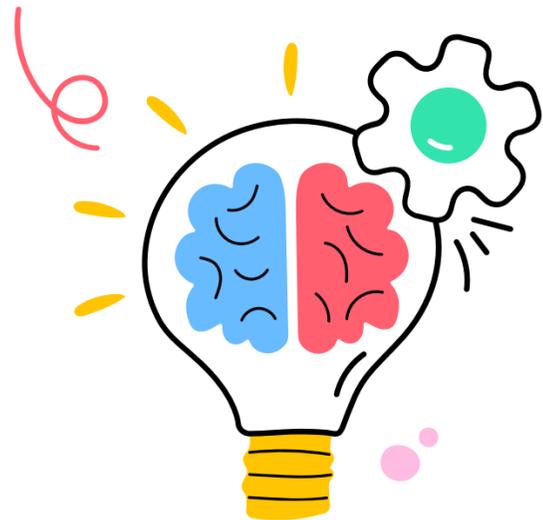
# Identifying & Addressing the County's Significant Health Needs (SHNs)



**Primary &  
Secondary  
Data**



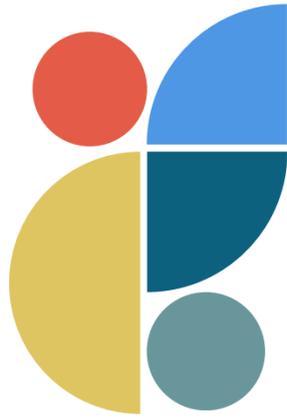
**Community  
Survey**



**Expertise and  
interpretation**



**Partner &  
Community  
Collaboration**



# 2023 Prioritized Significant Health Needs

## Significant Health Needs (SHNs)



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



**Access to Specialty and Extended Care**



**Access to Mental/Behavioral Health and Substance Use**



**Increased Community Connections**



**Injury and Disease Prevention and Management**



**Safe and Violence-free Environment**



**Active Living and Healthy Eating**



**Access to Functional Needs**



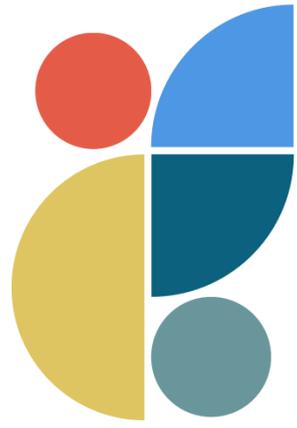
**Access to Quality Primary Care Health Services**



**Access to Dental Care and Preventative Services**



**System Navigation**



# Multi-sectoral collaboration is **essential** to addressing root causes of SHNs

## CHIP Partners



# Community Health Improvement Plan

## 2 Priority Areas

### HEALTH PRIORITY AREA

Service Environment

GOAL



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

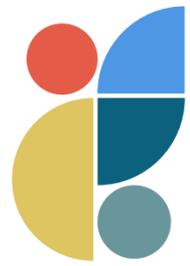
### HEALTH PRIORITY AREA

Risk Behaviors

GOAL



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

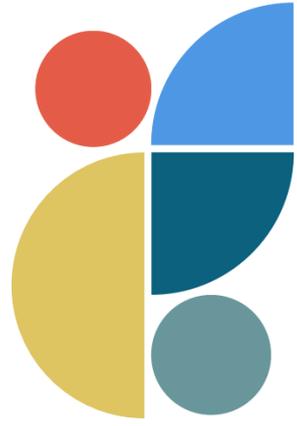


# Community Health Improvement Plan

***VISION:***

***Yolo County is a Place  
Where Everyone Can Thrive***





# How Do We Achieve this Vision?

**Working Collaboratively  
& Focusing Upstream**





# Upstream Investments: Focusing on the early years

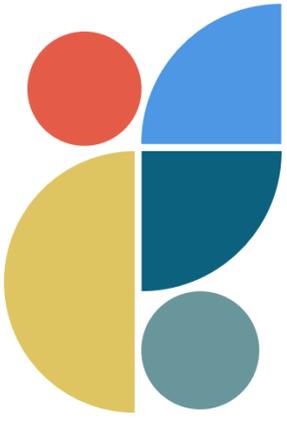
**VISION:** Yolo County is a Place Where Everyone Can **Thrive**

Addressing Root Causes of Poor Health & Wellbeing by going upstream in the life span: Children & Youth

Improving systems & conditions for families

Identifying indicators of upstream change for children & youth

**Kindergarten  
Ready:  
Thrive  
at  
5**

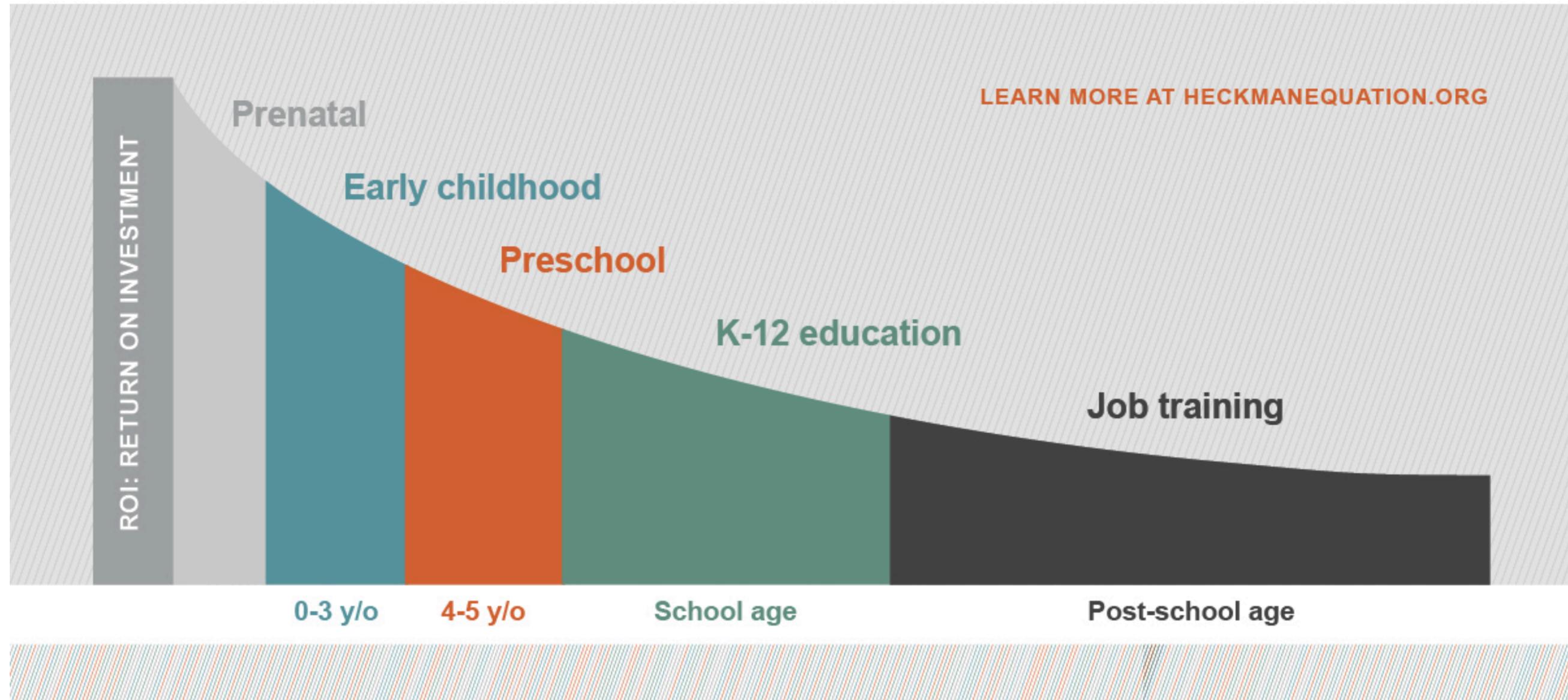


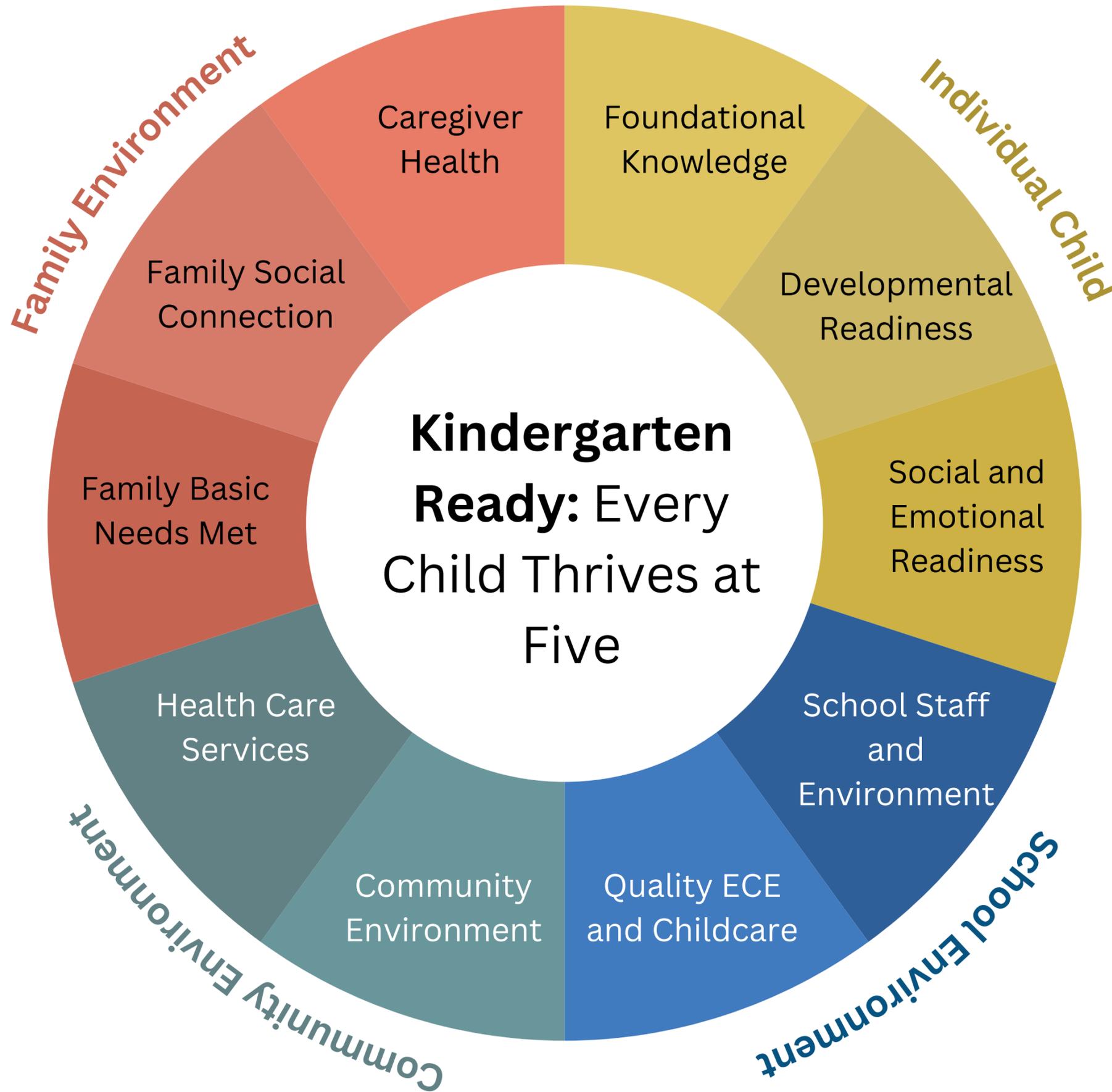
# Investing upstream in the lifespan has exponential impact on long-term outcomes



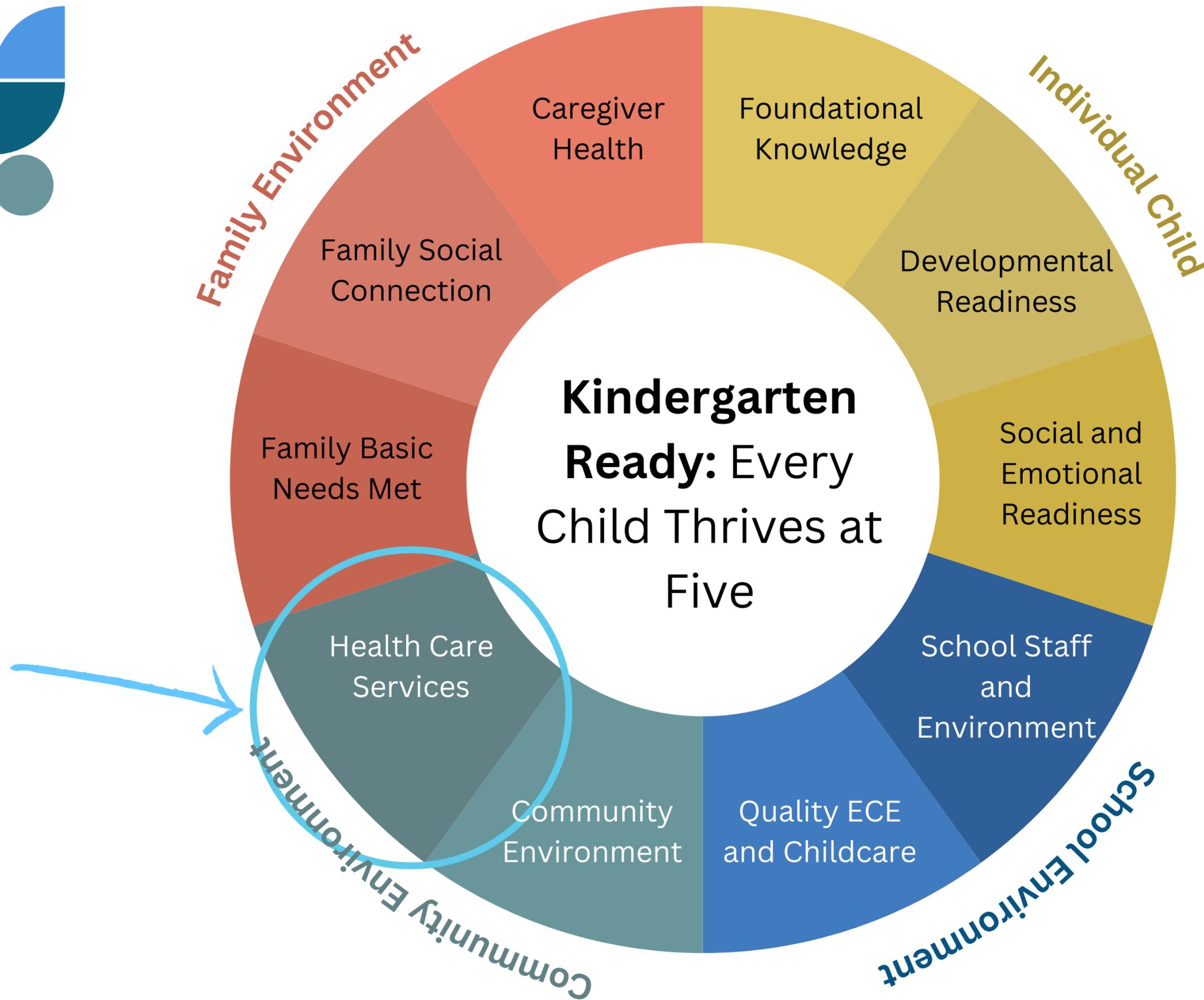
Return on Investment

**Economic impact of investing in early childhood learning.**

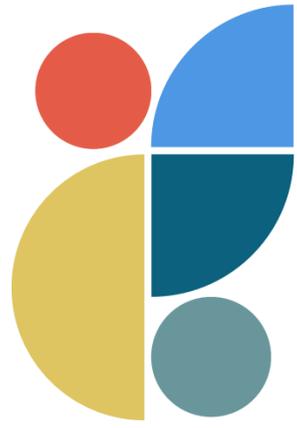




**Kindergarten readiness is an early life indicator of social, economic, community, and educational conditions**

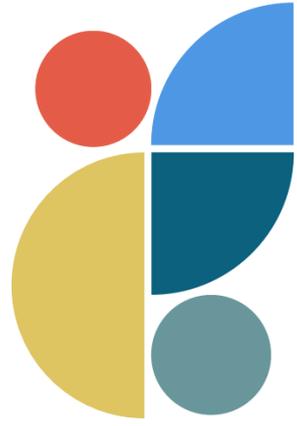


**The SDOH  
Have a Huge  
Influence on  
Children  
Thriving at 5**



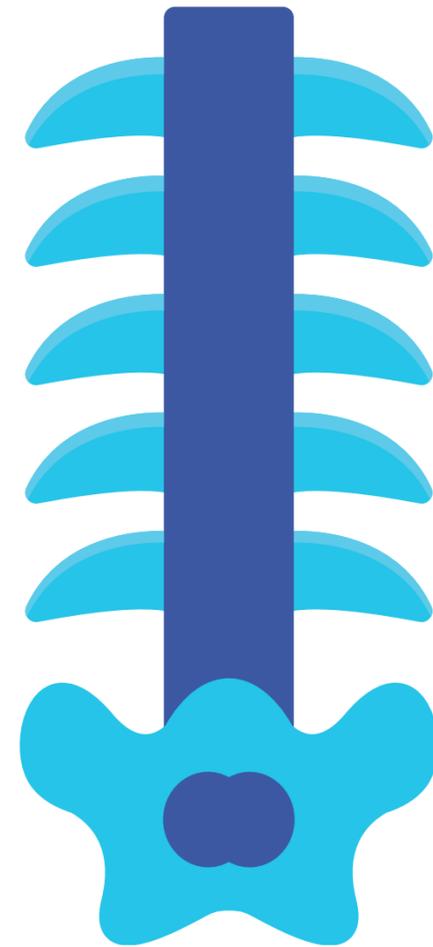
# Collective Impact Approach: Creating Alignment & Focus





# Creating Alignment: Healthy Yolo Collaborative

**HHSA Public  
Health to Be the  
Backbone of the  
Collaborative**

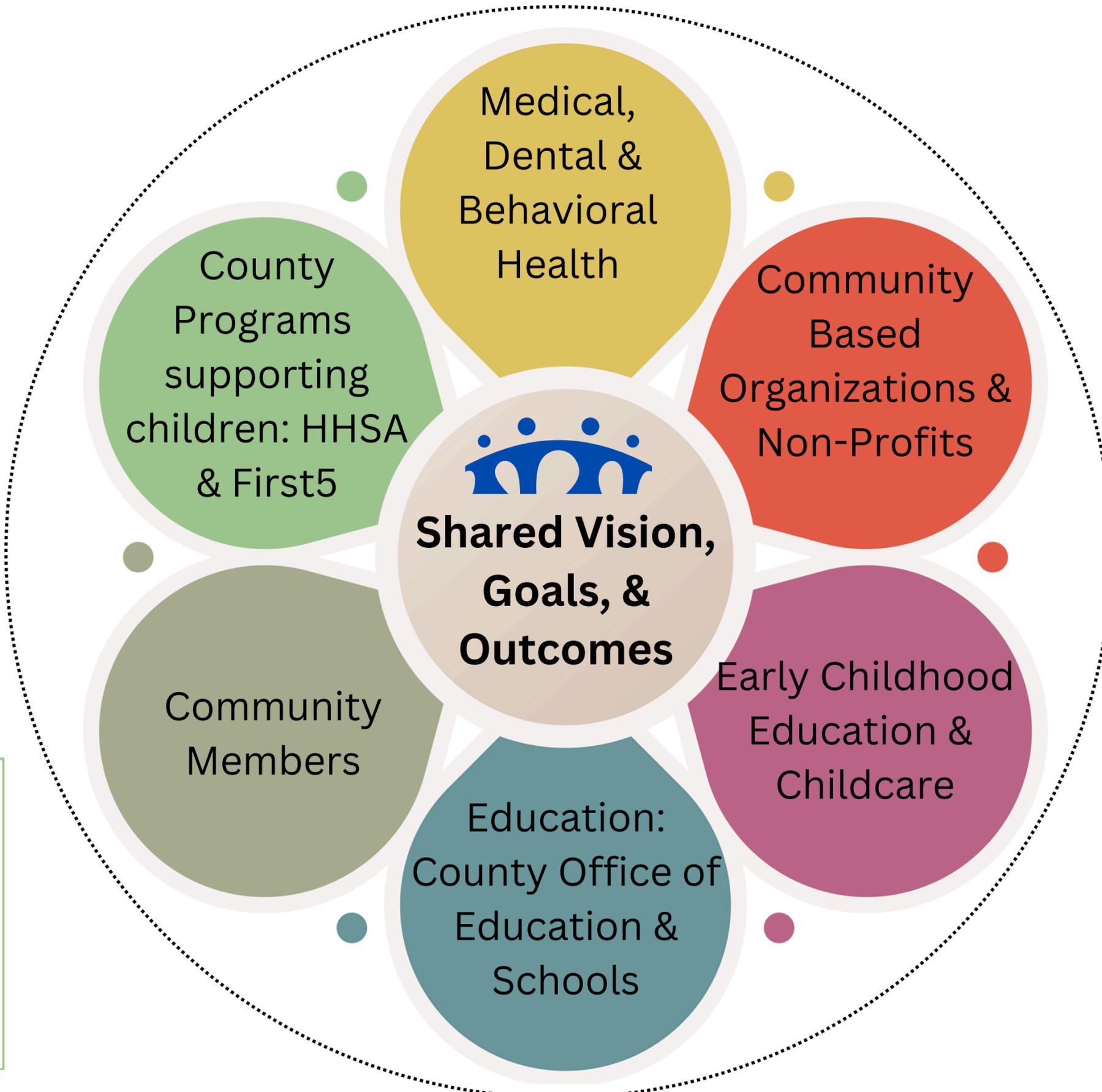




# Healthy Yolo

*Partnering to create the conditions and systems to improve health and wellbeing for Yolo County*





**HHSA BACKBONE**  
Administrative leadership, data, tracking progress, supporting partners

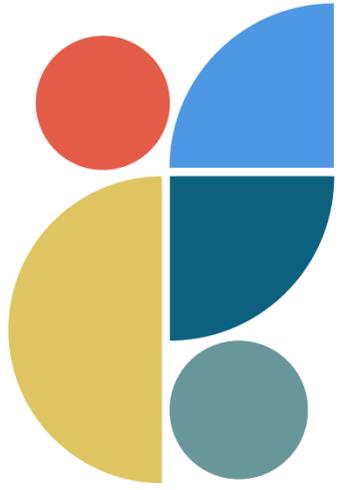
**Partnering strategically using the collective impact model to improve long-term outcomes and address root causes of disparities**



# Focus:

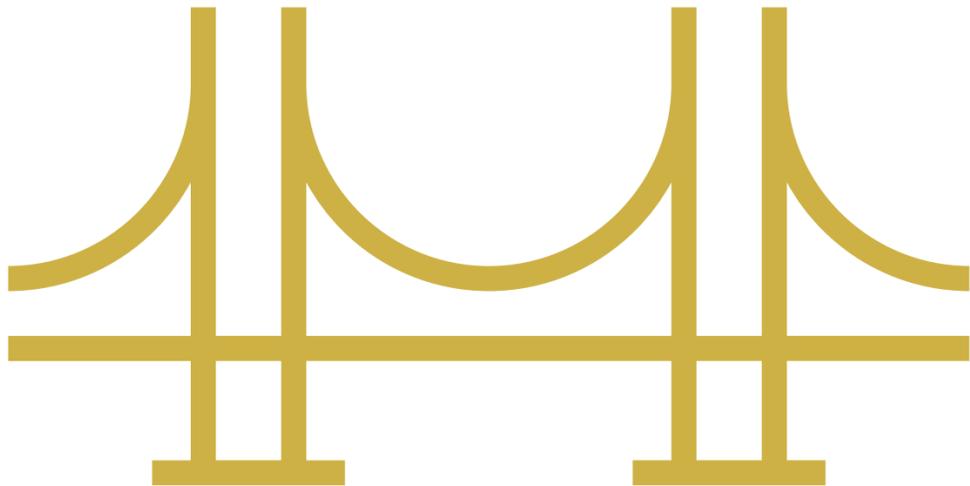
# Mile deep, inch wide approach

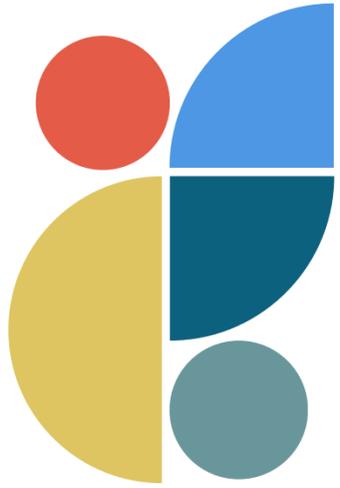




**Mile deep & an inch  
wide:**

**Geographic Focus:**  
West Sacramento





# Why West Sacramento?

**4 of the lowest scoring  
census tracts on the HPI**

**14.3% Poverty Rate**

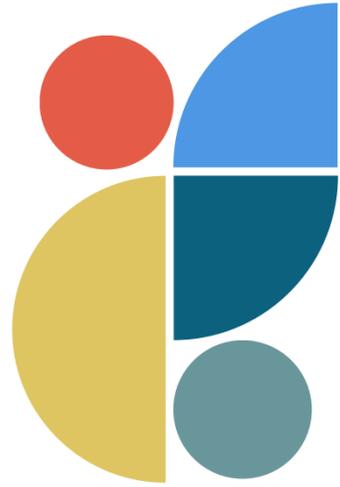
State: 12.2 %

Woodland: 9.2%

**Diverse Communities of Color:**

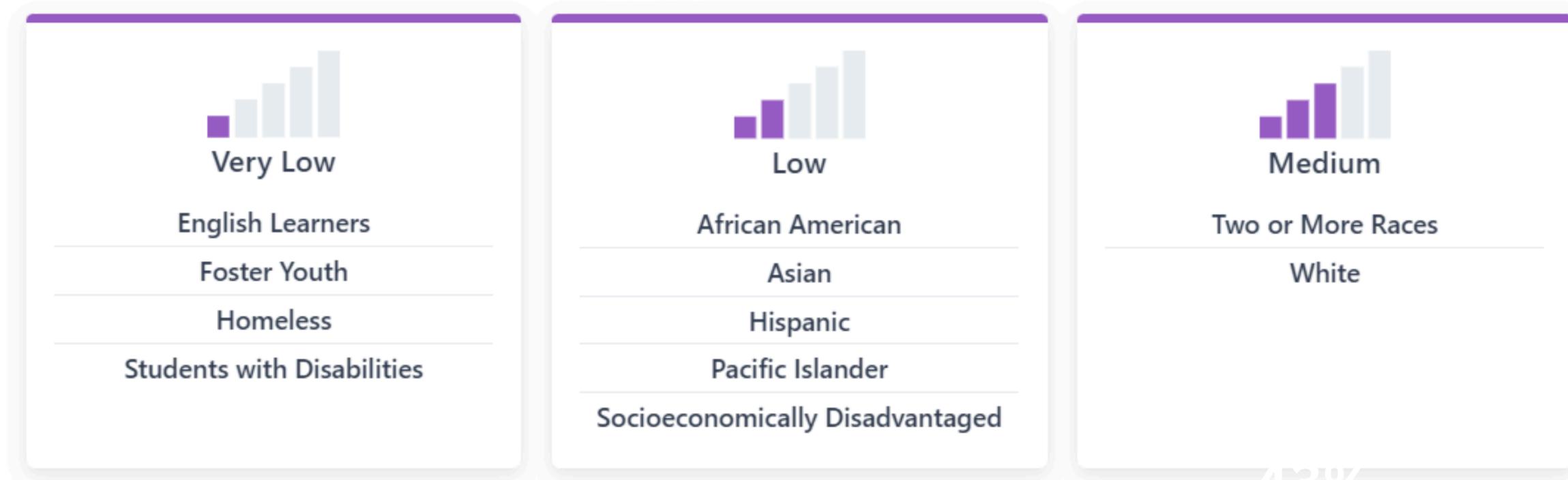
**4.9% AA/ 32% Latino/ 12.3% Asian**

**Grown refugee community**



# Population Matters

Different outcomes are apparent for different groups



Addressing inequities early strengthens opportunities for **all** youth to **thrive.**

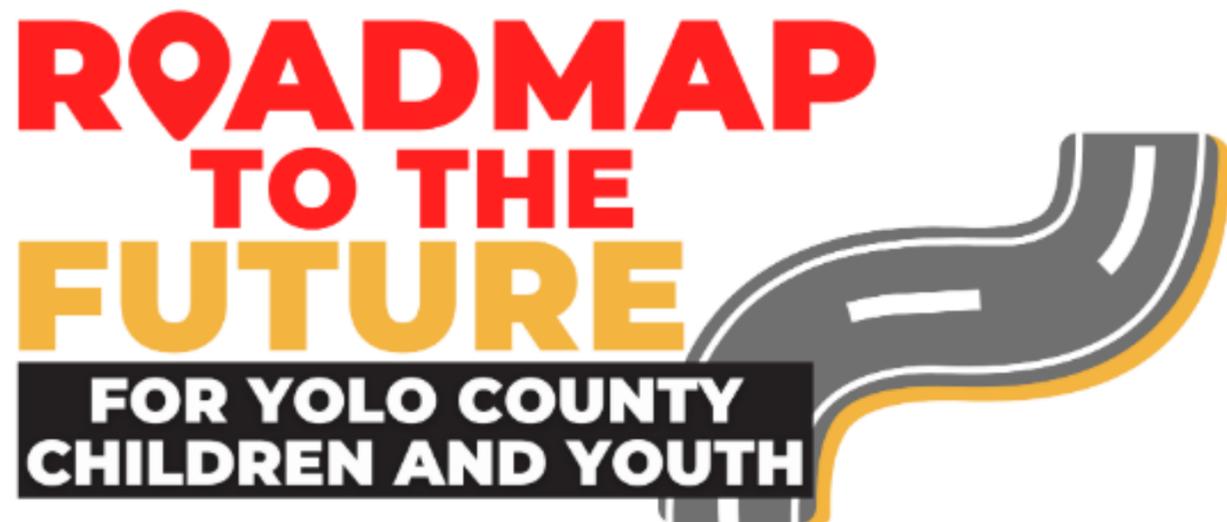
Performance Level for Language Arts Standards  
2022-2023 (Washington Unified)



# Why West Sacramento? Opportunities and Assets



## The CHILD Project: Road to Resilience



*Because Every Child Deserves Every Chance*

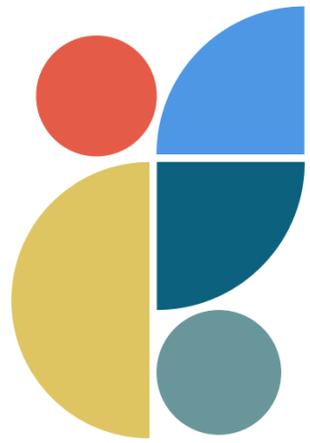


# Healthy Yolo Next Steps & timeline

**September- October  
2024:** Healthy Yolo  
Collaborative launch

**June - August 2024:**  
System Mapping with  
Partners & Community

**October- December  
2024:**  
Identify key  
outcomes/intervention  
strategies/metrics



# Thank You!



## Healthy Yolo Backbone Team

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Samar Lichtenstein

Kanat Tibet

Duncan McMartin

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**Web:** [healthyyolo.org](http://healthyyolo.org)