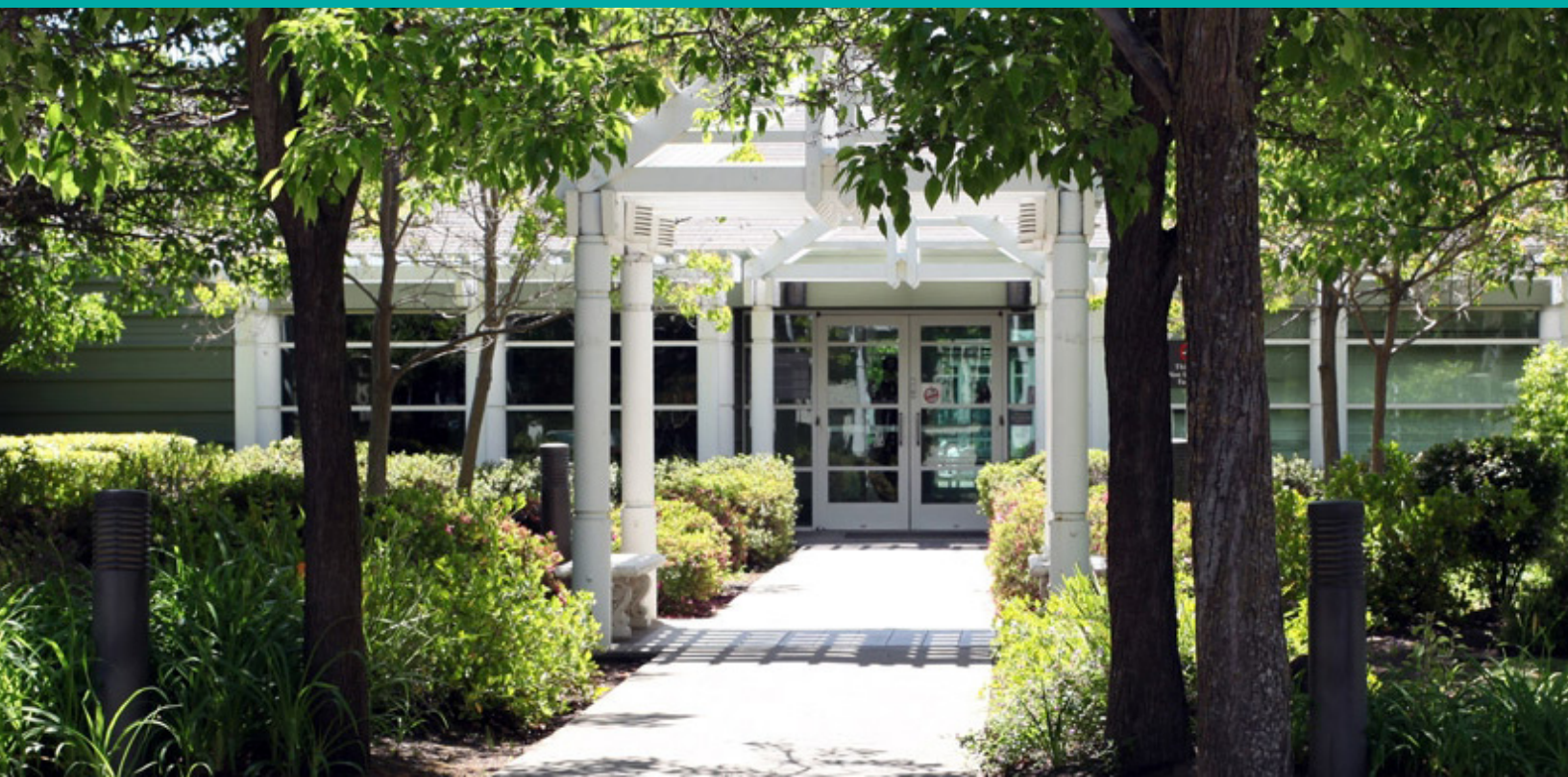
SUTTER MEDICAL CENTER SACRAMENTO AND SUTTER CENTER FOR PSYCHIATRY

2022 Community Health Needs Assessment



Mission

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

Vision

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

Community Health Needs Assessment

The following report contains Sutter Medical Center Sacramento and Sutter Center for Psychiatry's 2022 Community Health Needs Assessment (CHNA), which is used to identify and prioritize the significant health needs of the communities we serve. CHNAs are conducted once every three years, in collaboration with other healthcare providers, public health departments and a variety of community organizations. This CHNA report guides our strategic investments in community health programs and partnerships that extend Sutter Health's not-for-profit mission beyond the walls of our hospitals, improving health and quality of life in the areas we serve.

2022 Community Health Needs Assessment

Conducted on behalf of

Dignity Health Affiliates

Mercy Hospital of Folsom
1650 Creekside Dr.
Folsom, CA 95630

Mercy San Juan Medical Center
6501 Coyle Ave.
Carmichael, CA 95608

Mercy General Hospital
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Sacramento, CA 95819

Methodist Hospital of Sacramento
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Sacramento, CA 95826

UC Davis Health

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Sacramento, CA 95817

Conducted by

COMMUNITY HEALTH INSIGHTS

January 2022

Acknowledgments

We are deeply grateful to all those who contributed to this community health needs assessment. Many dedicated healthcare practitioners, community health experts and members of various social service organizations serving the most vulnerable members of the Sacramento County community gave their time and expertise as key informants and survey respondents to help guide and inform the findings of the assessment. Specific survey respondents that expressed a desire to be recognized in the report are listed in the technical section of the report in the Community Service Provider Survey section. Many community residents also participated and volunteered their time to tell us what it is like to live in the community and shared the challenges they face trying to achieve better health. We also appreciate the collaborative spirit of Kaiser Permanente and their willingness to share the information they gathered while conducting a similar health assessment in the Sacramento area. Last, we especially acknowledge the sponsors of this assessment, Dignity Health, Sutter Health, and UC Davis Health, who, using the results of these assessments, continuously work to improve the health of the communities they serve. To everyone who supported this important work, we extend our heartfelt gratitude.

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

- Dale Ainsworth, PhD, MSOD, Managing Partner of Community Health Insights and Associate Professor of Public Health at California State University, Sacramento
- Heather Diaz, DrPH, MPH, Managing Partner of Community Health Insights and Professor of Public Health at California State University, Sacramento
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- Traci Van, Senior Community Impact Specialist of Community Health Insights

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Report Summary

Purpose

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs of the greater Sacramento area community. The priorities identified in this report help to guide nonprofit hospitals' community health improvement programs and community benefit activities as well as their collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and in California, Senate Bill 697) that nonprofit hospitals conduct a community health needs assessment at least once every three years. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com) and was a collaboration between Dignity Health, Sutter Health, and UC Davis Health. Multiple other community partners collaborated to conduct the CHNA.

Community Definition

The definition of the community served included most portions of Sacramento County and a small portion of western El Dorado County, California. Regarded as a highly diverse community, Sacramento County covers 994 square miles and is home to approximately 1.5 million residents. The CHNA uses this definition of the community served, as this is the primary geographic area served by the seven nonprofit hospitals that collaborated on this CHNA.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[1] This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 87 community health experts, social service providers, and medical personnel. Additionally, 57 community residents or community service provider organizations participated in 11 focus groups across the service area. Finally, 31 community service providers responded to a Community Service Provider (CSP) survey about health need identification and prioritization.

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

At the time that this CHNA was conducted, the COVID-19 pandemic was impacting communities across the United States, including Sacramento County. The process for conducting the CHNA remained

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

fundamentally the same. However, adjustments were made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the quantitative data analysis and COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs (SHNs). This began by identifying 12 potential health needs (PHNs). These PHNs were compiled from previous CHNAs conducted across Northern California over a period of approximately six years. Data were analyzed to discover which, if any, of the PHNs were present in the service area. After identifying those PHNs that were present as significant health needs, they were prioritized based on rankings provided by primary data sources described above. Qualitative data were also analyzed to detect *emerging health needs*; that is, a health need that emerged from data analysis beyond those 12 PHNs identified in previous CHNAs. (For detailed accounting of how health needs were identified and ranked see the Technical Section of the 2022 CHNA).

Because of the dynamic and evolving nature of health needs, identified significant health needs change over time and new needs may appear. For this assessment, one new emergent health need was identified: Health Equity: Equal Access to Opportunities to be Healthy (#6). Furthermore, data analysis identified three potential health needs (PHNs) that met the threshold of significance to be included in this assessment that were not identified in the previous assessment conducted in 2019. These were: Increased Community Connections (#9), Access to Dental Care and Preventative Services (#12), and Healthy Physical Environment (#13).

List of Prioritized Significant Health Needs

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

1. Access to Mental/Behavioral Health and Substance-Use Services
2. Access to Basic Needs Such as Housing, Jobs, and Food
3. Access to Quality Primary Care Health Services
4. System Navigation
5. Injury and Disease Prevention and Management
6. Health Equity: Equal Access to Opportunities to be Healthy (new, emergent)
7. Active Living and Healthy Eating
8. Safe and Violence-Free Environment
9. Increased Community Connections (new from PHNs)
10. Access to Specialty and Extended Care
11. Access to Functional Needs (transportation and physical mobility)
12. Access to Dental Care and Preventive Services
13. Healthy Physical Environment

Communities of Concern

Communities of Concern are geographic areas in Sacramento County, defined by ZIP Code boundaries, 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. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. For this assessment, 50 ZIP Codes in total were included across all of Sacramento County; of these, 19 met the requirements to be included as a Community of Concern. The total population within these communities was approximately 700,000 residents, representing 44% of the total population in the service area.

Conclusion

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

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 significant health needs 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 the nonprofit hospitals listed below. Collectively, these nonprofit hospitals serve Sacramento County, California, located in the north-central part of the state. The total population of the service area was 1,564,555 in 2020. The CHNA was conducted over a period of 10 months, beginning in March 2021 and concluding in December 2021. This CHNA report meets requirements of the Patient Protection and Affordable Care Act (and in California, of Senate Bill 697) that nonprofit hospitals conduct a CHNA at least once every three years.

<table>
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<tr><td>Mercy Hospital of Folsom
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</table>

Community Health Insights (www.communityhealthinsights.com) conducted the CHNA. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. Community Health Insights has conducted health assessments for healthcare systems and local health departments over the previous decade. For this assessment Community Health Insights collaborated with Harder+Company, a consulting firm working on behalf of Kaiser Permanente to conduct a CHNA in the Sacramento region, by sharing primary data.

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

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.[3] 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. The 2019 CHNA was made public for Sutter Health in Sacramento County. The community was invited to provide written comments on the CHNA reports and Implementation Strategies both within the documents and on the web site where they are widely available to the public. The email address of SHCB@sutterhealth.org was created to ensure comments were received and responded to. No written comments were received.

Data Used in the CHNA

Data collected and analyzed included both primary (or qualitative data) and secondary (or quantitative data). Primary data included 42 interviews with 87 community health experts, 11 focus groups conducted with a total of 57 community residents or community-facing service providers, and 31 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 subcounty 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 significant health needs. 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 and exercise and tobacco, alcohol, and drug use; 2) clinical care, including access to quality care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, and neighborhood safety; and 4) physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 68 different health outcome and health factor indicators were collected for the CHNA.

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

Data Analysis

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the 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 significant health need.

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

Findings – Sacramento County

Prioritized Significant Health Needs – Sacramento County

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the service area. In all, 13 significant health needs were identified. After these were identified, they were prioritized based on an analysis of primary data. The findings are displayed in Figure 1.

Because of the dynamic and evolving nature of health needs, identified significant health needs change over time. For this assessment, an emergent health need was identified: Health Equity: Equal Access to Opportunities to be Healthy (#6). Furthermore, data analysis identified three significant health needs that were not identified in the previous assessment conducted in 2019. These were: Increased Community Connections (#9), Access to Dental Care and Preventative Services (#12), and Healthy Physical Environment (#13).

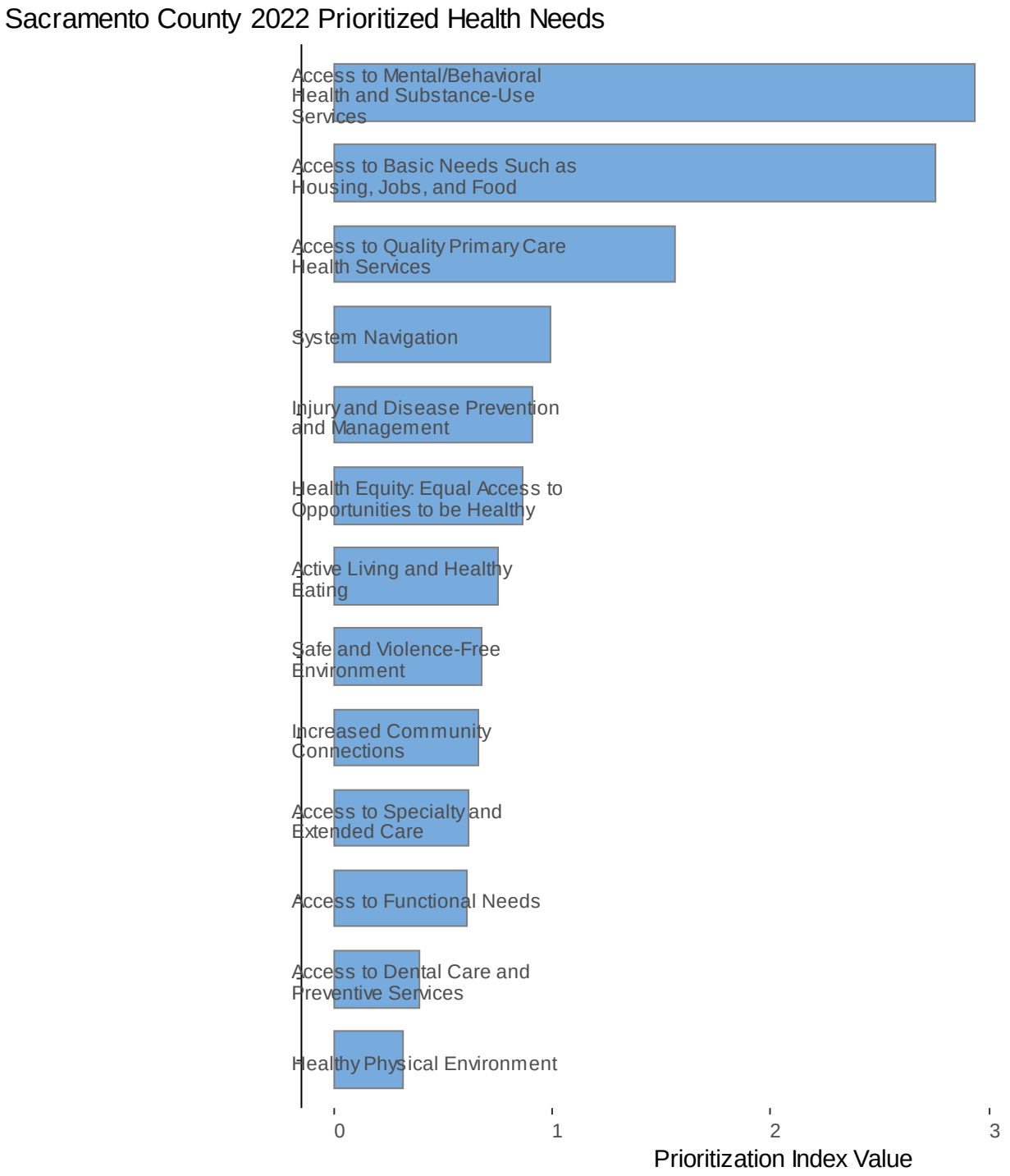

Figure 1: Prioritized, Significant Health Needs for Sacramento County

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 values of these measures for each significant health need.

Table 1: Health need prioritization inputs for Sacramento County

Prioritized Health Needs	% of Key Informants and Focus Groups Identifying Health Need	% of Times Key Informants and Focus Groups Identified Health Need as a Top Priority	% of Community Survey Respondents that Identified Health Need as a Top Priority
Access to Mental/Behavioral Health and Substance-Use Services	88%	33%	77%
Access to Basic Needs Such as Housing, Jobs, and Food	94%	26%	74%
Access to Quality Primary Care Health Services	72%	12%	32%
System Navigation	53%	4%	23%
Injury and Disease Prevention and Management	69%	4%	3%
Health Equity: Equal Access to Opportunities to be Healthy	69%	4%	~
Active Living and Healthy Eating	50%	4%	6%
Safe and Violence-Free Environment	28%	1%	26%
Increased Community Connections	44%	4%	6%
Access to Specialty and Extended Care	34%	1%	16%
Access to Functional Needs	53%	1%	0%
Access to Dental Care and Preventive Services	19%	2%	10%
Healthy Physical Environment	6%	1%	16%

~ Because this was an emergent health need it was not included as a potential health need; therefore, the Community Service Provider survey did not list this health need as an option for respondents to select.

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.[4] 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.

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

Health Need Tables Description

The significant health needs are described below, in prioritized order. The secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health need. (Each indicator is listed in the order it appears in the data set listed in the technical report). Qualitative themes that emerged during analysis are also provided in each table. A full listing of all quantitative indicators can be found in the technical section of this report. Secondary indicators that were associated with a health need were assigned to that health need based on expert review. Furthermore, some indictors were assigned to multiple health needs.

1. 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.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.</td><td rowspan="2">The following indicators performed worse in Sacramento County when compared to state averages.</td></tr>
<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>• There are not enough mental health and substance-use services (treatment centers, detox centers, crisis stabilization units, etc.) in the community.
• Additional mental health services are needed specifically for youth, including trauma informed care.
• It is difficult to enter and navigate the mental health system.
• The stigma and around seeking mental health services prevents some from seeking care.
• The cost of mental health services is prohibitive; treatment options for those on Medi-Cal are severely limited.
• The mental health system is siloed from the healthcare system. Need better integration between these two.
• There has been a notable increase in mental health issues in the community due to the pandemic.</td><td>• It’s difficult for people to navigate for mental, behavioral, and substance-use services.
• Additional services for those who are homeless and experiencing mental, behavioral, and/or substance use services are needed.
• There aren’t enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).</td><td>• Life Expectancy
• Premature Age-Adjusted Mortality
• Premature Death
• Suicide Mortality
• Poor Mental Health Days
• Frequent Mental Distress
• Poor Physical Health Days
• Frequent Physical Distress
• Poor or Fair Health
• Excessive Drinking
• Drug Induced Death
• Adult Smoking
• Primary Care Shortage Area
• Mental Health Care Shortage Area
• Medically Underserved Area
• Firearm Fatalities Rate
• Disconnected Youth</td></tr>
</table>

2. 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[5] 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.[6]

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.</td><td rowspan="2">The following indicators performed worse in Sacramento County when compared to state averages.</td></tr>
<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>• Housing access and affordability is a critical issue in the area; subsidies and rent control are needed.
• Housing vouchers are stigmatized; many landlords will not accept them.
• Housing costs continue to escalate; barriers to secure housing continue to rise.
• The number of people experiencing homelessness has significantly increase.
• The community must address income inequality.
• The working poor do not qualify for many services; they are unable to access needed healthcare and mental health services.
• More investment is needed in poorer communities.
• Many jobs do not pay a living wage, nor do they offer employees health insurance.
• Food insecurity is a critical issue for many in the area.</td><td>• Lack of affordable housing is a significant issue in the area.
• The area needs additional low-income housing options.
• Services for homeless residents in the area are insufficient.</td><td>• Infant Mortality
• Child Mortality
• Life Expectancy
• Premature Age-Adjusted Mortality
• Premature Death
• Hypertension Mortality
• Diabetes Prevalence
• Low Birthweight
• Poor Mental Health Days
• Frequent Mental Distress
• Poor Physical Health Days
• Frequent Physical Distress
• Poor or Fair Health
• Asthma ED Rates
• Asthma ED Rates for Children
• Drug Induced Death
• Adult Obesity
• Limited Access to Healthy Foods
• Food Environment Index
• Medically Underserved Area
• COVID-19 Cumulative Full Vaccination Rate
• Disconnected Youth
• Third Grade Reading Level
• Third Grade Math Level
• Children in Single-Parent Households
• Children Eligible for Free Lunch</td></tr>
</table>

[5] McLeod, S. 2014. Maslow's Hierarchy of Needs. Retrieved from: http://www.simplypsychology.org/maslow.html
[6] See: 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 by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
		• Children in Poverty • Median Household Income

3. Access to Quality Primary Care Health Services

Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners and physician assistants, 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 by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
• The community needs more providers that accept Medi-Cal. • Community members with high-deductible health plans avoid care as they cannot afford the out-of-pocket costs. • Having health insurance does not guarantee one can access the healthcare system. • The cost of medications creates a barrier for many. • The healthcare system seems to be built to serve more affluent populations; it is difficult for lower income residents to access quality healthcare. • Physicians cannot afford to care for those on Medi-Cal; reimbursement must increase. • A single-payer system is needed to improve access and quality healthcare for all. • There is no comprehensive health plan for the undocumented.	• Patients have difficulty obtaining appointments outside of regular business hours. • Wait times for appointments are excessively long. • Quality health insurance is unaffordable.	• Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Alzheimer's Disease Mortality • Influenza and Pneumonia Mortality • Diabetes Prevalence • Low Birthweight • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Colorectal Cancer Prevalence • Breast Cancer Prevalence • Lung Cancer Prevalence

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
		• Asthma ED Rates • Asthma ED Rates for Children • Primary Care Shortage Area • Medically Underserved Area • Preventable Hospitalization • COVID-19 Cumulative Full Vaccination Rate

4. System Navigation

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
• There is too much "red tape" when trying to access social services. • Many community members struggle with how to access and navigate the healthcare system. • The healthcare system is fragmented, making navigation a challenge for many. • System navigation challenges are compounded by language barriers. • There needs to be better linkages between primary and specialty care.	• People may not be aware of the services they are eligible for. • It is difficult for people to navigate multiple, different healthcare systems. • Dealing with medical and insurance paperwork can be overwhelming.	• No quantitative indicators were used in analysis for this health need. Currently, there are no indicators available that describe the degree of navigation difficulty for Sacramento County residents.

[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 by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
• More culturally informed and linguistically appropriate navigators, social workers, and case managers are needed to meet the demand for services. • Systems are particularly challenging for those with mental health and development challenges.		

5. 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 by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
• Preventative services have been avoided due to the pandemic. • Health education is critical to prevention, and its relatively inexpensive. • Community health education must be expanded; move away from reactive care and into prevention. • Health information needs to be linguistically appropriate. • The community must increase access to preventative healthcare screenings.	• There isn't really a focus on prevention around here. • There should be greater focus on chronic disease prevention (e.g., diabetes, heart disease). • 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,	• Infant Mortality • Child Mortality • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Suicide Mortality • Unintentional Injuries Mortality • Alzheimer's Disease Mortality • Diabetes Prevalence • Low Birthweight • Poor Mental Health Days • Frequent Mental Distress

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
	Spanish-speaking residents, elderly, LGBTQ individuals, and immigrants).	• Frequent Physical Distress • Poor or Fair Health • Asthma ED Rates • Asthma ED Rates for Children • Excessive Drinking • Drug Induced Death • Adult Obesity • Physical Inactivity • Chlamydia Incidence • Adult Smoking • COVID-19 Cumulative Full Vaccination Rate • Firearm Fatalities Rate • Motor Vehicle Crash Death • Disconnected Youth • Third Grade Reading Level • Third Grade Math Level

6. Health Equity: Equal Access to Opportunities to be Healthy

Health equity is defined as everyone having the same opportunity to be as healthy as possible.[8] Health is largely determined by social factors. Some communities have resources needed to be healthy readily available to them, while others do not. Many people experience barriers as the result of policies, practices, systems, and structures that discriminate against certain groups. Individual and community health can be improved by removing or mitigating practices that result in health inequity. While health equity is described as a specific health need in this assessment, it is recognized that equity plays a role in each health need 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 by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
• Healthcare services including mental health and specialty care	• This health need was not a previously identified health need and emerged during	• This health need was not previously identified; therefore, no quantitative indicators were

[8] Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. *What is Health Equity?* (May 1, 2017). The Robert Wood Johnson Foundation. Retrieved: https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
are unaffordable to low-income populations. • There is prejudice and limited cultural competence in the healthcare system. • The pandemic has shined a light on structural inequities that lead to health disparities. • Language barriers lead to health inequities. • Structured racism is a public health crisis. • Over-policing is an issue in some communities. • Income and education inequity are pervasive in the community. • There is little to no investment in communities of color. • Hate crimes against the Asian American Pacific Islander (AAPI) community have continued to increase. • Representation is important; the community needs individuals of color in healthcare provider and administration roles.	data analysis. Therefore, the Community Service Provider survey did refer to this health need.	associated with this health need during data analysis.

7. 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 are often overloaded with fast food and other establishments where unhealthy food is sold. They are often challenged with food insecurity, lacking the means to consistently secure food for themselves or their families. When families rely on food pantries and school meals alone, these may not always provide sufficient nutrition for maintaining health.

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>• Healthy foods are not as affordable as less healthy foods.
• Many parts of the community are not built to support a healthy lifestyle—no sidewalks or bike paths.
• Our communities are “car-centric,” and result in less physical activity
• Food deserts are found throughout the Sacramento area.</td><td>• There are food deserts where fresh, unprocessed foods are not available.
• Food insecurity is an issue here.
• Students need healthier food options in school.
• The built environment doesn’t support physical activity (e.g., neighborhoods aren’t walkable, roads aren’t bike friendly, or parks are inaccessible.
• The community needs nutrition education programs.
• Homelessness in parks or other public spaces deters their use.
• Grocery store options in the area are limited.</td><td>• Life Expectancy
• Premature Age-Adjusted Mortality
• Premature Death
• Stroke Mortality
• Diabetes Mortality
• Heart Disease Mortality
• Hypertension Mortality
• Cancer Mortality
• Diabetes Prevalence
• Poor Mental Health Days
• Frequent Mental Distress
• Poor Physical Health Days
• Frequent Physical Distress
• Poor or Fair Health
• Colorectal Cancer Prevalence
• Breast Cancer Prevalence
• Asthma ED Rates
• Asthma ED Rates for Children
• Adult Obesity
• Physical Inactivity
• Limited Access to Healthy Foods
• Food Environment Index</td></tr>
</table>

8. 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) physical safety is essential. Feeling unsafe affects the way people act and react to everyday life occurrences. Furthermore, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.[9]

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

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>There are not enough safe places for youth to play outdoors.
Some women stay in abusive marriages due to the stigma of being divorced.
There is growing violence and gang activity in parts of the community.
More investment needed in violence prevention, including teams that respond to gang violence.
Lack of affordable housing forces many to move into unsafe environments.
Hate crimes against the Asian American Pacific Islander (AAPI) community continue to rise; many go unreported due to fear of retaliation.
Pedestrian safety continues to be an issue; the Stockton and Fruitridge intersection is known for being dangerous for pedestrians.</td><td>People feel unsafe because of crime.
There are not enough resources to address domestic violence and sexual assault.
Human trafficking is an issue in the area.</td><td>Life Expectancy
Premature Death
Hypertension Mortality
Poor Mental Health Days
Frequent Mental Distress
Frequent Physical Distress
Poor or Fair Health
Physical Inactivity
Homicide Rate
Firearm Fatalities Rate
Violent Crime Rate
Motor Vehicle Crash Death
Disconnected Youth</td></tr>
</table>

9. 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.”[10] Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

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

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>• Community engagement is needed to rebuild trust between communities and the medical and scientific community.
• Healthcare, mental health, and social services are siloed; these need more integration.
• The community needs more grassroots efforts to build support for disenfranchised groups.
• The community needs to embed social workers in the police department.
• Substance-use organizations need to be more integrated in local emergency departments.
• Isolation has increased during the pandemic, especially for certain groups, e.g., seniors.
• The loss of trust in government and sense of fragmentation among communities has grown during the pandemic.
• “People heal better when they can come together.”
• Federally Qualified Health Centers (FQHCs) can be hubs to link patients to other services, but often fall short.</td><td>• Health and social service providers operate in silos; cross-sector connections are needed.
• Building community connections doesn’t seem like a focus in the area.
• Relations between law enforcement and the community need to improve.
• City and County leaders need to work together.</td><td>• Infant Mortality
• Child Mortality
• Life Expectancy
• Premature Age-Adjusted Mortality
• Premature Death
• Stroke Mortality
• Diabetes Mortality
• Heart Disease Mortality
• Hypertension Mortality
• Suicide Mortality
• Unintentional Injuries Mortality
• Diabetes Prevalence
• Low Birthweight
• Poor Mental Health Days
• Frequent Mental Distress
• Poor Physical Health Days
• Frequent Physical Distress
• Poor or Fair Health
• Excessive Drinking
• Drug Induced Death
• Physical Inactivity
• Primary Care Shortage Area
• Mental Health Care Shortage Area
Medically Underserved Area
• Preventable Hospitalization
• COVID-19 Cumulative Full Vaccination Rate
• Homicide Rate
• Firearm Fatalities Rate
• Violent Crime Rate
• Disconnected Youth
Children in Single-Parent Households</td></tr>
</table>

10. Access to Specialty and Extended Care

Extended care services, which include specialty care, are services 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 to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>• More dialysis services are needed in the community; existing services cannot keep up with demand.
• There are excessive wait-times for appointments to see specialists.
• The community needs more specialists willing to serve low-income residents.
• Specialty services are unaffordable to the low-income community.
• Long-term care is expensive and unavailable for many low-wage earners.
• Many have to travel outside of the community to see specialists.
• Medi-Cal insurance plans have a narrow set of services available, with high out-of-pocket costs.
• For those without insurance that need specialty care, it can take months to get enrolled in Medi-Cal.
• Hospice care is needed for the homeless community.</td><td>• Wait times for specialists' appointments are excessively long.
• The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care).
• People have to travel to reach specialists.
• Too few specialty and extended care providers accept Medi-Cal.</td><td>• Infant Mortality
• Life Expectancy
Premature Age-Adjusted Mortality
• Premature Death
• Stroke Mortality
• Chronic Lower Respiratory Disease Mortality
• Diabetes Mortality
• Heart Disease Mortality
• Hypertension Mortality
• Cancer Mortality
• Alzheimer's Disease Mortality
• Diabetes Prevalence
• Poor Mental Health Days
• Frequent Mental Distress
• Poor Physical Health Days
• Frequent Physical Distress
• Poor or Fair Health
• Lung Cancer Prevalence
• Asthma ED Rates
• Asthma ED Rates for Children
• Drug Induced Death
• Preventable Hospitalization</td></tr>
</table>

11. Access to Functional Needs – Transportation and Physical Disability

Functional needs include indicators related to transportation and disability. 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 by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
• Access to transportation to receive medical services is a challenge for many. • Public transportation is a challenge as it does not serve many parts of the community. • Public transportation shuts down in the evenings leaving many without transportation after business hours. • There are limited transportation options for lower-income populations that cannot afford a car. • There are limited public transportation options for those living with disabilities.	• There were no responses by those who participated in the survey to the question of how this health need expressed itself in the Sacramento County community.	• Disability • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Adult Obesity • COVID-19 Cumulative Full Vaccination Rate

12. Access to Dental Care and Preventive Services

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
• Dental providers offer minimal services to Medi-Cal enrollees. • Many Medi-Cal enrollees are treated in emergency departments for dental issues because they cannot access a dentist. • There are excessive wait times for children to see a dentist.	• There aren't enough providers in the area that accept Medi-Cal. • Dental care is unaffordable, even if you have insurance. • There aren't enough dental providers in the area. • The lack of access to dental care leads to overuse of emergency departments. • Quality dental services for kids are limited.	• Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Dentists per 100K of population

13. Healthy Physical Environment

Living in a pollution-free environment is essential for health. Individual health is determined by a number of 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 other factors such as one's lifestyle, heredity, or access to medical services.[11]

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>• Illegal dumping is an issue in parts of the community.
• Landlords that do not maintain properties should be held legally accountable.</td><td>• Low-income housing is substandard.
• The air quality contributes to high rates of asthma.
• Wildfires in the region harm the air quality.</td><td>• Infant Mortality
• Life Expectancy
• Premature Age-Adjusted Mortality
• Premature Death
• Chronic Lower Respiratory Disease Mortality
• Hypertension Mortality
• Cancer Mortality
• Frequent Mental Distress
• Frequent Physical Distress
• Poor or Fair Health
• Colorectal Cancer Prevalence
• Breast Cancer Prevalence
• Lung Cancer Prevalence
• Asthma ED Rates
• Asthma ED Rates for Children
• Adult Smoking
• Air Pollution - Particulate Matter
• Drinking Water Violations</td></tr>
</table>

Description of Community Served – Sacramento County

Sacramento County was the designated area served by the participating hospitals for the 2022 CHNA. This definition of the community served was used because this is the primary geographic area served by the seven nonprofit hospitals that collaborated on this CHNA.

Sacramento County was incorporated in 1850, and much of its rich history was influenced by the discovery of gold in the area in 1848. The county is home to California's capital city, Sacramento. The county includes seven incorporated cities, with the City of Sacramento being the largest. Covering a geographic area of 994 square miles and home to approximately 1.56 million residents, Sacramento

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

County sits at the northern portion of California's Central Valley, situated along the Interstate 5 corridor. The area consists of both urban and rural communities and includes the Sacramento–San Joaquin Delta that connects the Sacramento River to the San Francisco Bay through some 700 miles of winding waterways. Sacramento is a diverse community, and a report ranked the city the fourth most racially and ethnically diverse large city in the US.[12]

Sacramento County has over 30 cities, census-designated places, and unincorporated communities that include neighborhoods with rich heritages such as Oak Park, known as Sacramento's first suburb, to newer communities such as the City of Rancho Cordova, incorporated in 2003. Sacramento County ranks as California's 26th most overall healthy county among the 58 in the state.[13] The area is served by a number of healthcare organizations, including those that collaborated on this assessment.
In this CHNA, two additional ZIP Codes from El Dorado County, a neighboring county east of Sacramento, were included to capture the portion of the community served by Mercy Hospital of Folsom, located near the border of these two counties. With some exceptions, findings described in this report are organized both at the county level and, as detailed later in this report, by designated regions within the county.

Regions of Sacramento County

Sacramento County has a population of over 1.5 million residents and is comprised of many communities, each with unique attributes and characteristics that influence community health. In an effort to capture these unique attributes for this CHNA, the county was subdivided into four distinct regions to allow for more detailed data collection and analysis. These regions are shown in Figure 2. Primary data collection included interviews with community health experts and community residents that lived and worked in the communities within these regions, thus providing a richer and more robust understanding of each community's unique features. When available, secondary data were collected and analyzed within each region as well.

[12] McCann, A. (May 3, 2018). *2018's Most Diverse Cities in the U.S*. Washington DC: WalletHub. (Retrieved: https://wallethub.com/edu/most-diverse-cities/12690/#methodology).
[13] See: https://www.countyhealthrankings.org/app/california/2021/rankings/outcomes/overall

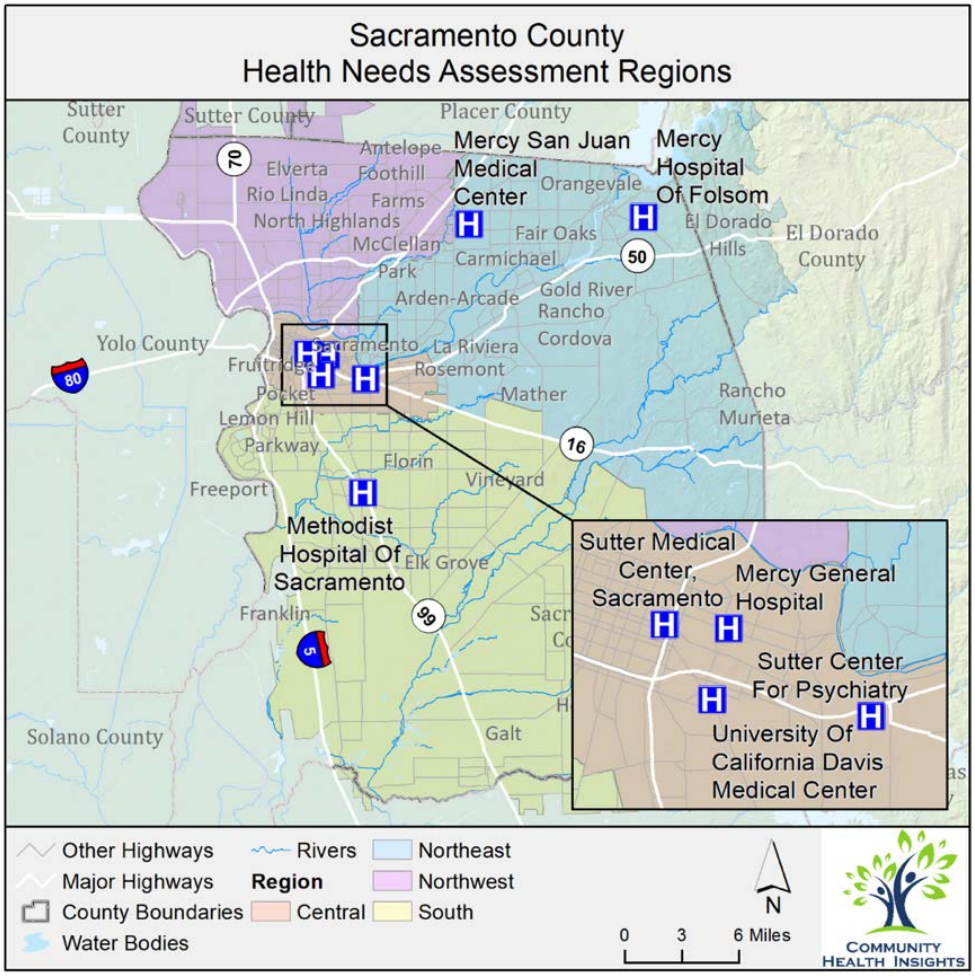


Figure 2: Map of Sacramento County regions

The following sections give more detailed information and findings that are unique to each region. To begin, a description of each community is presented, followed by sociodemographic information for each ZIP Code in the region. These are followed by displays of two informative findings of the CHNA: 1) the California Healthy Places Index, and 2) Communities of Concern within each region.

California Healthy Places Index

The California Healthy Places Index (HPI) is an index based on 25 health-related measures for communities across California.[14] 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. 2021. The California Health Places Index (HPI): About. Retrieved 26 July 2021 from https://healthyplacesindex.org/about/.

Communities of Concern

Communities of Concern are geographic areas in Sacramento County that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA methodology because, after the 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). For this assessment, a total of 50 ZIP Codes were included across all of Sacramento County; of these, 19 met the requirements to be included as a Community of Concern. The total population within these communities was approximately 700,000 residents, representing 44% of the total population in the service area.

Findings for Each Region

Prioritized Significant Health Needs by Region

While a goal of the assessment was to identify the health needs of Sacramento County as a whole, it was also important to identify and prioritize health needs for the multiple communities within the county. To accomplish this data were collected and analyzed at two levels. Health need identification and prioritization for the county overall was based on all qualitative data collected across the county. However, health need identification and prioritization for each region was based on qualitative data collected only within that particular region. This resulted in differences between the health needs identified and prioritized for the entire county and those identified and prioritized for each region.

After each region's health needs were identified, they were prioritized based on an analysis of primary data sources that mentioned the health need as a priority. The findings are displayed in Table 2.

Table 2: Ranking of prioritized significant health needs for each region and Sacramento County

Significant Health Need	North-east	North-west	Central	South	*County*
Access to Mental/Behavioral/ Substance-use Services	1	1	2	2	*1*
Access to Basic Needs Such as Housing, Jobs, and Food	2	2	1	1	*2*
Access to Quality Primary Care Health Services	3	3	3	3	*3*
System Navigation	4	7	4	4	*4*
Injury and Disease Prevention and Management	5	5	6	7	*5*
Health Equity: Equal Access to Opportunities to be Healthy	7	9	5	5	*6*
Active Living and Healthy Eating	9	6	11	9	*7*
Safe and Violence-Free Environment	11	11	7	6	*8*
Increased Community Connections	6	4	8	8	*9*
Access to Specialty and Extended Care	10	10	10	10	*10*
Access to Functional Needs	8	8	9	11	*11*
Access to Dental Care and Preventive Services	13	12	12	13	*12*
Healthy Physical Environment	12	13	13	12	*13*

Northeast Region

The Northeast Region is comprised of 15 ZIP Codes and is home to 540,637 residents. Table 3 displays population characteristics for each ZIP Code. Data are compared to the state and county rates, and ZIP Codes that negatively varied or performed poorly when compared to either the county or state benchmark are highlighted.

Table 3: Population characteristics for each ZIP Code located in Northeast Region

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95608	62,539	30.8	41.7	$64,059	14.7	6.5	6.0	6.7	38.7	15.4
95610	46,305	31.8	36.5	$61,461	12.1	6.2	6.8	10.0	41.6	15.9
95621	41,740	29.0	39.7	$63,214	10.8	6.2	4.7	9.3	36.5	15.5
95628	40,855	25.7	45.4	$86,181	8.4	4.7	4.7	5.5	31.6	11.1
95630	78,159	38.2	40.7	$114,405	5.6	3.1	2.5	6.2	28.2	7.6
95655	4,156	44.8	36.4	$86,486	13.5	8.6	2.7	6.7	33.9	7.5
95662	32,172	23.6	41.2	$80,434	7.9	5.4	5.2	6.6	34.9	13.7
95670	55,558	46.8	36.7	$67,015	13.1	7.3	6.3	10.0	37.2	13.7
95683	6,326	24.2	50.1	$108,338	4.5	3.5	0.6	3.1	25.5	12.7
95742	12,472	55.7	34.5	$132,636	6.2	6.4	3.5	3.6	25.8	9.1
95762	43,052	25.7	44.4	$142,453	3.2	4.4	1.7	3.7	30.0	7.6
95821	35,812	45.4	37.4	$42,456	24.3	8.9	5.7	10.5	48.7	12.1
95825	37,473	54.4	32.1	$40,515	31.4	10.7	8.2	13.8	51.6	11.4
95827	20,666	57.1	35.2	$59,115	12.6	7.7	5.9	13.7	39.0	15.5
95864	23,352	29.2	46.4	$105,849	7.4	4.4	3.1	3.9	27.6	12.0
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

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

Healthy Places Index – Northeast Region

Figure 3 displays the HPI for the Northeast Region. As described earlier, 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. In the map, those communities with lower values are designated “less healthy” and are shaded in blue.

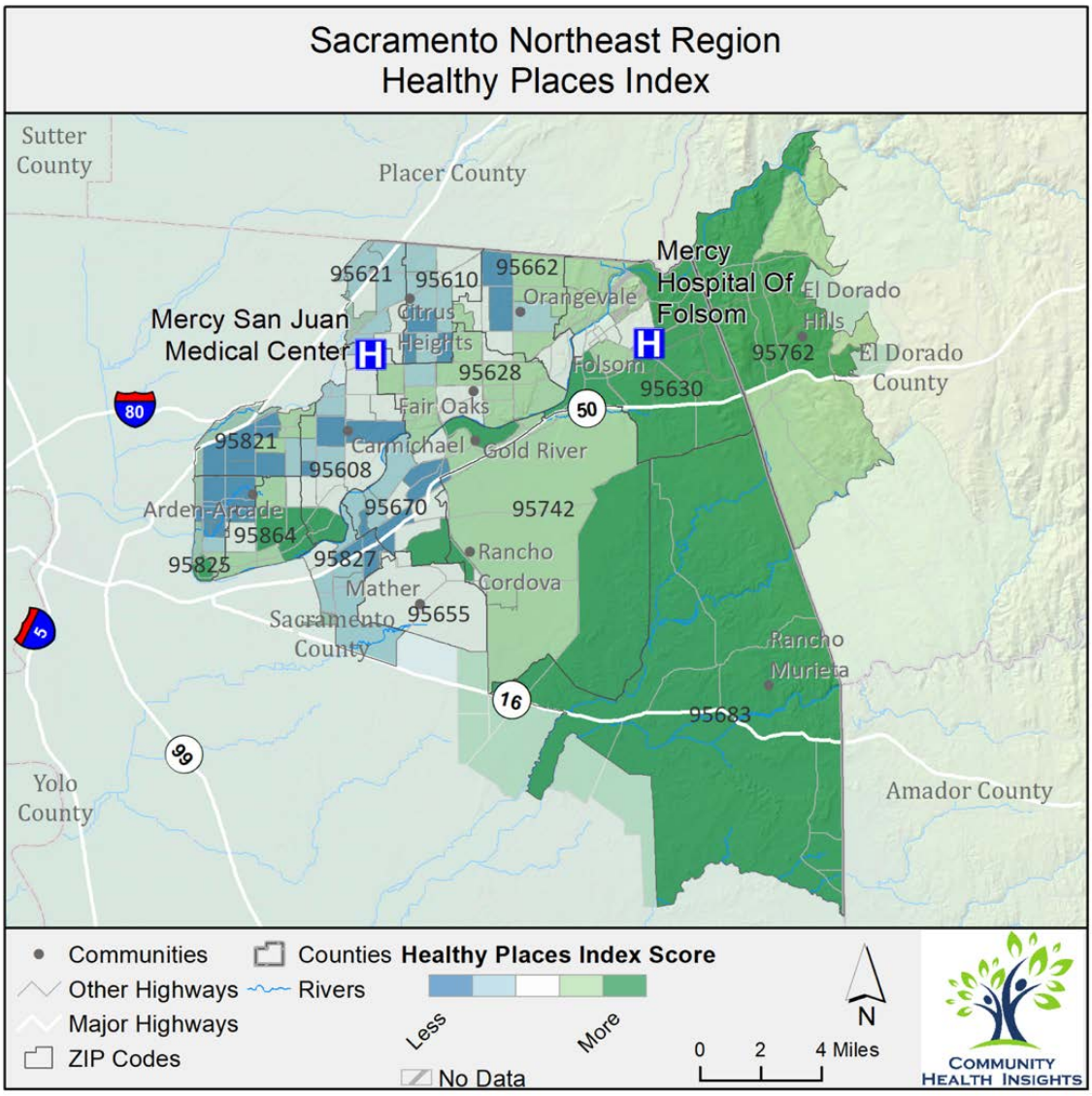


Figure 3: Healthy Places Index for Northeast Region

Northeast Region Communities of Concern

Six ZIP Codes in the Northeast Region met the criteria to be classified as Communities of Concern. These are shown in Figure 4 and described in Table 4 with the census population provided for each.

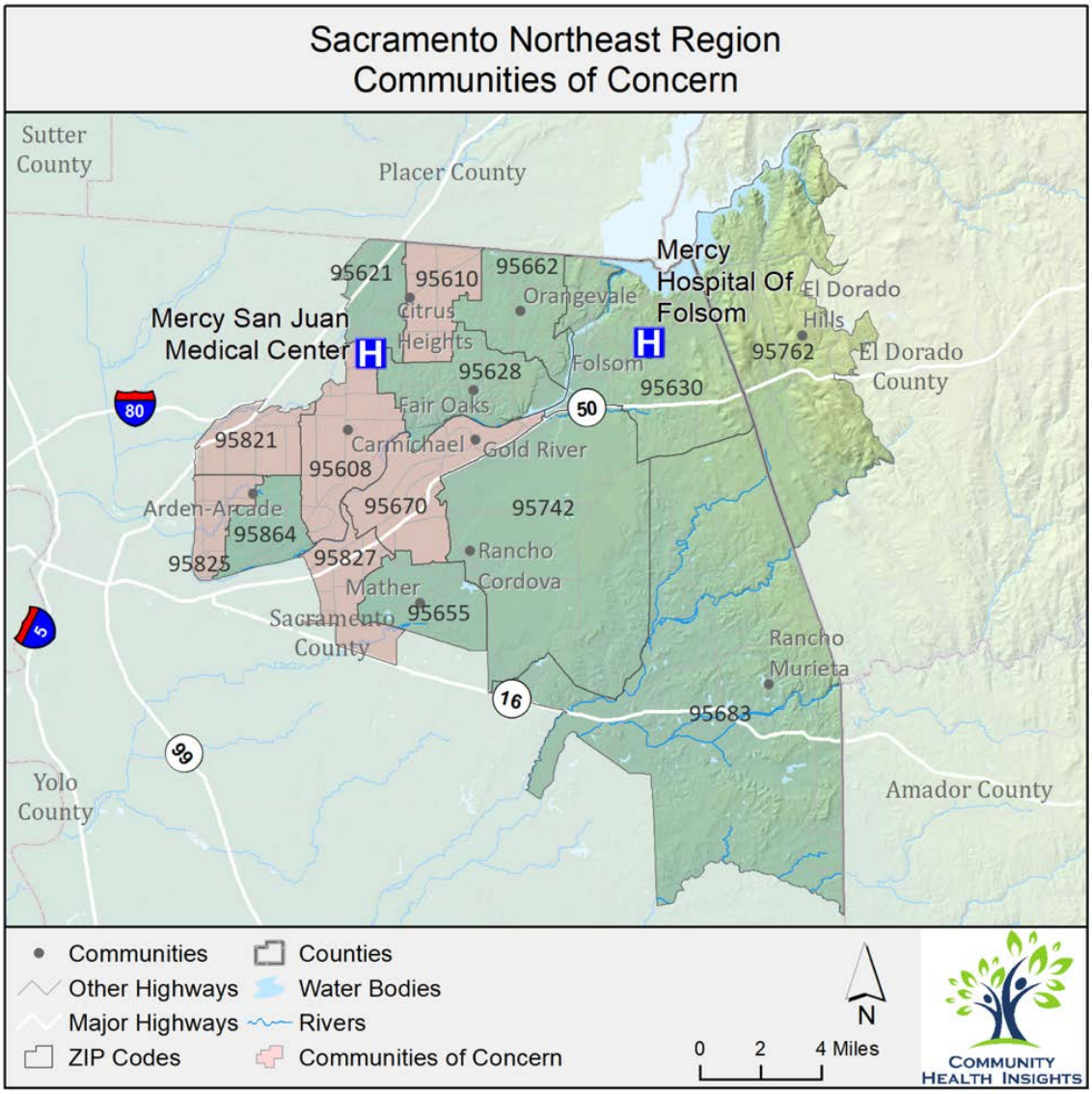


Figure 4: Communities of Concern for Northeast Region

Table 4: Identified Communities of Concern for the Northeast Region

ZIP Code	***Community\Area***	***Population***
95608	Carmichael	62,539
95610	Citrus Heights	46,305
95670	Rancho Cordova	55,558
95821	Arden Arcade, North Highlands	35,812
95825	Arden Arcade, North Highlands	37,473
95827	Rancho Cordova, Rosemont	20,666
	Total Population in Communities of Concern	*258,353*
	Total Population in Northeast Region	*540,637*
Percentage of Northeast Region Population in Communities of Concern		*47.8%*

Northwest Region

The Northwest Region is comprised of 13 ZIP Codes. The area is home to 336,702 residents. Table 5 displays population characteristics for each ZIP Code. Data are compared to the state and county rates, and ZIP Codes that negatively varied or performed poorly when compared to either the county or state benchmark are highlighted.

Table 5: Population characteristics for each ZIP Code located in the Northwest Region

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95626	6,065	28.2	41.4	$75,481	11.4	4.4	7.5	12.2	35.9	10.1
95652	789	51.3	30.7	$33,000	61.3	10.7	2.9	15.1	62.8	27.0
95660	35,461	54.4	31.1	$45,845	25.1	4.6	7.2	18.2	44.6	11.6
95673	16,636	35.2	36.8	$70,876	15.2	5.0	6.0	13.4	33.6	12.9
95815	25,673	70.7	32.3	$34,583	29.8	11.9	10.3	24.2	54.5	12.4
95833	39,905	71.9	31.5	$63,418	11.7	6.1	5.8	12.3	37.4	9.1
95834	30,076	75.7	32.2	$64,996	15.6	6.6	4.1	11.8	42.1	8.7
95835	40,170	65.7	38.2	$102,895	4.7	3.5	4.9	7.4	32.0	6.9
95837	300	16.3	47.3	$219,063	11.0	9.0	7.3	5.0	17.7	11.0
95838	39,053	78.4	31.0	$48,416	22.7	6.9	7.5	25.7	49.5	11.1
95841	21,229	44.4	34.5	$50,295	19.1	4.1	7.7	8.2	43.7	11.2
95842	33,522	48.6	32.9	$53,458	19.7	8.3	7.2	13.3	45.8	12.9
95843	47,823	41.3	32.9	$81,028	11.2	3.5	5.8	7.2	35.8	8.5
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

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

California Healthy Places Index – Northwest Region

Figure 5 displays the HPI for the Northeast Region. As described earlier, 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. In the map, those communities with lower values are designated “less healthy” and are shaded in blue.

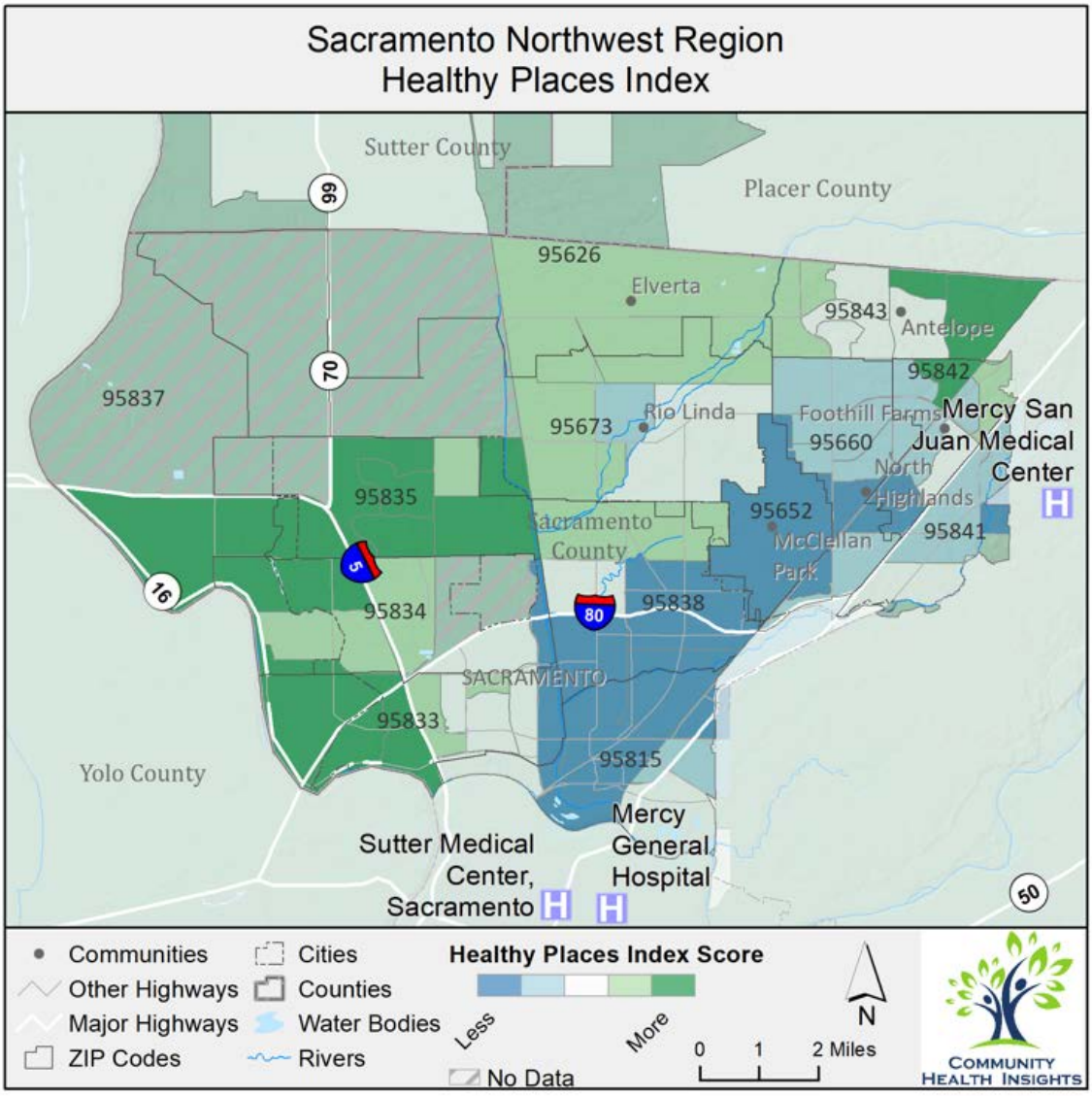


Figure 5: Healthy Place Index for Northwest Region

Communities of Concern – Northwest Region

Five ZIP Codes in the Northwest Region met the criteria to be classified as Communities of Concern. These are shown in Figure 6 and described in Table 6 with the census population provided for each.

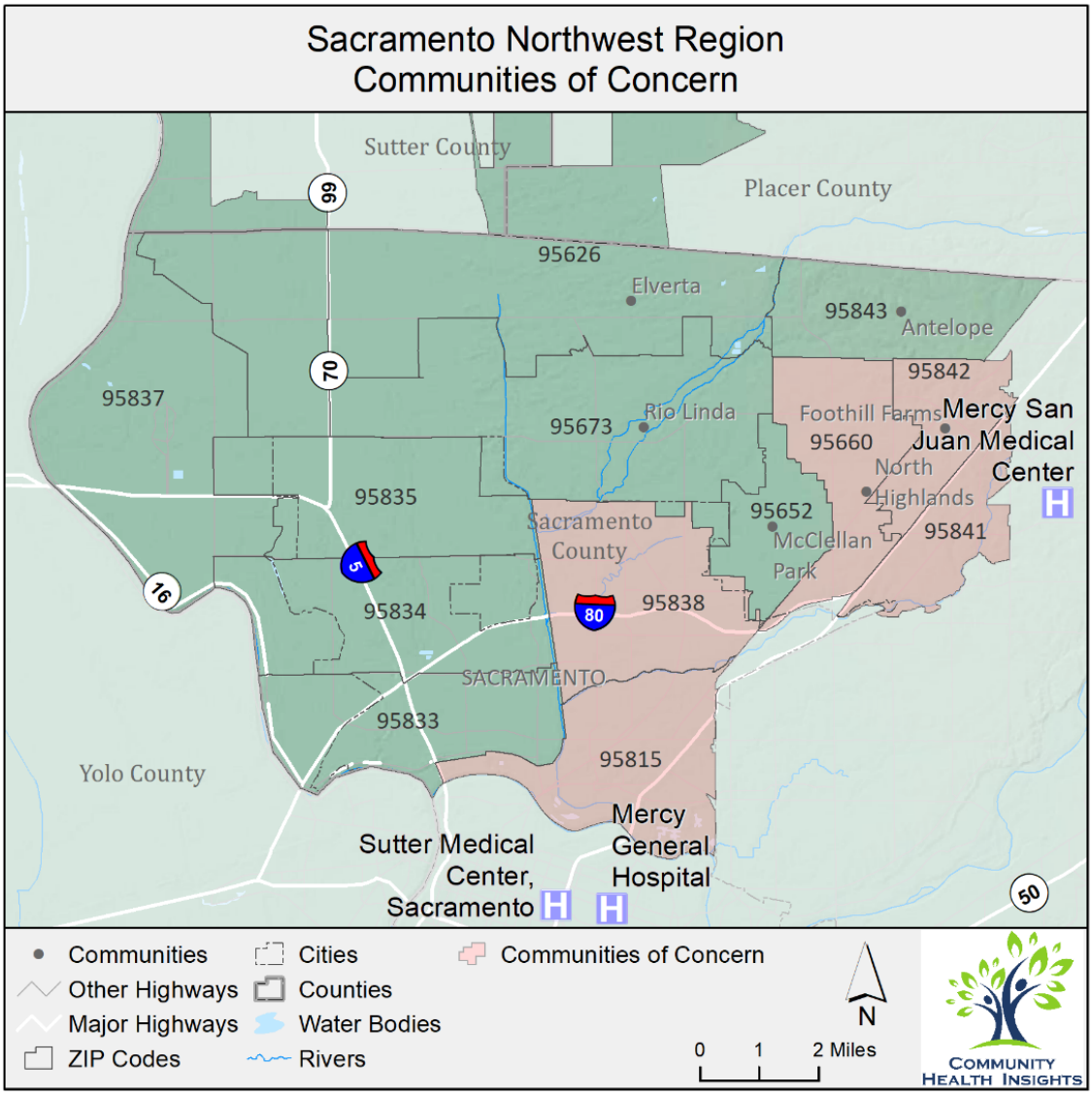


Figure 6: Communities of Concern for Northwest Region

Table 6: Identified Communities of Concern for the Northwest Region

ZIP Code	***Community/Area***	***Population***
95660	North Highlands	35,461
95815	North Sacramento	25,673
95838	Del Paso Heights	39,053
95841	Arden Arcade, North Highlands	21,229
95842	Arden Arcade, North Highlands, Foothill Farms	33,522
	Total Population in Communities of Concern	154,938
	Total Population in Northwest Region	336,702
Percentage of Northwest Region Population in Communities of Concern		46.0%

Central Region

The Central Region is comprised of eight ZIP Codes. The area is home to 166,256 residents. Table 7 displays population characteristics for each ZIP Code. Data provided are compared to the state and county rates, and ZIP Codes that negatively varied or performed poorly when compared to either the county or state benchmark are highlighted.

Table 7: Population characteristics for each ZIP Code located in the Central Region

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95811	6,294	48.2	32.0	$59,254	26.2	5.2	4.9	9.4	35.4	13.9
95814	11,908	49.7	34.0	$33,938	27.8	6.8	4.8	13.4	47.5	18.5
95816	17,199	31.5	34.6	$72,270	9.7	4.2	5.6	4.7	29.9	11.9
95817	13,758	54.0	35.5	$50,925	21.9	6.3	7.1	15.7	37.8	14.0
95818	21,625	44.2	39.2	$84,908	15.0	6.2	2.6	6.1	27.5	10.6
95819	19,890	30.5	36.4	$106,514	6.8	4.2	2.1	1.6	23.5	7.6
95820	36,437	67.5	35.1	$51,068	21.6	9.9	9.5	20.2	41.3	14.5
95826	39,145	52.2	33.5	$64,241	17.7	6.3	5.0	8.1	36.4	13.3
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

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

California Healthy Places Index – Central Region

Figure 7 displays the HPI for the Central Region. As described earlier, 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. In the map, those communities with lower values are designated “less healthy” and are shaded in blue.

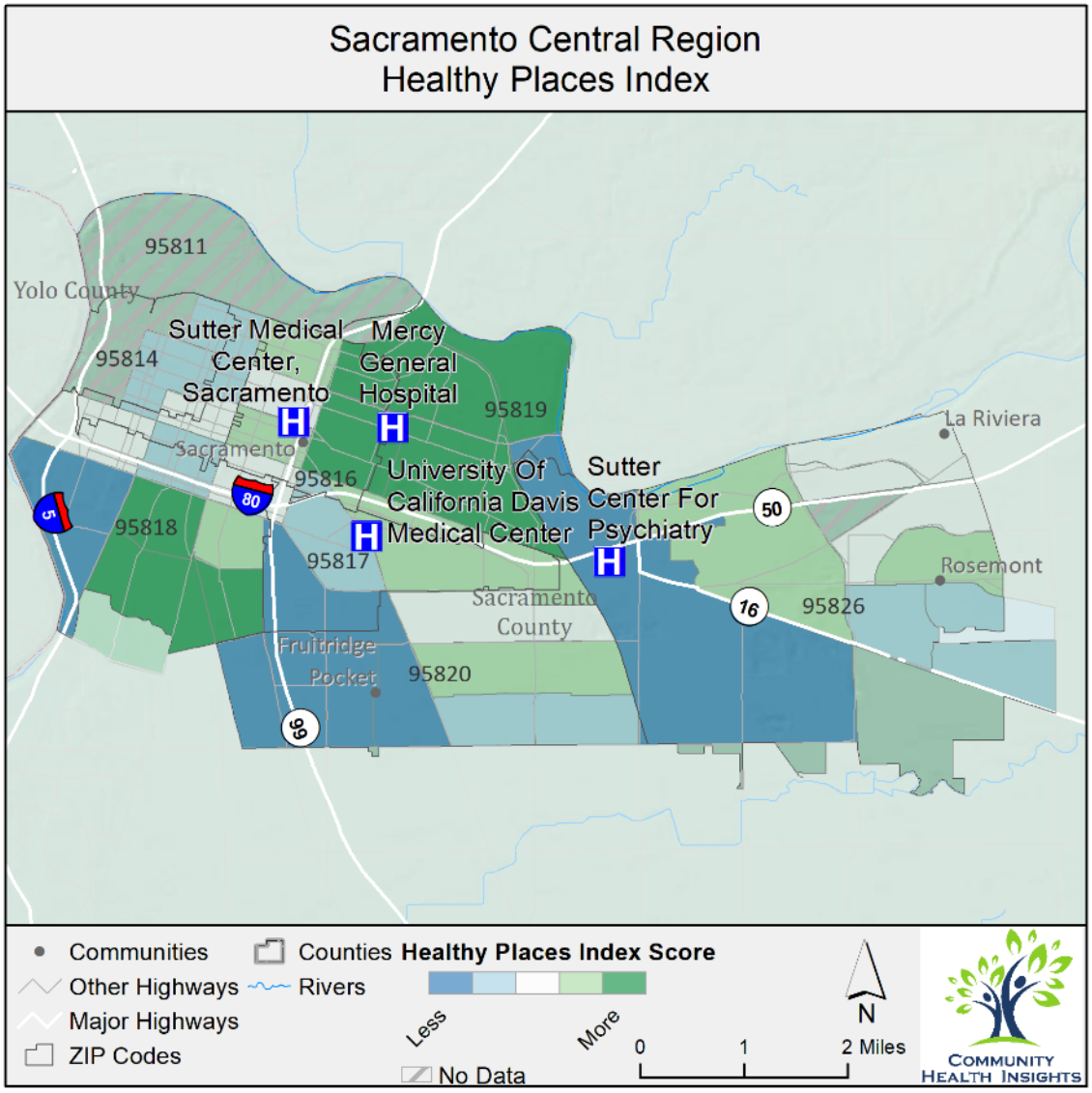


Figure 7: Healthy Places Index for Central Region

Communities of Concern – Central Region

Four ZIP Codes in the Central Region met the criteria to be classified as Communities of Concern. These are shown in Figure 8 and described in Table 8 with the census population provided for each.

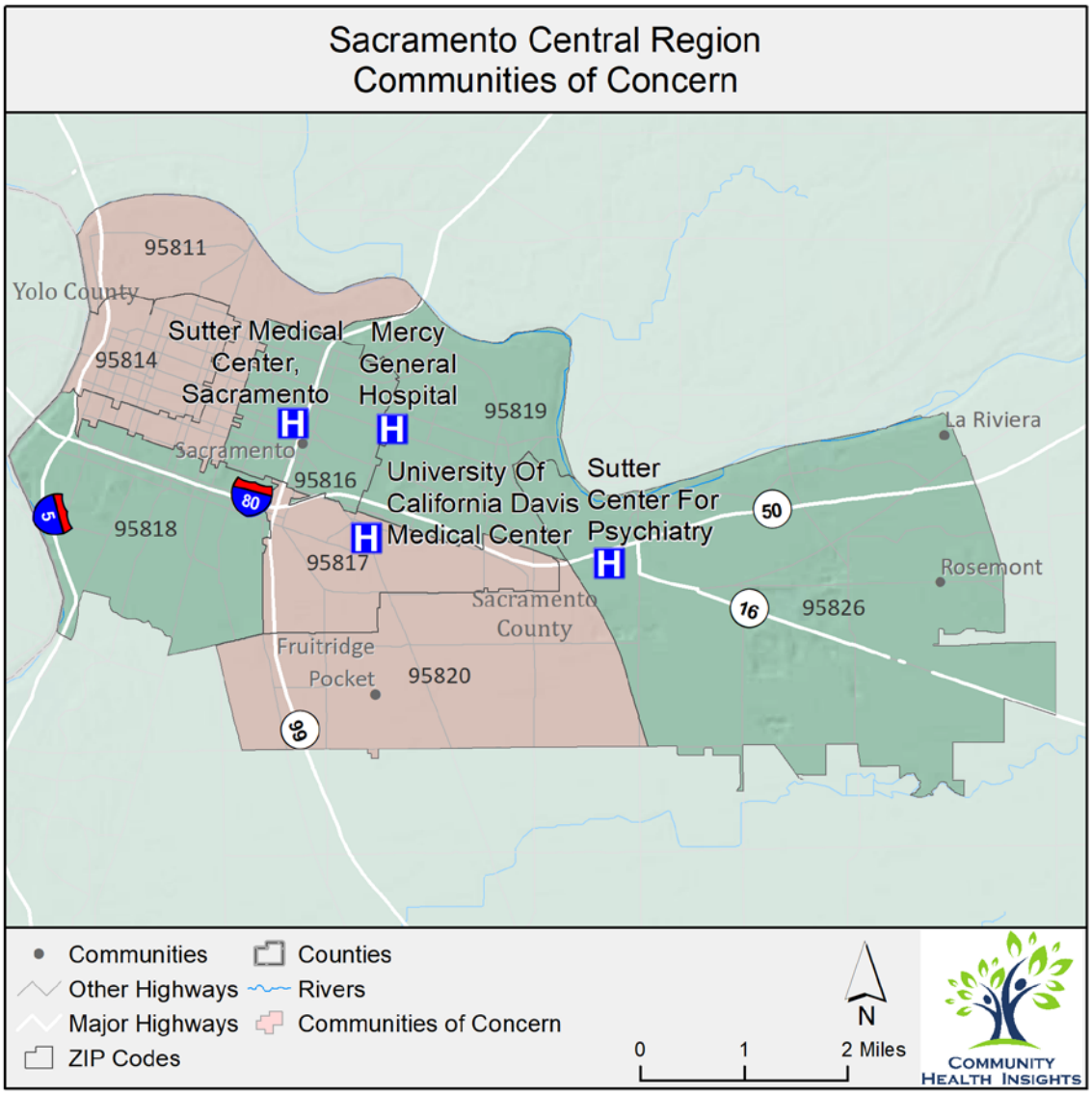


Figure 8: Communities of Concern for Central Region

Table 8: Identified Communities of Concern for the Central Region

ZIP Code	***Community/Area***	***Population***
95811	Downtown Sacramento	6,294
95814	Downtown Sacramento	11,908
95817	Oak Park	13,758
95820	Oak Park, Tahoe Park	36,437
	Total Population in Communities of Concern	68,397
	Total Population in Central Region	166,256
	Percentage of Central RegionPopulation in Community of Concern	41.14%

Southern Region

The Southern Region is comprised of 14 ZIP Codes and is home to 520,960 residents. Table 9 displays population characteristics for each ZIP Code. Data provided are compared to the state and county rates, and ZIP Codes that negatively varied or performed poorly when compared to the either the state or county benchmark are highlighted.

Table 9: Population characteristics for each ZIP Code located in the Southern Region.

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95624	65,948	60.0	37.9	$93,090	8.4	6.1	2.9	10.3	34.3	11.2
95632	31,911	52.9	36.5	$76,334	9.5	6.0	6.5	18.1	30.9	11.6
95638	2,126	30.6	49.6	$92,708	8.2	3.4	3.9	9.1	25.1	13.2
95693	7,037	36.5	47.7	$100,265	7.9	4.6	1.6	9.4	26.4	9.3
95757	50,727	72.3	36.1	$105,390	7.7	3.8	2.0	9.7	34.6	8.9
95758	65,811	68.2	37.4	$85,221	9.4	6.6	3.2	10.3	32.5	9.7
95822	44,741	74.1	38.1	$57,535	15.8	8.3	6.0	17.0	37.3	14.4
95823	79,440	84.8	31.4	$47,553	22.2	10.0	7.7	22.7	48.1	12.4
95824	30,296	85.7	32.7	$38,985	30.8	9.6	9.7	37.7	47.8	14.4
95828	58,717	81.4	36.4	$53,229	20.6	11.1	6.9	24.1	42.9	13.8
95829	28,264	67.7	35.5	$93,377	9.2	4.7	4.2	11.1	32.3	9.4
95830	734	36.1	54.6	$101,786	9.5	2.1	0.4	5.5	27.5	30.0
95831	43,094	63.9	43.8	$79,368	7.4	4.6	3.4	6.7	32.0	11.7
95832	12,114	91.3	29.7	$47,341	22.1	12.7	5.1	26.2	48.7	14.6
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

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

California Healthy Places Index – Southern Region

Figure 10 displays the HPI for the Southern Region. As described earlier, 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. In the map, those communities with lower values are designated “less healthy” and are shaded in blue.

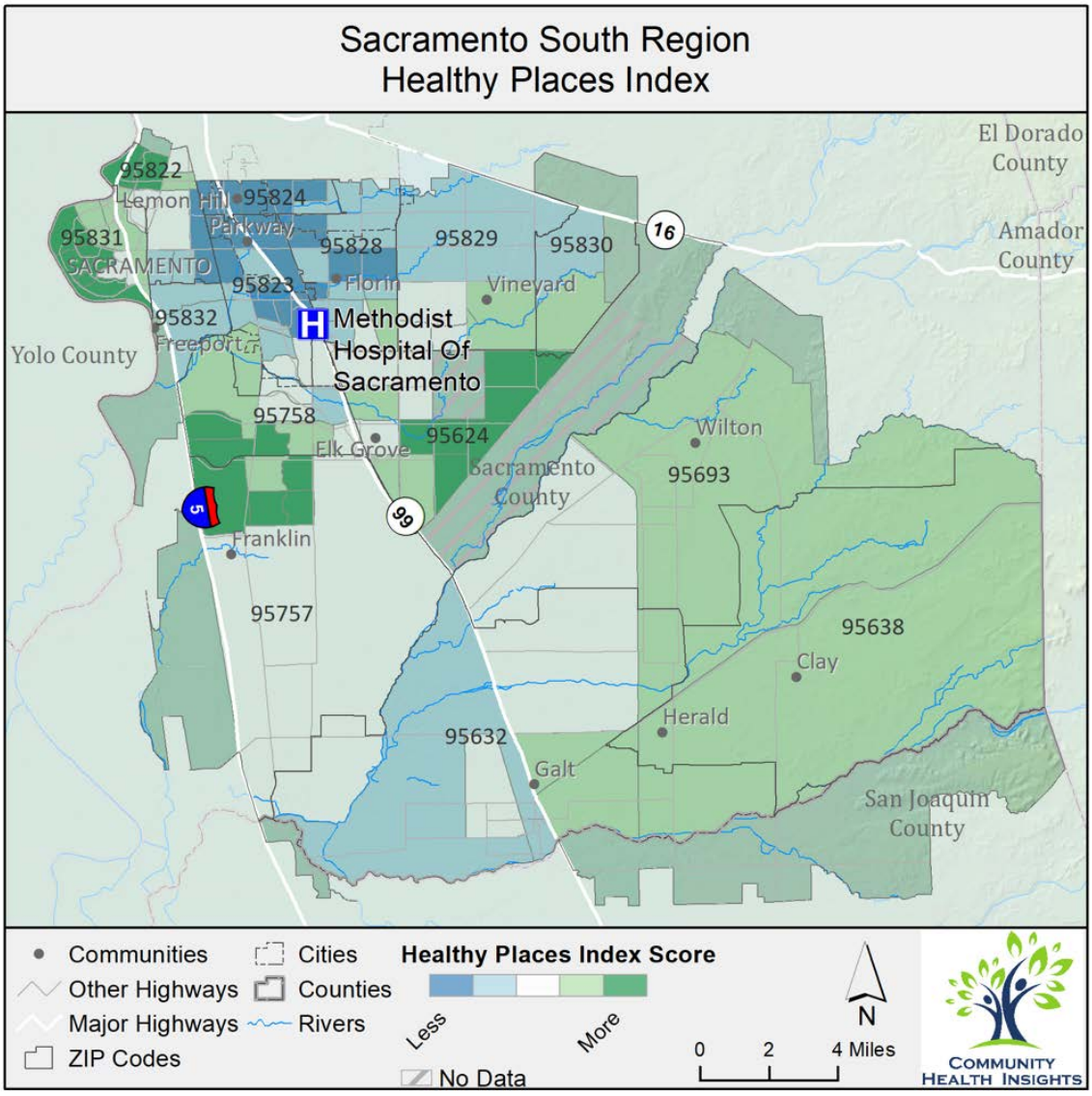


Figure 9: Healthy Place Index for the Southern Region

Communities of Concern – Southern Region

Five ZIP Codes in the Southern Region met the criteria to be classified as Communities of Concern. These are shown in Figure 10 and described in Table 10 with the census population provided for each.

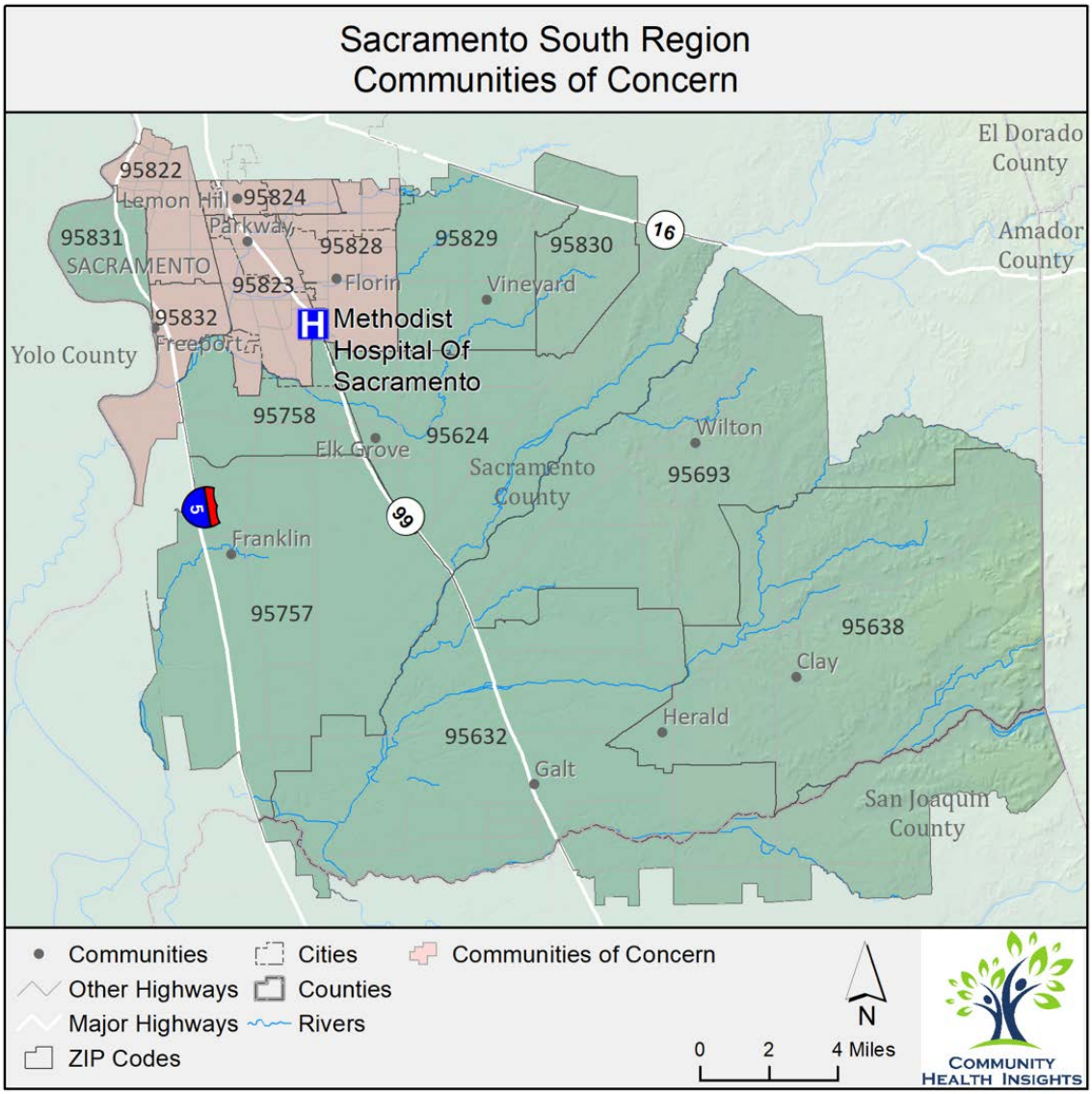


Figure 10: Communities of Concern for the Southern Region

Table 10: Identified Communities of Concern for the Southern Region

ZIP Code	*Community/Area*	*Population*
95822	South Sacramento	44,741
95823	South Sacramento	79,440
95824	South Sacramento	30,296
95828	South Oak Park, South Sacramento	58,717
95832	Meadowview, Freeport	12,114
Total Population in Communities of Concern		225,308
Total Population in Southern Region		520,960
Percentage of Southern Region Population in Communities of Concern		43.3%

Health Equity

The following section is a high-level summary of health equity in Sacramento County and is not intended to provide an extensive exploration of inequity in the service area. Quantifying and describing inequity in a community is challenging due to data limitations and the fact that inequity is a contributor to all health needs that exist in a community. The manner in which inequity manifests across Sacramento County is described in greater detail earlier in this report.

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."

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."[15]

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

This section of the report follows the organizing framework used throughout this assessment—the Robert Wood Johnson Foundation's County Health Rankings model.[16] The model shows that health outcomes are the result of health factors one experiences throughout life. Understanding where inequities appear helps in the planning of targeted interventions to reduce the ill-effects of inequity.

Health Outcomes - the Results of Inequity

Table 11 displays disparities among race and ethnic groups for the service area for life expectancy, mortality, and low birth weight.

[15] 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.
[16] See: County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

Table 11: Health outcomes comparing race and ethnicity in the service area

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births	~	4.6	8.6	4.7	3.8	4.9
Life Expectancy	Average number of years a person can expect to live	74.8	84.9	75.1	82.8	78.9	79.6
Child Mortality	Number of deaths among children under age 18 per 100,000 population	~	35.9	62.3	39.8	37.9	41.5
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted)	479	217.8	523.2	258.5	338.7	325
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted)	10,827	4,368	10,712	5,352	6,430	6,381
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams)	7.9%	8.1%	11%	6.4%	5.4%	6.9%

~ Data Not Available; unless otherwise noted, data sources included in the technical section of the report.

When examining health outcomes across all race and ethnic groups disparities are apparent. For example, the infant mortality rate for Blacks is over twice the rate for Whites.

Health Factors - Inequities in the Service Area

Inequities can be seen in data that help describe health factors in the service area, such as education attainment and income. These health factors are displayed in Table 12 and are compared across race and ethnic groups. The indicators used in this table were selected based their ability to describe inequity across race and ethnic groups across Sacramento County. The inclusion of these particular equity-oriented indicators was guided by a review of previous research.[17]

Table 12: Health factors comparing race and ethnicity in the service area

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Some College[a]	Percentage of adults ages 25 and over with some post-secondary education	55.7%	65%	65.3%	46.7%	72.6%	65.3%
High School Completion[a]	Percentage of adults ages 25 and over with at least a high school diploma or equivalent	81.5%	82.2%	90.1%	74%	94.2%	87.7%

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

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	~	3.1	2.3	2.6	3.1	2.8
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	~	3	2.1	2.4	2.9	2.7
Children in Poverty	Percentage of people under age 18 in poverty	32.3%	18.7%	28.9%	23.7%	13.5%	16%
Median Household Income	The income where half of households in a county earn more and half of households earn less	$54,080	$74,804	$48,321	$57,031	$75,110	$71,891
Uninsured Population[b]	Percentage of the civilian non-institutionalized population without health insurance	7.5%	4.7%	4.2%	9.4%	4%	5.5%

~ Data Not Available; unless otherwise noted, data sources included in the technical section of the report
[a]From 2019 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.
[b]From 2019 American Community Survey 5-year estimates table S2701.

When comparing health factor data across race and ethnic groups inequities are apparent. For example, median household income is notably lower for Black and Hispanic groups compared all others. Furthermore, the percent of Hispanics that were uninsured was significantly higher than most other groups.

Population Groups Experiencing Disparities

The following section describes populations in the service area identified through qualitative data analysis 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 11 displays the results of this analysis. The groups are not mutually exclusive—one group may 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.

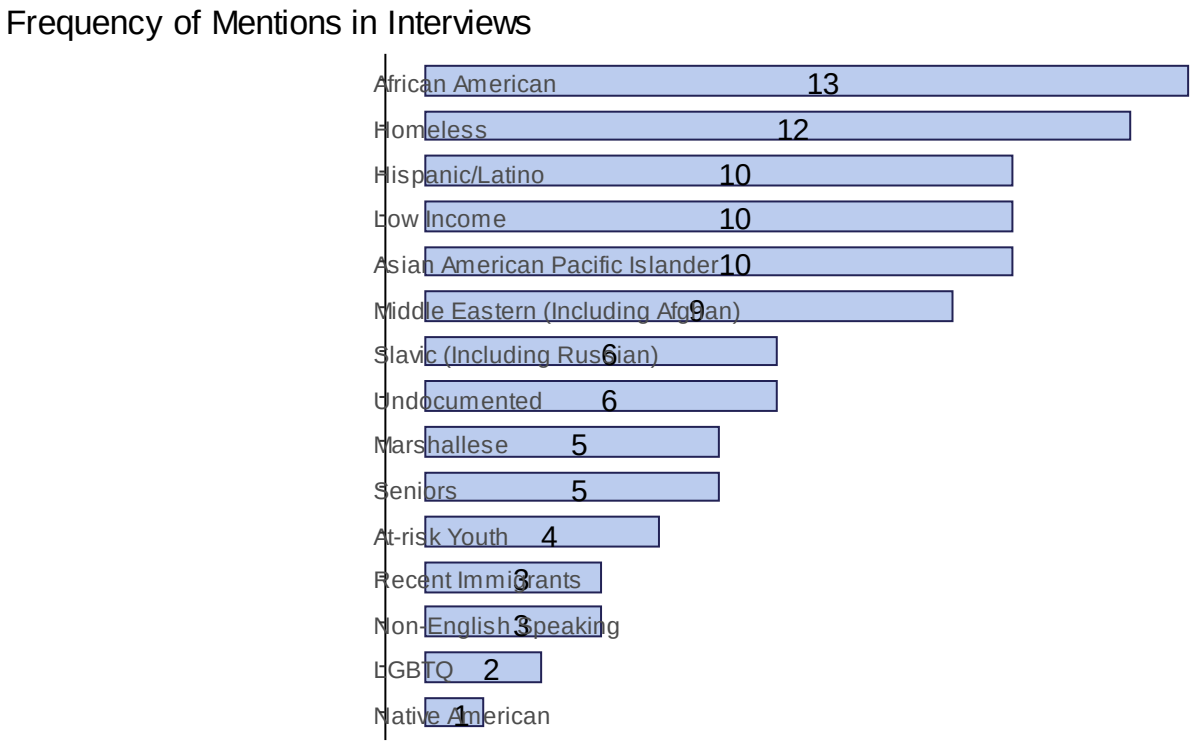


Figure 11: Populations experiencing disparities in the service area

The Impact of COVID on Health Needs

COVID-related health indicators for the service area are noted in Table 13.

Table 13: COVID-19-related rates for the service area

Indicators	Description	Sacramento	California	
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	150.8	185.1	Sacramento: 150.8 California: 185.1
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases.	1.4%	1.5%	Sacramento: 1.4% California: 1.5%
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	10,567	12,087	Sacramento: 10,567.2 California: 12,087.6
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	60,513	63,134	Sacramento: 60,513.9 California: 63,134.6

Data in Table 13 collected as of 11/17/21. Data sources included in the technical section of the report.

Table 14 displays COVID-19 cases and testing percentages by race and ethnicity for Sacramento County.

Table 14: Cases/testing percentages and cases per 100K of population by race/ethnicity in Sacramento County

	% County Population	% Cases in Sacramento County	% Testing in Sacramento County	Cases per 100K of population
Black	10.6	13.3	11.9	1,751
Hispanic/Latino	22.9	25.6	21.6	1,558
Asian American	16.2	17.6	17.4	1,514
White	46.1	39.7	46.7	1,202
Multi-Race	2.6	1.1	0.6	620
American Indian or Alaskan Native	0.6	~	~	~
Native Hawaiian/other Pacific Islander	1.0	~	~	~

~ Data not shown because there were fewer than 20,000 people in this group.
Source: COVID19.CA.GOV. Retrieved January 12, 2022.

Key informants and focus group participants, as well as respondents to the Community Service Provider survey were asked how the COVID-19 pandemic had impacted health needs. A summary of their responses is described in Table 15.

Table 15: The impacts of COVID-19 on health need as identified in primary data sources

Primary Data Analysis	
Key Informant and Focus Group Data	Community Service Provider Survey Data
• The pandemic exacerbated existing challenges faced by many in the community. • There has been a marked increase in demand for mental, behavioral, and substance-use services due to the stress of the pandemic; especially in youth and seniors. • Violence, both in the home and community, has increased. • There has been a marked increase in violence and hate crimes against the AAPI community. • There has been an increase in evictions leading to homelessness during the pandemic. • Community members have been avoiding preventative care (e.g., immunizations, wellness visits, screenings) and chronic disease management (e.g., medications) due to fear of exposure to COVID. • Children not being in school led to a host of issues, such as the struggles of distance learning and the loss of services offered by schools. • Youth experienced a rise in domestic violence due to being home more; schools, which often detect this violence, were unable to intervene or report it. • The "digital divide" further exposed the challenges many face in distance learning and the shift to telehealth.	• Some community service providers have lost funding during the pandemic, hampering their ability to deliver services. • There is a lot of misinformation spreading through the community regarding COVID. • Evictions have and will continue to increase as a result of the pandemic. Those behind on rent are falling further behind and will struggle to recover. • Many live in over-crowded housing due to affordability, and are at greater risk of infection. • The pandemic highlighted ongoing inequities in Black and Brown communities, including education and income inequities. • There has been a surge in domestic and neighborhood violence due to the pandemic. • Many parents have been struggling with multiple children learning at home; this exposed the lack of/poor quality internet access for many. • More community health workers are needed to combat misinformation and increase vaccination rates. • "I think it is important to acknowledge that the pandemic also showed the resiliency of the essential workers and support in this

Primary Data Analysis	
• The trust between communities and government has been eroded. • COVID spread through essential workers that were unable to stay home; many live in multi-generational homes in close proximity to others, increasing the spread of COVID. • The pandemic exposed how vulnerable many of our social services and systems are.	community. Our health systems rose to the challenge. Our essential non-profits stayed open and pivoted. This was a great crisis response and is not acknowledged enough!"

Resources Potentially Available to Meet the Significant Health Needs

In all, 877 resources were identified in the service area that were potentially available to meet the identified significant health needs. These resources were provided by a total of 321 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 2019 Sacramento County CHNA, verifying that the resources still existed, and then adding newly identified resources to the 2022 CHNA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 16.

Table 16: Resources potentially available to meet significant health needs

Significant Health Needs (in Priority Order)	Number of Resources
Access to Mental/Behavioral Health and Substance-Use Services	110
Access to Basic Needs Such as Housing, Jobs, and Food	134
Access to Quality Primary Care Health Services	77
System Navigation	60
Injury and Disease Prevention and Management	90
Health Equity: Equal Access to Opportunities to be Healthy	*
Active Living and Healthy Eating	83
Safe and Violence-Free Environment	75
Increased Community Connections	170
Access to Specialty and Extended Care	44
Access to Functional Needs	11
Access to Dental Care and Preventive Services	14
Healthy Physical Environment	9
Total Resources	**877**

*Note: Most, if not all, resources noted work in some way to reduce or eliminate health inequity.

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

Impact and Evaluation of Actions Taken by Hospital

Regulations require that each hospital's CHNA report include "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to

address the significant health needs identified in the hospital facility's prior CHNA(s) (p. 78969)."[18] The impact of actions taken by Sutter Health since the previously conducted CHNA can be found in Appendix A of this report.

Conclusion

This CHNA report details health needs of the Sacramento County community as a part of a partnership between Dignity Health, Sutter Health, and UC Davis Health. It provides an overall health and social examination of Sacramento County and the needs of community members experiencing health disparities. The CHNA provides a comprehensive profile to guide decision-making for the implementation of community health improvement efforts.

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

2022 CHNA Technical Section

The following section presents a detailed account of data collection, analysis, and results as well as appendices to the community health needs assessment (CHNA) report for Sacramento County.

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 12. This model organizes a population's individual health-related characteristics in terms of how they relate to up- or downstream 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 describing interrelated individual, environmental, and community characteristics, which in turn are influenced by underlying policies and programs.

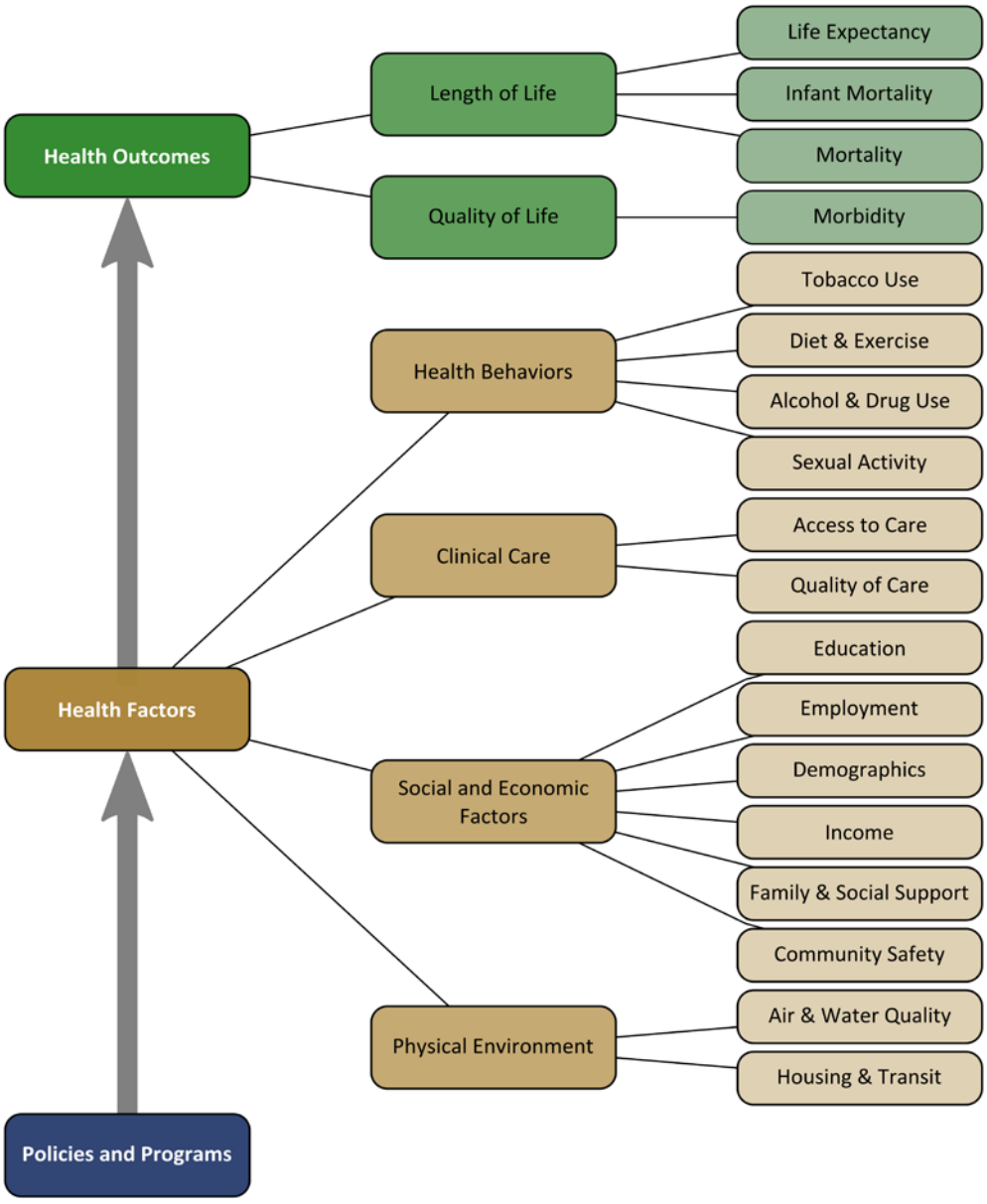


Figure 12: Community Health Assessment Conceptual Model as modified from the County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2015

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 13 outlines the data collection and analysis stages of this process. The project began by confirming the service area for Sacramento 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 (CSP) 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 significant health needs (SHNs) for the service area. SHNs were then prioritized based on analysis of the primary data. Finally, information was collected regarding the resources available within the community to meet the identified health needs. An evaluation of the impact of the hospital's prior efforts was obtained from hospital representatives and any written comments on the previous CHNA were gathered and included in the report.

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

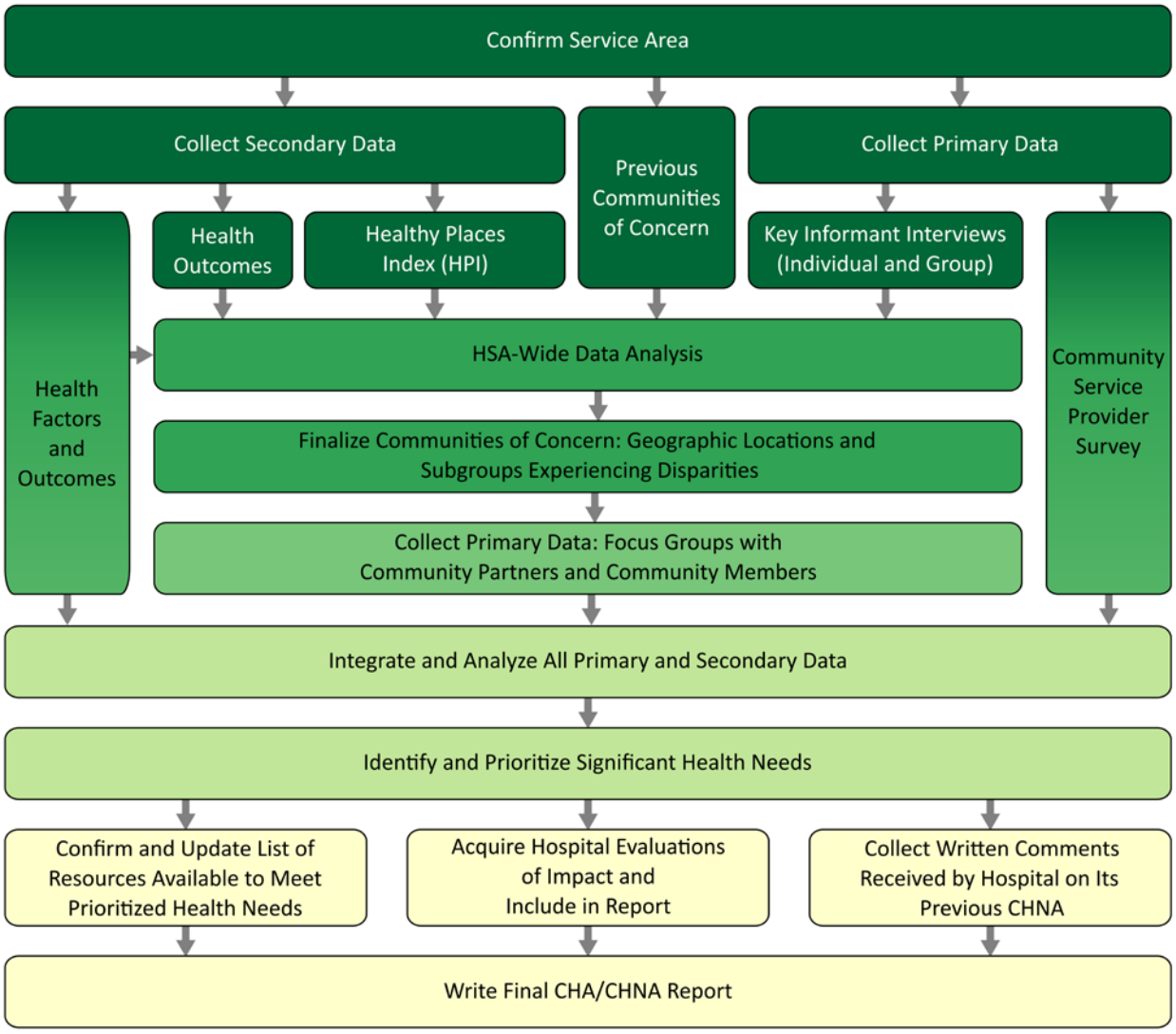


Figure 13: CHNA process model

Results of Data Analysis

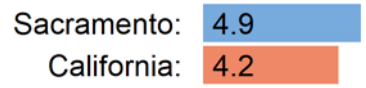
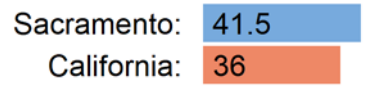
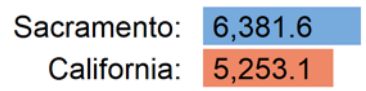
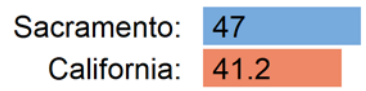
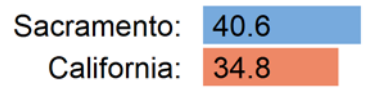
Compiled Secondary Data

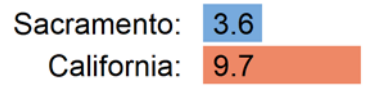
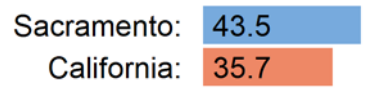
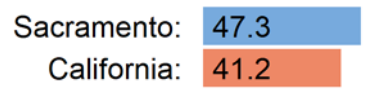
The tables and figures that follow show the specific values for the health need indicators used as part of the health need identification process. Indicator values for Sacramento County were compared to the California state benchmark and are highlighted below when performance was worse in the county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

Length of Life

Table 17: County length of life indicators compared to state benchmarks

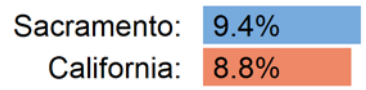
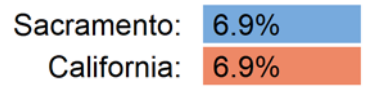
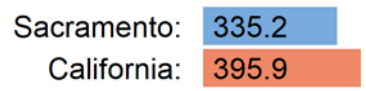
Indicators	Description	Sacramento	California
Early Life			

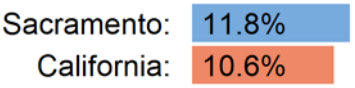
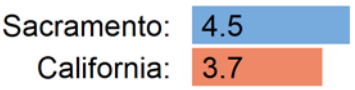
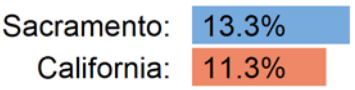
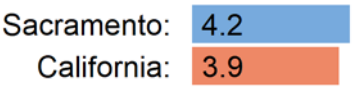
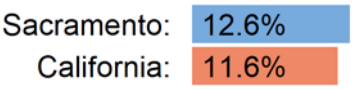
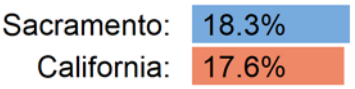
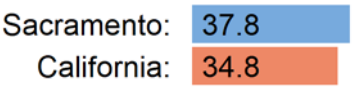
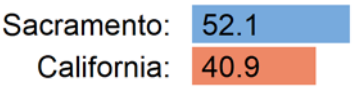
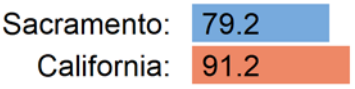
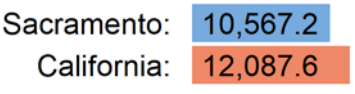
Indicators	Description	Sacramento	California	
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	4.9	4.2	
Child Mortality	Number of deaths among children under age 18 per 100,000 population.	41.5	36	
Life Expectancy	Average number of years a person can expect to live.	79.6	81.7	
Overall				
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	325	268.4	
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	6,381.6	5,253.1	
Stroke Mortality	Number of deaths due to stroke per 100,000 population.	47	41.2	
Chronic Lower Respiratory Disease Mortality	Number of deaths due to chronic lower respiratory disease per 100,000 population.	40.6	34.8	
Diabetes Mortality	Number of deaths due to diabetes per 100,000 population.	30.2	24.1	
Heart Disease Mortality	Number of deaths due to heart disease per 100,000 population.	171.1	159.5	
Hypertension Mortality	Number of deaths due to hypertension per 100,000 population.	17.8	13.8	
Cancer, Liver, and Kidney Disease				
Cancer Mortality	Number of deaths due to cancer per 100,000 population.	169.7	152.9	
Liver Disease Mortality	Number of deaths due to liver disease per 100,000 population.	13.7	13.9	

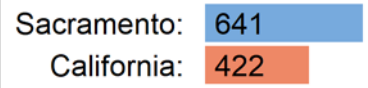
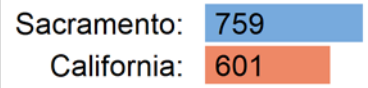
Indicators	Description	Sacramento	California	
Kidney Disease Mortality	Number of deaths due to kidney disease per 100,000 population.	3.6	9.7	
Intentional and Unintentional Injuries				
Suicide Mortality	Number of deaths due to suicide per 100,000 population.	13.6	11.2	
Unintentional Injuries Mortality	Number of deaths due to unintentional injuries per 100,000 population.	43.5	35.7	
COVID				
COVID19 Mortality	Number of deaths due to COVID19 per 100,000 population.	150.8	185.1	
COVID19 Case Fatality	Percentage of COVID19 deaths per laboratory-confirmed COVID19 cases.	1.4%	1.5%	
Other				
Alzheimer's Disease Mortality	Number of deaths due to Alzheimer's disease per 100,000 population.	47.3	41.2	
Influenza and Pneumonia Mortality	Number of deaths due to influenza and pneumonia per 100,000 population.	16.2	16	

Quality of Life

Table 18: County quality of life indicators compared to state benchmarks

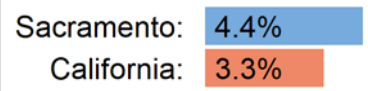
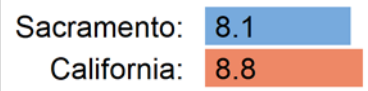
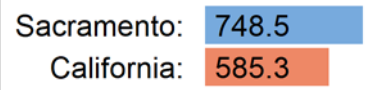
Indicators	Description	Sacramento	California	
Chronic Disease				
Diabetes Prevalence	Percentage of adults aged 20 and above with diagnosed diabetes.	9.4%	8.8%	
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	6.9%	6.9%	
HIV Prevalence	Number of people aged 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	335.2	395.9	

Indicators	Description	Sacramento	California	
Disability	Percentage of the total civilian noninstitutionalized population with a disability	11.8%	10.6%	
Mental Health				
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	4.5	3.7	
Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	13.3%	11.3%	
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	4.2	3.9	
Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	12.6%	11.6%	
Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	18.3%	17.6%	
Cancer				
Colorectal Cancer Prevalence	Colon and rectum cancers per 100,000 population (age-adjusted).	37.8	34.8	
Breast Cancer Prevalence	Female in situ breast cancers per 100,000 female population (age-adjusted).	31.8	27.9	
Lung Cancer Prevalence	Lung and bronchus cancers per 100,000 population (age-adjusted).	52.1	40.9	
Prostate Cancer Prevalence	Prostate cancers per 100,000 male population (age-adjusted).	79.2	91.2	
COVID				
COVID19 Cumulative Incidence	Number of laboratory-confirmed COVID19 cases per 100,000 population.	10,567.2	12,087.6	
Other				

Indicators	Description	Sacramento	California	
Asthma ED Rates	Emergency department visits due to asthma per 10,000 (age-adjusted).	641	422	
Asthma ED Rates for Children	Emergency department visits due to asthma among ages 5-17 per 10,000 population ages 5-17 (age-adjusted).	759	601	

Health Behavior

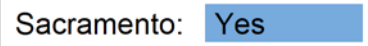
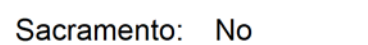
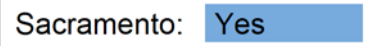
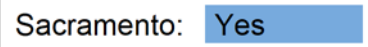
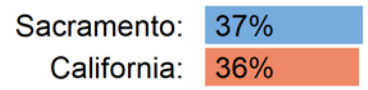
Table 19: County health behavior indicators compared to state benchmarks

Indicators	Description	Sacramento	California	
Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	20.4%	18.1%	
Drug Induced Death	Drug induced deaths per 100,000 (age-adjusted).	19.4	14.3	
Adult Obesity	Percentage of the adult population (ages 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.	29.9%	24.3%	
Physical Inactivity	Percentage of adults aged 20 and over reporting no leisure-time physical activity.	19.8%	17.7%	
Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	4.4%	3.3%	
Food Environment Index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	8.1	8.8	
Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity.	97.4%	93.1%	
Chlamydia Incidence	Number of newly diagnosed chlamydia cases per 100,000 population.	748.5	585.3	
Teen Birth Rate	Number of births per 1,000 female population ages 15-19.	17.4	17.4	

Indicators	Description	Sacramento	California	
Adult Smoking	Percentage of adults who are current smokers (age-adjusted).	14%	11.5%	

Clinical Care

Table 20: County clinical care indicators compared to state benchmarks

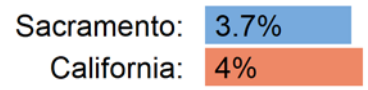
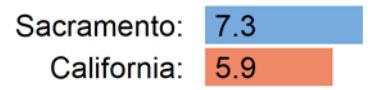
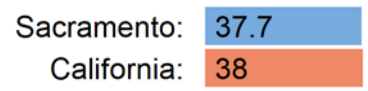
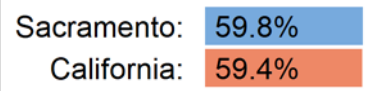
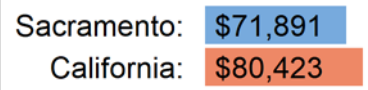
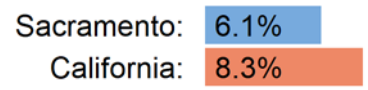
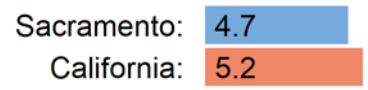
Indicators	Description	Sacramento	California	
Primary Care Shortage Area	Presence of a primary care health professional shortage area within the county.	Yes		
Dental Care Shortage Area	Presence of a dental care health professional shortage area within the county.	No		
Mental Health Care Shortage Area	Presence of a mental health professional shortage area within the county.	Yes		
Medically Underserved Area	Presence of a medically underserved area within the county.	Yes		
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.	37%	36%	
Dentists	Dentists per 100,000 population.	78.3	87	
Mental Health Providers	Mental health providers per 100,000 population.	385.9	373.4	
Psychiatry Providers	Psychiatry providers per 100,000 population.	14.5	13.5	
Specialty Care Providers	Specialty care providers (non-primary care physicians) per 100,000 population.	222.6	190	
Primary Care Providers	Primary care physicians per 100,000 population + other primary care providers per 100,000 population.	155.4	147.3	

Indicators	Description	Sacramento	California	
Preventable Hospitalization	Preventable hospitalizations per 100,000 (age-sex-poverty adjusted)	1,042.8	948.3	Sacramento: 1,042.8 California: 948.3
COVID				
COVID19 Cumulative Full Vaccination Rate	Number of completed COVID19 vaccinations per 100,000 population.	60,513.9	63,134.6	Sacramento: 60,513.9 California: 63,134.6

Socio-Economic and Demographic Factors

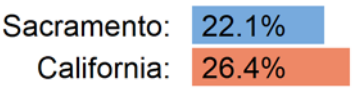
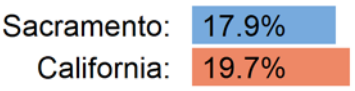
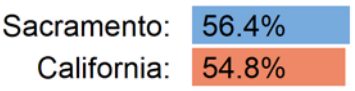
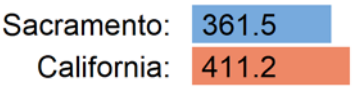
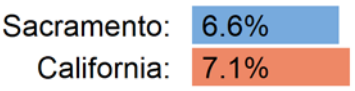
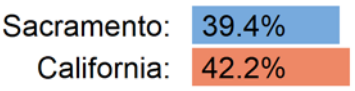
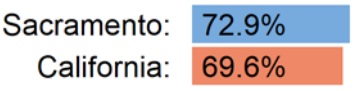
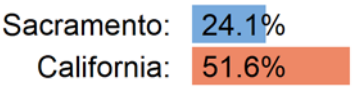
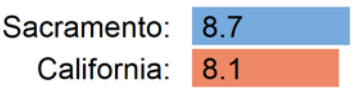
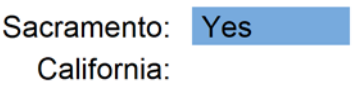
Table 21: County socio-economic and demographic factors indicators compared to state benchmarks

Indicators	Description	Sacramento	California	
Community Safety				
Homicide Rate	Number of deaths due to homicide per 100,000 population.	5.9	4.8	Sacramento: 5.9 California: 4.8
Firearm Fatalities Rate	Number of deaths due to firearms per 100,000 population.	9.7	7.8	Sacramento: 9.7 California: 7.8
Violent Crime Rate	Number of reported violent crime offenses per 100,000 population.	508.2	420.9	Sacramento: 508.2 California: 420.9
Juvenile Arrest Rate	Felony juvenile arrests per 1,000 juveniles	2	2.1	Sacramento: 2 California: 2.1
Motor Vehicle Crash Death	Number of motor vehicle crash deaths per 100,000 population.	10.6	9.5	Sacramento: 10.6 California: 9.5
Education				
Some College	Percentage of adults ages 25-44 with some post-secondary education.	66.9%	65.7%	Sacramento: 66.9% California: 65.7%
High School Completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	87.7%	83.3%	Sacramento: 87.7% California: 83.3%
Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	8.2%	6.4%	Sacramento: 8.2% California: 6.4%

Indicators	Description	Sacramento	California	
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	2.8	2.9	
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	2.7	2.7	
Employment				
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	3.7%	4%	
Family and Social Support				
Children in Single-Parent Households	Percentage of children that live in a household headed by single parent.	25.8%	22.5%	
Social Associations	Number of membership associations per 10,000 population.	7.3	5.9	
Residential Segregation (Non-White/White)	Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents.	37.7	38	
Income				
Children Eligible for Free Lunch	Percentage of children enrolled in public schools that are eligible for free or reduced-price lunch.	59.8%	59.4%	
Children in Poverty	Percentage of people under age 18 in poverty.	16%	15.6%	
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$71,891	$80,423	
Uninsured Population under 64	Percentage of population under age 65 without health insurance.	6.1%	8.3%	
Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	4.7	5.2	

Physical Environment

Table 22: County physical environment indicators compared to state benchmarks

Indicators	Description	Sacramento	California	
Housing				
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.	22.1%	26.4%	
Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing.	17.9%	19.7%	
Homeownership	Percentage of occupied housing units that are owned.	56.4%	54.8%	
Homelessness Rate	Number of homeless individuals per 100,000 population.	361.5	411.2	
Transit				
Households with no Vehicle Available	Percentage of occupied housing units that have no vehicles available.	6.6%	7.1%	
Long Commute - Driving Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	39.4%	42.2%	
Access to Public Transit	Percentage of population living near a fixed public transportation stop	72.9%	69.6%	
Air and Water Quality				
Pollution Burden Percent	Percentage of population living in a census tract with a CalEnviroscreen 3.0 pollution burden score percentile of 50 or greater	24.1%	51.6%	
Air Pollution - Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	8.7	8.1	
Drinking Water Violations	Presence of health-related drinking water violations in the county.	Yes		

Primary Data Collection and Processing

Primary Data Collection

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

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

Key Informant Results

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

As a part of the interview process, all key informants were asked to identify vulnerable populations. The interviewer asked each participant to verbally explain what vulnerable populations existed in the county. As needed for a visual aid, key informants were provided a map of the service area 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 23 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 23: Key Informant List

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Mercy General Hospital	05/17/2021	6	Acute Care Hospital: Healthcare services	All residents of Sacramento County
La Familia	05/19/2021	2	Behavioral, mental, physical health services; employment and education	Low income; medically underserved, racial or ethnic minorities; immigrants
Methodist Hospital	05/20/2021	7	Acute Care Hospital: Healthcare services	All residents of Sacramento County
Mercy Hospital of Folsom	05/21/2021	4	Acute Care Hospital: Healthcare services	All residents of Sacramento County
Sutter Medical Center Sacramento	05/27/2021	2	Acute Care Hospital: Healthcare services	All residents of Sacramento County

Organization	Date	Number of Participants	Area of Expertise	Populations Served
San Juan School Unified District	05/28/2021	1	Education	School-aged children
UC Davis Medical Center	06/01/2021	5	Acute Care Hospital: Healthcare services	All residents of Sacramento County
Mercy San Juan Medical Center	06/01/2021	9	Acute Care Hospital: Healthcare services	All residents of Sacramento County
Sacramento Native American Health Center	06/02/2021	1	FQHC: Healthcare services	Low income; medically underserved, racial or ethnic minorities
Sacramento Covered	06/04/2021	1	Healthcare outreach and enrollment	All residents of Sacramento County
El Dorado Community Health Center	06/07/2021	1	FQHC: Healthcare services	Low income, medically underserved, racial or ethnic minorities
People Reaching Out	06/08/2021	1	Youth development and prevention services	Low income, underserved communities
Slavic Assistance Center	06/10/2021	1	Health promotion, education and training	Low income Slavic immigrants and refugee individuals and families
Elk Grove Food Bank (Pt. Pleasant Methodist Church)	06/10/2021	1	Community based organization; social services	Low income, food insecure; seniors; racial and ethnic minorities
Asian Resource Center, Inc.	06/16/2021	1	Community based organization; education, training, employment assistance;	Immigrant, refugees in Sacramento County
Sacramento County Public Health	06/16/2021	1	Public Health	All residents of Sacramento County
Planned Parenthood	06/18/2021	1	Healthcare services	Low income, non-English speaking; racial or ethnic minorities
WellSpace Health	06/18/2021	1	FQHC: Healthcare services	Low income, medically underserved, racial or ethnic minorities
Sacramento Food Bank & Family Services	06/18/2021	1	Community based organization; social services	Low income, food insecure; immigrants and refugees
Mutual Assistance Center	07/02/2021	1	Community based organization; Social and economic infrastructure	Low income, medically underserved, racial or ethnic minorities
CA Endowment Building Healthy Communities	07/21/2021	13	Initiative addressing health inequities	South Sacramento; low income, racial and ethnic minorities
National Alliance on Mental Illness (NAMI)	08/02/2021	1	Mental health	All residents of Sacramento County
Sacramento Housing Alliance	08/03/2021	1	Housing, affordable housing, rent control	All residents of Sacramento County

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Valley Vision	08/03/2021	1	Climate and environmental health	All residents of Sacramento County
Latino Leadership Council	08/03/2021	1	Undocumented/underinsured	Latino residents in South Natomas, Citrus Heights, Antelope
Yolo County Children's Alliance	08/03/2021	1	Child abuse prevention, advocacy	Families with youth in West Sacramento and Woodland
Anti-Recidivism Coalition	08/04/2021	1	Reentry and criminal justice reform	Reentry population in Sacramento County
Sacramento Steps Forward	08/10/2021	1	Homeless population	Residents of Sacramento County experiencing homelessness
World Relief Sacramento	08/11/2021	1	Refugee resettlement	Refugee community in Sacramento County
WEAVE	08/12/2021	1	Domestic violence, human trafficking	All residents of Sacramento County
Hope Cooperative	08/12/2021	1	Mental health, homeless	All residents of Sacramento County
My Sister's House	08/13/2021	1	Domestic violence	All residents of Sacramento County
Sac Breathe	08/13/2021	1	Lung health	All residents of Sacramento County
Sierra Health Foundation	08/13/2021	1	Community health	All residents of Sacramento County
Sacramento LGBT Community Center	08/17/2021	1	LGBTQ Community	LGBTQ Community in Sacramento County
Sacramento Area School Districts	08/17/2021	3	Youth and schools	All residents of Sacramento County
Lao Family Community Development Center	08/18/2021	1	Southeast Asian community (Hmong, Mien, Vietnamese, Cambodian)	Refugee community in Sacramento County
Sacramento ACT	08/24/2021	1	Faith, community advocacy	All residents of Sacramento County
Health Education Council	08/24/2021	1	Health disparities	All residents of Sacramento County
Ethnic Chambers of Commerce	08/25/2021	4	Economic development	All residents of Sacramento County
Cal Voices	08/25/2021	1	Mental health	All residents of Sacramento County
Public Housing Agency	08/25/2021	1	Coalition building, trauma healing	Young men of color in Sacramento County

Key Informant Interview Guide

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

1) BACKGROUND

a) Please tell me about your current role and the organization you work for?

i) Probe for:

(1) Public health (division or unit)

(2) Hospital health system

(3) Local non-profit

(4) Community member

b) How would you define the community (ies) you or your organization serves?

i) Probe for:

(1) Specific geographic areas?

(2) Specific populations served?

(a) Who? Where? Racial/ethnic make-up, physical environment (urban/ rural, large/small)

2) CHARACTERISTICS OF A HEALTHY COMMUNITY

a) In your view, what does a healthy community look like?

i) Probe for:

(1) Social factors

(2) Economic factors

(3) Clinical care

(4) Physical/built environment (food environment, green spaces)

(5) Neighborhood safety

3) HEALTH ISSUES

a) What would you say are the biggest health needs in the community?

1) Probe for:

i) How has the presence of COVID impacted these health needs?

b) INSERT MAP exercise: Please use the map provided to help our team understand where communities that experience the greatest health disparities live?

(1) Probe for:

(a) What specific geographic locations struggle with health issues the most?

(b) What specific groups of community members experience health issues the most?

4) CHALLENGES/BARRIERS

a) Looking through the lens of equity, what are the challenges (barriers or drivers) to being healthy for the community as a whole?

i) Do these inequities exist among certain population groups?

ii) Probe for:

(1) Health Behaviors (maladaptive, coping)

(2) Social factors (social connections, family connectedness, relationship with law enforcement)

(3) Economic factors (income, access to jobs, affordable housing, affordable food)

(4) Clinical Care factors (access to primary care, secondary care, quality of care)

(5) Physical (Built) environment (safe and healthy housing, walkable communities, safe parks)

5) SOLUTIONS

a) What solutions are needed to address the health needs and or challenges mentioned?

i) Probe for:

(1) Policies

(2) Care coordination

(3) Access to care

(4) Environmental change

6) PRIORITY

a) **Which would you say are currently the most important or urgent health issues or challenges to address (at least 3 to 5) in order to improve the health of the community?**

7) **RESOURCES**
   a) **What resources exist in the community to help people live healthy lives?**
      (1) Probe for:
         (a) Barriers to accessing these resources.
         (b) New resources that have been created since 2016
         (c) New partnerships/projects/funding

8) **PARTICIPANT DRIVEN SAMPLING:**
   a) **What other people, groups or organizations would you recommend we speak to about the health of the community?**
      a. Name 3 types of service providers that you would suggest we include in this work?
      b. Name 3 types of community members that you would recommend we speak to in this work?

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

Focus Group Results

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

Table 24 contains a listing of community resident groups that contributed input to the CHNA. The table describes the organization hosting the focus group, the date it occurred, the total number of participants, and population represented by focus group members.

Table 24: Focus Group List

Hosting Organization	Date	Number of Participants	Population Represented
Sacramento Covered	08/02/2021	10	Financially insecure, unsheltered, medically underserved
La Familia Counseling Center	08/17/2021	8	Low income and medically underserved; Hispanic, immigrants
Mutual Assistance Network	08/17/2021	4	Financially insecure, immigrants, Hispanic, African American
Folsom Cordova Partnership	08/17/2021	1	Economically challenged individuals and families
WIND Youth Services	08/19/2021	5	Youth experiencing homelessness; LGBTQ, Hispanic, African American
Cancer Support Group (El Dorado Co)	08/20/2021	4	Seniors; cancer survivors
Asian Resource Center, Inc.	08/24/2021	8	Asian community
Elk Grove HART	08/26/2021	2	Low income, housing insecure
Sacramento LGBT Community Center	08/28/2021	10	LGBTQ community
Opening Doors	08/30/2021	2	Immigrants and refugees; Iraq; Afghanistan; Russian Ukraine
Sutter Medical Center, Sacramento, WellSpace ED Navigators	08/31/2021	3	Low income, people experiencing homeless

Focus Group Interview Guide

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

2022 CHNA Focus Group Interview Protocol

14. Let's start by introducing ourselves. Please tell us your name, the town you live in, and one thing that you are proud of about your community.
15. We would like to hear about the community where you live. Tell us in a few words what you think of as "your community". What it is like to live in your community?
16. What do you think that a "healthy environment" is?
17. When thinking about your community based on the healthy environment you just described, what are the biggest health needs in your community?
18. Are needs more prevalent in a certain geographic area, or within a certain group of the community?
19. How has the presence of COVID impacted these health needs?
20. What are the challenges or barriers to being healthy in your community?
21. What are some solutions that can help solve the barriers and challenges you talked about?
22. Based on what we have discussed so far, what are currently the most important or urgent top 3 health issues or challenges to address to improve the health of the community?
23. Are these needs that have recently come up or have they been around for a long time?
24. What are resources that exist in the community that help your community live healthy lives and address the health issues and inequity we have discussed?
25. Is there anything else you would like to share with our team about the health of the community?

Primary Data Processing

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

Community Service Provider Survey

A web-based survey was administered to community service providers (CSPs) who delivered health and social services to residents of the service area. CSPs affiliated with the nonprofit hospitals included in this report served as the initial sampling frame. An email recruitment message was sent to these CSPs detailing the survey's aims and inviting them to participate. A snowball sampling technique was used, encouraging participants to forward the recruitment message to other CSPs in their networks. The survey was designed using Qualtrics, an online survey platform, and was available for approximately two weeks. Individuals completing the survey were given the option to be acknowledged or remain anonymous. Those who indicated a desire to be acknowledged are listed here:

Bridget Alexander, Janine Bera, Jessica Brown, Kathilynn Carpenter, Sharon Chandler, Sunjung Cho, Kaitlynn DiCicco, Rosa Flores, Terri Galvan, Crystal Harding, Beth Hassett, Josiah Kitonga, Mai Lee, Kelsey Long, Bonnie Rea, Julie Rhoten, Shari Roeseler, Marbella Sala, Genelle Smiht, Dimitrius Stone, Nilda Valmores, and Gina Warren

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

When the survey period was over, incomplete and duplicate responses were removed from the dataset and the survey responses were checked for accuracy. Descriptive statistics and frequencies were used to summarize the health needs. This information was used along with other data sources to both identify and rank SHNs in the community and to describe how the health needs were expressed. Table 25 displays a summary of the survey for Sacramento County.

Table 25: Community Service Provider survey summary results of Sacramento County

Service Provider Survey Snapshot | Sacramento County	
Health Needs	**% Report -ing**
Most Frequently Reported	
Access to Mental/Behavioral Health and Substance-Use Services	96.8
Access to Basic Needs	96.8
A Safe and Violence-Free Environment	83.9
System Navigation	80.6
Top 3/ Priority *(Most Frequently Reported Characteristics)*	
Access to Mental/Behavioral Health and Substance-Use Services. • *It's difficult for people to navigate for mental/behavioral healthcare.* • *There aren't enough services here for those who are homeless and dealing with substance-use issues.* • *Additional services for those who are homeless and experiencing mental/behavioral health issues are needed.* • *There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).* • *Substance-use is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse).*	77.4
Access to Basic Needs • *Lack of affordable housing is a significant issue in the area.* • *The area needs additional low-income housing options.*	74.2

- *Services for homeless residents in the area are insufficient.*
- *It is difficult to find affordable childcare.*

Access to Quality Primary Care Health Services • *Patients have difficulty obtaining appointments outside of regular business hours.* • *Wait-times for appointments are excessively long.*	32.3

Secondary Data Collection and Processing

The term "secondary data" refers to those quantitative variables used in this analysis that were obtained from third party sources. Secondary data were used to 1) inform the identification of Communities of Concern, 2) support the identification of health needs, and 3) describe the population and illuminate issues of health equity within the service area. This section details the data sources as well as the process for collecting secondary data and preparing them for analysis.

Community of Concern Identification Datasets

Two main secondary data sources were used in the identification of Communities of Concern: California Healthy Places Index (HPI)[19], derived from health factor indicators available at the US Census tract level, and mortality data from the California Department of Public Health (CDPH)[20] 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 2015-2019 due to each of the causes listed in Table 26.

Table 26: 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
Diseases of heart	I00-I09, I11, I13, I20-I51
Essential hypertension and hypertensive renal disease	I10, I12, I15
Accidents (unintentional injuries)	V01-X59, Y85-Y86
Chronic liver disease and cirrhosis	K70, K73-K74
Nephritis, nephrotic syndrome and nephrosis	N00-N07, N17-N19, N25-N27
Pneumonia and influenza	J09-J18
Cerebrovascular disease (stroke)	I60-I69
Intentional self-harm (suicide)	*U03, X60-X84, Y87.0

While the HPI dataset was used as-is, additional processing was required to prepare the mortality data for analysis. This included two main steps. First, ZIP Codes associated with PO Boxes were merged with

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

the larger ZIP Codes in which they were located. Once this was completed, smoothed mortality rates were calculated for each resulting ZIP Code.

ZIP Code Consolidation

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

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

To incorporate these patients into the analysis, the point location (latitude and longitude) of all ZIP Codes in California[21] were compared to ZCTA boundaries.[22] 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.[23] 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

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[21] Datasheer, L.L.C. 2018. ZIP Code Database Free. Retrieved 16 Jul 2018 from http://www.Zip-Codes.com.
[22] US Census Bureau. 2021. TIGER/Line Shapefile, 2019, 2010 nation, U.S., 2010 Census 5-Digit ZIP Code Tabulation Area (ZCTA5) National. Retrieved 9 Feb 2021 from https://www.census.gov/cgi-bin/geo/shapefiles/index.php.
[23] Anselin, Luc. 2003. Rate Maps and Smoothing. Retrieved 14 Jan 2018 from http://www.dpi.inpe.br/gilberto/tutorials/software/geoda/tutorials/w6_rates_slides.pdf

address this issue by adjusting the calculated rate for areas with small populations so that they more closely resemble the mean rate for the entire study area. The amount of this adjustment is greater in areas with smaller populations, and less in areas with larger populations.

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

Significant Health Need Identification Dataset

The second main set of data used in the CHNA includes the health factor and health outcome indicators used to identify significant health needs (SHNs). The selection of these indicators was guided by the previously identified conceptual model. Table 27 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 27: Health factor and health outcome indicators used in health need identification

Conceptual Model Alignment			Indicator	Data Source	Time Period
Health Outcomes	Length of Life	Infant Mortality	Infant Mortality	County Health Rankings	2013 - 2019
		Life Expectancy	Child Mortality	County Health Rankings	2016 - 2019
			Life Expectancy	County Health Rankings	2017 - 2019
			Premature Age-Adjusted Mortality	County Health Rankings	2017 - 2019
			Premature Death	County Health Rankings	2017 - 2019
			Stroke Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Chronic Lower Respiratory Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Diabetes Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Heart Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Hypertension Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Cancer Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Liver Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Kidney Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Suicide Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Unintentional Injuries Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			COVID19 Mortality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2021-11-17
			COVID19 Case Fatality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2021-11-17
			Alzheimer's Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Influenza and Pneumonia Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
	Quality of Life	Morbidity	Diabetes Prevalence	County Health Rankings	2017
			Low Birthweight	County Health Rankings	2013 - 2019
			HIV Prevalence	County Health Rankings	2018
			Disability	2019 American Community Survey 5 year estimate variable S1810_C03_001E	2015 - 2019
			Poor Mental Health Days	County Health Rankings	2018
			Frequent Mental Distress	County Health Rankings	2018
			Poor Physical Health Days	County Health Rankings	2018
			Frequent Physical Distress	County Health Rankings	2018
			Poor or Fair Health	County Health Rankings	2018
			Colorectal Cancer Prevalence	California Cancer Registry	2013 - 2017
			Breast Cancer Prevalence	California Cancer Registry	2013 - 2017
			Lung Cancer Prevalence	California Cancer Registry	2013 - 2017
			Prostate Cancer Prevalence	California Cancer Registry	2013 - 2017

Conceptual Model Alignment			Indicator	Data Source	Time Period
			COVID19 Cumulative Incidence	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2021-11-17
			Asthma ED Rates	Tracking California	2018
			Asthma ED Rates for Children	Tracking California	2018
Health Factors	Health Behavior	Alcohol and Drug Use	Excessive Drinking	County Health Rankings	2018
			Drug Induced Death	CDPH 2021 County Health Status Profiles	2017 - 2019
		Diet and Exercise	Adult Obesity	County Health Rankings	2017
			Physical Inactivity	County Health Rankings	2017
			Limited Access to Healthy Foods	County Health Rankings	2015
			Food Environment Index	County Health Rankings	2015 & 2018
			Access to Exercise Opportunities	County Health Rankings	2010 & 2019
		Sexual Activity	Chlamydia Incidence	County Health Rankings	2018
			Teen Birth Rate	County Health Rankings	2013 - 2019
		Tobacco Use	Adult Smoking	County Health Rankings	2018
	Clinical Care	Access to Care	Primary Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Dental Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Mental Health Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Medically Underserved Area	U.S. Heath Resources and Services Administration	2021
			Mammography Screening	County Health Rankings	2018
			Dentists	County Health Rankings	2019
			Mental Health Providers	County Health Rankings	2020
			Psychiatry Providers	County Health Rankings	2020
			Specialty Care Providers	County Health Rankings	2020
			Primary Care Providers	County Health Rankings	2018; 2020
		Quality Care	Preventable Hospitalization	California Office of Statewide Health Planning and Development Prevention Quality Indicators for California	2019
			COVID19 Cumulative Full Vaccination Rate	CDPH COVID-19 Vaccine Progress Dashboard Data	Collected on 2021-11-17
	Socio-Economic and Demographic Factors	Community Safety	Homicide Rate	County Health Rankings	2013 - 2019
			Firearm Fatalities Rate	County Health Rankings	2015 - 2019

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Violent Crime Rate	County Health Rankings	2014 & 2016
			Juvenile Arrest Rate	Criminal Justice Data: Arrests, OpenJustice, California Department of Justice	2015 - 2019
			Motor Vehicle Crash Death	County Health Rankings	2013 - 2019
		Education	Some College	County Health Rankings	2015 - 2019
			High School Completion	County Health Rankings	2015 - 2019
			Disconnected Youth	County Health Rankings	2015 - 2019
			Third Grade Reading Level	County Health Rankings	2018
			Third Grade Math Level	County Health Rankings	2018
		Employment	Unemployment	County Health Rankings	2019
		Family and Social Support	Children in Single-Parent Households	County Health Rankings	2015 - 2019
			Social Associations	County Health Rankings	2018
			Residential Segregation (Non-White/White)	County Health Rankings	2015 - 2019
		Income	Children Eligible for Free Lunch	County Health Rankings	2018 - 2019
			Children in Poverty	County Health Rankings	2019
			Median Household Income	County Health Rankings	2019
			Uninsured Population under 64	County Health Rankings	2018
			Income Inequality	County Health Rankings	2015 - 2019
	Physical Environment	Housing and Transit	Severe Housing Problems	County Health Rankings	2013 - 2017
			Severe Housing Cost Burden	County Health Rankings	2015 - 2019
			Homeownership	County Health Rankings	2015 - 2019
			Homelessness Rate	US Dept. of Housing and Urban Development 2020 Annual Homeless Assessment Report	2020
			Households with no Vehicle Available	2019 American Community Survey 5-year estimate variable DP04_0058PE	2015 - 2019
			Long Commute - Driving Alone	County Health Rankings	2015 - 2019
			Access to Public Transit	OpenMobilityData, Transitland, TransitWiki.org, Santa Ynez Valley Transit; US Census Bureau	2021; 2020

Conceptual Model Alignment			Indicator	Data Source	Time Period
		Air and Water Quality	Pollution Burden Percent	California Office of Environmental Health Hazard Assessment	2018
			Air Pollution - Particulate Matter	County Health Rankings	2016
			Drinking Water Violations	County Health Rankings	2019

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

County Health Rankings Data

All indicators listed with County Health Rankings (CHR) as their source were obtained from the 2021 County Health Rankings[24] dataset. This was the most common source of data, with 52 associated indicators included in the analysis. Indicators were collected at both the county and state levels. County-level indicators were used to represent the health factors and health outcomes in the service area. State-level indicators served 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 28.

Table 28: Sources and time periods for indicators obtained from County Health Rankings.

CHR Indicator	Time Period	Data Source
Infant Mortality	2013 - 2019	National Center for Health Statistics - Mortality Files
Child Mortality	2016 - 2019	National Center for Health Statistics - Mortality Files
Life Expectancy	2017 - 2019	National Center for Health Statistics - Mortality Files
Premature Age-Adjusted Mortality	2017 - 2019	National Center for Health Statistics - Mortality Files
Premature Death	2017 - 2019	National Center for Health Statistics - Mortality Files
Diabetes Prevalence	2017	United States Diabetes Surveillance System
Low Birthweight	2013 - 2019	National Center for Health Statistics - Natality files
HIV Prevalence	2018	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Poor Mental Health Days	2018	Behavioral Risk Factor Surveillance System
Frequent Mental Distress	2018	Behavioral Risk Factor Surveillance System
Poor Physical Health Days	2018	Behavioral Risk Factor Surveillance System

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

CHR Indicator	Time Period	Data Source
Frequent Physical Distress	2018	Behavioral Risk Factor Surveillance System
Poor or Fair Health	2018	Behavioral Risk Factor Surveillance System
Excessive Drinking	2018	Behavioral Risk Factor Surveillance System
Adult Obesity	2017	United States Diabetes Surveillance System
Physical Inactivity	2017	United States Diabetes Surveillance System
Limited Access to Healthy Foods	2015	USDA Food Environment Atlas
Food Environment Index	2015 & 2018	USDA Food Environment Atlas, Map the Meal Gap from Feeding America
Access to Exercise Opportunities	2010 & 2019	Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files
Chlamydia Incidence	2018	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Teen Birth Rate	2013 - 2019	National Center for Health Statistics - Natality files
Adult Smoking	2018	Behavioral Risk Factor Surveillance System
Mammography Screening	2018	Mapping Medicare Disparities Tool
Dentists	2019	Area Health Resource File/National Provider Identification file
Mental Health Providers	2020	CMS, National Provider Identification
Psychiatry Providers	2020	Area Health Resource File
Specialty Care Providers	2020	Area Health Resource File
Primary Care Providers	2018; 2020	Area Health Resource File/American Medical Association; CMS, National Provider Identification
Homicide Rate	2013 - 2019	National Center for Health Statistics - Mortality Files
Firearm Fatalities Rate	2015 - 2019	National Center for Health Statistics - Mortality Files
Violent Crime Rate	2014 & 2016	Uniform Crime Reporting - FBI
Motor Vehicle Crash Death	2013 - 2019	National Center for Health Statistics - Mortality Files
Some College	2015 - 2019	American Community Survey, 5-year estimates
High School Completion	2015 - 2019	American Community Survey, 5-year estimates
Disconnected Youth	2015 - 2019	American Community Survey, 5-year estimates
Third Grade Reading Level	2018	Stanford Education Data Archive
Third Grade Math Level	2018	Stanford Education Data Archive
Unemployment	2019	Bureau of Labor Statistics
Children in Single-Parent Households	2015 - 2019	American Community Survey, 5-year estimates
Social Associations	2018	County Business Patterns
Residential Segregation (Non-White/White)	2015 - 2019	American Community Survey, 5-year estimates
Children Eligible for Free Lunch	2018 - 2019	National Center for Education Statistics
Children in Poverty	2019	Small Area Income and Poverty Estimates
Median Household Income	2019	Small Area Income and Poverty Estimates
Uninsured Population under 64	2018	Small Area Health Insurance Estimates

CHR Indicator	Time Period	Data Source
Income Inequality	2015 - 2019	American Community Survey, 5-year estimates
Severe Housing Problems	2013 - 2017	Comprehensive Housing Affordability Strategy (CHAS) data
Severe Housing Cost Burden	2015 - 2019	American Community Survey, 5-year estimates
Homeownership	2015 - 2019	American Community Survey, 5-year estimates
Long Commute - Driving Alone	2015 - 2019	American Community Survey, 5-year estimates
Air Pollution - Particulate Matter	2016	Environmental Public Health Tracking Network
Drinking Water Violations	2019	Safe Drinking Water Information System

The provider rates for the primary care physicians and other primary care 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 county and state level from the CDPH Cal-ViDa[25] online data query system for the years 2015-2019. Empirically bayes smoothed rates (EBRs) were calculated for each mortality indicator using the total county population figure reported in the 2017 American Community Survey 5-year Estimates table B03002. Data for 2017 were used because this represented the central year of the 2015–2019 range of years for which CDPH data were collected. The population data for 2017 were multiplied by five to match the five years of mortality data used to calculate smoothed rates. The smoothed mortality rates were then multiplied by 100,000 so that the final rates represented deaths per 100,000 people.

COVID-19 Data

Data on the cumulative number of cases and deaths[26] and completed vaccinations[27] for COVID-19 were used to calculate mortality, case-fatality, incidence, and vaccination rates. County mortality, incidence, and vaccination rates were calculated by dividing each of the respective values by the total population variable from the 2019 American Community Survey 5-year estimates table B01001, and then multiplying the resulting value by 100,000 to create rates per 100,000. Case-fatality rates were calculated by dividing COVID-19 mortality by the total number of cases, then multiplying by 100, representing the percentage of cases that ended in death.

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[25] State of California, Department of Public Health. 2021. California Vital Data (Cal-ViDa), Death Query. Retrieved 1 Jun 2021 from https://cal-vida.cdph.ca.gov/.
[26] State of California, Department of Public Health. 2021. Statewide COVID-19 Cases Deaths Tests. Retrieved 17 November 2021 from https://data.chhs.ca.gov/dataset/f333528b-4d38-4814-bebb-12db1f10f535/resource/046cdd2b-31e5-4d34-9ed3-b48cdbc4be7a/download/covid19cases_test.csv.
[27] State of California, Department of Public Health. 2021. COVID-19 Vaccine Progress Dashboard Data. Retrieved 24 November 2021 from https://data.chhs.ca.gov/dataset/e283ee5a-cf18-4f20-a92c-ee94a2866ccd/resource/130d7ba2-b6eb-438d-a412-741bde207e1c/download/covid19vaccinesbycounty.csv.

Drug-Induced Deaths Data

Drug-induced death rates were obtained from Table 19 of the 2021 County Health Status Profiles[28] 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[29] (HRSA). These included Dental, Mental Health, and Primary Care Health Professional Shortage Areas and Medically Underserved Areas/Populations. They also included the number of specialty care providers and psychiatrists per 100,000 residents, derived from the county-level Area Health Resource Files.

Health Professional Shortage Areas

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

Psychiatry and Specialty Care Providers

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 2018. This number was then divided by the 2018 total population given in the 2018 American Community Survey 5-year Estimates table B03002, and then multiplied by 100,000 to give the total number of specialty care physicians per 100,000 residents.

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

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[28] State of California, Department of Public Health, Vital Records Data and Statistics. 2021. County Health Status Profiles 2021: CHSP 2021 Tables 1-29. Spreadsheet. Retrieved on 21 Jul 2021 from https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP_2021_Tables_1-29_04.16.2021.xlsx.

[29] US Health Resources & Services Administration. 2021. Area Health Resources Files and Shortage Areas. Retrieved on 3 Feb 2021 from https://data.hrsa.gov/data/download.

Health Resource Files. It should be noted that psychiatrists are included in the list of specialty care physicians, so this indicator represents a subset of specialty care providers rather than a separate group.

California Cancer Registry

Data obtained from the California Cancer Registry[30] 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 2013 to 2017, and report cases per 100,000. For low-population counties, rates were calculated for a group of counties rather than for individual counties. That group rate was used in this report to represent incidence rates for each individual county in the group.

Tracking California

Data on emergency department visits rates for all ages as well as children aged 5 to 17 were obtained from Tracking California[31]. These data report age-adjusted rates per 10,000. They were multiplied by 100 in this analysis to convert them to rates per 100,000 to make them more comparable to the standard used for other rate indicators.

US Census Bureau

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

California Office of Environmental Health Hazard Assessment

Data used to calculate the pollution burden percent indicator were obtained from the CalEnviroscreen 3.0[32] dataset produced by the California Office of Environmental Health Hazard Assessment. This indicator reports the percentage of the population within a given county, or within the state as a whole, that live in a US Census tract with a CalEnviroscreen 3.0 Pollution Burden score in the 50th percentile or higher. Data on total population came from Table B03002 from the 2019 American Community Survey 5-year Estimates dataset.

California Department of Health Care Access and Information

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

Data on preventable hospitalizations were obtained from the California Department of Health Care Access and Information (formerly Office of Statewide Health Planning and Development) Prevention Quality Indicators[33]. 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[34]. This indicator reports the rate of felony arrests per 1,000 juveniles under the age of 18. It was calculated by dividing the total number of juvenile felony arrests for each county or state from 2015 - 2019 by the total population under 18 as reported in Table B01001 in the 2017 American Community Survey 5-year Estimates program. Population data from 2017 were used as this was the central year of the period over which juvenile felony arrest data were obtained. Population figures from 2017 were multiplied by 5 to match the years of arrest data used. Empirical bayes smoothed rates were calculated to increase the reliability of rates calculated for small counties. Finally, juvenile felony arrest rates were also calculated for Black, White, and Hispanic populations following the same manner, but using input population data from 2017 American Community Survey 5-year Estimates Tables B01001H, B01001B, and B01001I respectively.

US Department of Housing and Urban Development

Data from the US Department of Housing and Urban Development's 2020 Annual Homeless Assessment Report[35] were used to calculate homelessness rates for the counties and states. 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. The CoC for Sacramento County encompasses the entire county and does not extend beyond its borders.

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

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

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

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

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

stops. Likely due to delays in data releases stemming from the COVID-19 pandemic, the most recent Census block population data available at the time of the analysis was from the 2010 Decennial Census[36], so this was the data used to represent the distribution of population for this indicator. Transit stop data were identified first by using tools in the TidyTransit[37] library for the R statistical programming language[38]. This was used to identify transit providers with stops located within 100 miles of the state boundaries. A search for transit stops for these agencies, as well as all other transit agencies in the state, was conducted by reviewing three main online sources: OpenMobilityData[39], Transitland[40], Transitwiki.org[41], and Santa Ynez Valley Transit.[42] Each of these websites list public transit data that have been made public by transit agencies. Transit data from all providers that could be identified were downloaded, and fixed transit stop locations were extracted from them.

The sf[43] library in R was then used to calculate 1/4-mile (402.336 meter) buffers around each of these transit stops, and then to identify which Census blocks fell within these areas. The total population of all tracts within the stops' buffer was then divided by the total population of each county or state to generate the final indicator value.

Detailed Analytical Methodology

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

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[36] US Census Bureau. 2011. Census Blocks with Population and Housing Counts. Retrieved on 7 Jun 2021 from https://www2.census.gov/geo/tiger/TIGER2010BLKPOPHU/.

[37] Flavio Poletti, Daniel Herszenhut, Mark Padgham, Tom Buckley and Danton Noriega-Goodwin. 2021. tidytransit: Read, Validate, Analyze, and Map Files in the General Transit Feed Specification. R package version 1.0.0. https://CRAN.R-project.org/package=tidytransit.

[38] R Core Team (2021). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL https://www.R-project.org/.

[39] OpenMobilityData. 2021. California, USA. Retrieved all feeds listed on 31 May to 1 June 2021 from https://openmobilitydata.org/l/67-california-usa.

[40] Transitland. 2021. Transitland Operators. Retrieved all operators with California locations on 31 May to 1 June 2021 from https://www.transit.land/operators.

[41] Transitwiki.org. 2021. List of publicly-accessible transportation data feeds: dynamic and others. Retrieved on 31 May to 1 June 2021 from https://www.transitwiki.org/TransitWiki/index.php/Publicly-accessible_public_transportation_data#List_of_publicly-accessible_public_transportation_data_feeds:_dynamic_data_and_others.

[42] Santa Ynez Valley Transit. GTFS Files. Retrieved on 1 Jun 2021 from http://www.cityofsolvang.com/DocumentCenter/View/2756/syvt_gtfs_011921.

[43] 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.

Community of Concern Identification

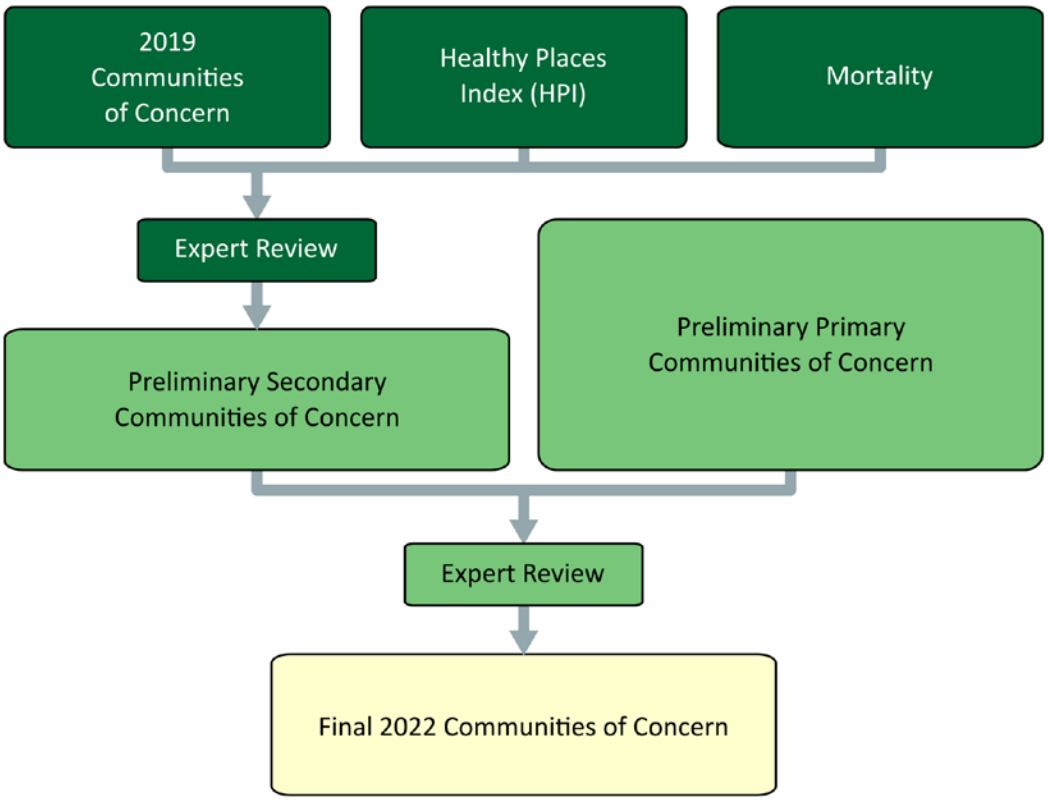

Figure 14: Community of Concern identification process

As illustrated in Figure 14, 2022 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 2019 CHNA; the census tract-level California Healthy Places Index (HPI); and the CDPH ZCTA-level mortality data.

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

2019 Community of Concern

A ZCTA was included if it was included in the 2019 CHNA Community of Concern list for the service. This was done to allow greater continuity between CHNA rounds and reflects the work of the hospital systems' orientation 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 service area. These census tracts represent areas with consistently high concentrations of demographic subgroups identified in the research literature as being more likely to experience health-related disadvantages.

CDPH Mortality Data

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

Integration of Secondary Criteria

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

Significant Health Need Identification

The general methods through which SHNs were identified are shown in Figure 15 and described here in greater detail. The first step in this process was to identify a set of potential health needs (PHN) 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 29.

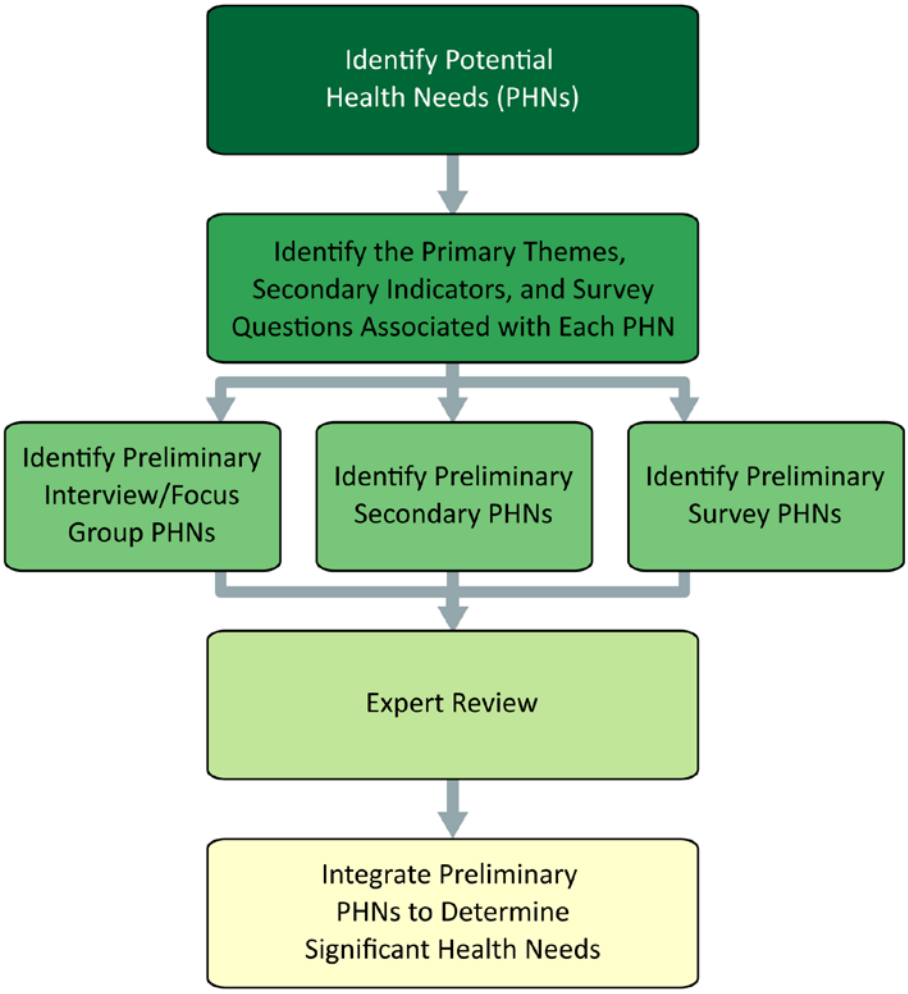

Figure 15: Significant health need identification process

Table 29: 2022 Potential Health Needs

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

The next step in the process was to identify primary themes and secondary indicators associated with each of these health needs as shown in Table 30 through Table 41. 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 30: Primary themes and secondary indicators associated with PHN1

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

Access to Quality Primary Care Health Services

Table 31: Primary themes and secondary indicators associated with PHN2

Primary Data Themes	Secondary Indicators
insurance is unaffordable.	Infant Mortality
Wait-times for appointments are excessively long.	Child Mortality
Out-of-pocket costs are too high.	Life Expectancy
There aren't enough primary care service providers in the area.	Premature Age-Adjusted Mortality
Patients have difficulty obtaining appointments outside of regular business hours.	Premature Death
	Stroke Mortality
Too few providers in the area accept Medi-Cal.	Chronic Lower Respiratory Disease
It is difficult to recruit and retain primary care providers in the region.	Mortality

Primary Data Themes	Secondary Indicators
Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine). The quality of care is low (e.g., appointments are rushed, providers lack cultural competence). Patients seeking primary care overwhelm local emergency departments. Primary care services are available, but are difficult for many people to navigate.	Diabetes Mortality Heart Disease Mortality Hypertension Mortality Cancer Mortality Liver Disease Mortality Kidney Disease Mortality COVID19 Mortality COVID19 Case Fatality Alzheimer's Disease Mortality Influenza and Pneumonia Mortality Diabetes Prevalence Low Birthweight Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health Colorectal Cancer Prevalence Breast Cancer Prevalence Lung Cancer Prevalence Prostate Cancer Prevalence Asthma ED Rates Asthma ED Rates for Children Primary Care Shortage Area Medically Underserved Area Mammography Screening Primary Care Providers Preventable Hospitalization COVID19 Cumulative Full Vaccination Rate Residential Segregation (Non-White/White) Uninsured Population under 64 Income Inequality Homelessness Rate

Active Living and Healthy Eating

Table 32: Primary themes and secondary indicators associated with PHN3

Primary Data Themes	Secondary Indicators
There are food deserts in the area where fresh, unprocessed foods are not available. Fresh, unprocessed foods are unaffordable. Food insecurity is an issue here. Students need healthier food options in schools. The built environment doesn't support physical activity (e.g., neighborhoods aren't 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,	Life Expectancy Premature Age-Adjusted Mortality Premature Death Stroke Mortality Diabetes Mortality Heart Disease Mortality Hypertension Mortality Cancer Mortality

Primary Data Themes	Secondary Indicators
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.	Kidney Disease Mortality Diabetes Prevalence Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health Colorectal Cancer Prevalence Breast Cancer Prevalence Prostate Cancer Prevalence Asthma ED Rates Asthma ED Rates for Children Adult Obesity Physical Inactivity Limited Access to Healthy Foods Food Environment Index Access to Exercise Opportunities Residential Segregation (Non-White/White) Income Inequality Severe Housing Cost Burden Homelessness Rate Long Commute - Driving Alone Access to Public Transit

Safe and Violence-Free Environment

Table 33: Primary themes and secondary indicators associated with PHN4

Primary Data 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 Hypertension Mortality Poor Mental Health Days Frequent Mental Distress Frequent Physical Distress Poor or Fair Health Physical Inactivity Access to Exercise Opportunities Homicide Rate Firearm Fatalities Rate Violent Crime Rate Juvenile Arrest Rate Motor Vehicle Crash Death Disconnected Youth Social Associations

Primary Data Themes	Secondary Indicators
	Income Inequality
	Severe Housing Problems
	Severe Housing Cost Burden
	Homelessness Rate

Access to Dental Care and Preventive Services

Table 34: Primary themes and secondary indicators associated with PHN5

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

Healthy Physical Environment

Table 35: Primary themes and secondary indicators associated with PHN6

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

Primary Data Themes	Secondary Indicators
	Air Pollution - Particulate Matter
	Drinking Water Violations

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

Table 36: Primary themes and secondary indicators associated with PHN7

Primary Data Themes	Secondary Indicators
Lack of affordable housing is a significant issue in the area.	Infant Mortality
The area needs additional low-income housing options.	Child Mortality
Poverty in the county is high.	Life Expectancy
Many people in the area do not make a living wage.	Premature Age-Adjusted Mortality
Employment opportunities in the area are limited.	Premature Death
Services for homeless residents in the area are insufficient.	Hypertension Mortality
Services are inaccessible for Spanish-speaking and immigrant residents.	COVID19 Mortality
Many residents struggle with food insecurity.	COVID19 Case Fatality
It is difficult to find affordable childcare.	Diabetes Prevalence
Educational attainment in the area is low.	Low Birthweight
	Poor Mental Health Days
	Frequent Mental Distress
	Poor Physical Health Days
	Frequent Physical Distress
	Poor or Fair Health
	COVID19 Cumulative Incidence
	Asthma ED Rates
	Asthma ED Rates for Children
	Drug Induced Death
	Adult Obesity
	Limited Access to Healthy Foods
	Food Environment Index
	Medically Underserved Area
	COVID19 Cumulative Full Vaccination Rate
	Some College
	High School Completion
	Disconnected Youth
	Third Grade Reading Level
	Third Grade Math Level
	Unemployment
	Children in Single-Parent Households
	Social Associations
	Residential Segregation (Non-White/White)
	Children Eligible for Free Lunch
	Children in Poverty
	Median Household Income
	Uninsured Population under 64
	Income Inequality
	Severe Housing Problems
	Severe Housing Cost Burden
	Homeownership
	Homelessness Rate

Primary Data Themes	Secondary Indicators
	Households with no Vehicle Available
	Long Commute - Driving Alone

Access to Functional Needs

Table 37: Primary themes and secondary indicators associated with PHN8

Primary Data Themes	Secondary Indicators
Many residents do not have reliable personal transportation.	Disability
Medical transport in the area is limited.	Frequent Mental Distress
Roads and sidewalks in the area are not well-maintained.	Frequent Physical Distress
The distance between service providers is inconvenient for those using public transportation.	Poor or Fair Health
	Adult Obesity
Using public transportation to reach providers can take a very long time.	COVID19 Cumulative Full
The cost of public transportation is too high.	Vaccination Rate
Public transportation service routes are limited.	Income Inequality
Public transportation schedules are limited.	Homelessness Rate
The geography of the area makes it difficult for those without reliable transportation to get around.	Households with no Vehicle Available
Public transportation is more difficult for some to residents to use (e.g., non-English speakers, seniors, parents with young children).	Long Commute - Driving Alone
	Access to Public Transit
There aren't enough taxi and ride-share options (e.g.,Uber, Lyft).	

Access to Specialty and Extended Care

Table 38: Primary themes and secondary indicators associated with PHN9

Primary Data Themes	Secondary Indicators
Wait-times for specialist appointments are excessively long.	Infant Mortality
It is difficult to recruit and retain specialists in the area.	Life Expectancy
Not all specialty care is covered by insurance.	Premature Age-Adjusted Mortality
Out-of-pocket costs for specialty and extended care are too high.	Premature Death
People have to travel to reach specialists.	Stroke Mortality
Too few specialty and extended care providers accept Medi-Cal.	Chronic Lower Respiratory Disease Mortality
The area needs more extended care options for the aging population (e.g. skilled nursing homes, in-home care)	Diabetes Mortality
There isn't enough OB/GYN care available.	Heart Disease Mortality
Additional hospice and palliative care options are needed.	Hypertension Mortality
The area lacks a kind of specialist or extended care option not listed here.	Cancer Mortality
	Liver Disease Mortality
	Kidney Disease Mortality
	COVID19 Mortality
	COVID19 Case Fatality
	Alzheimer's Disease Mortality
	Diabetes Prevalence
	Poor Mental Health Days
	Frequent Mental Distress
	Poor Physical Health Days
	Frequent Physical Distress

Primary Data Themes	Secondary Indicators
	Poor or Fair Health
	Lung Cancer Prevalence
	Asthma ED Rates
	Asthma ED Rates for Children
	Drug Induced Death
	Psychiatry Providers
	Specialty Care Providers
	Preventable Hospitalization
	Residential Segregation (Non-White/White)
	Income Inequality
	Homelessness Rate

Injury and Disease Prevention and Management

Table 39: Primary themes and secondary indicators associated with PHN10

Primary Data Themes	Secondary Indicators
There isn't really a focus on prevention around here.	Infant Mortality
Preventive health services for women are needed (e.g., breast and cervical cancer screening).	Child Mortality
	Stroke Mortality
There should be a greater focus on chronic disease prevention (e.g. diabetes, heart disease).	Chronic Lower Respiratory Disease Mortality
Vaccination rates are lower than they need to be.	Diabetes Mortality
Health education in the schools needs to be improved.	Heart Disease Mortality
Additional HIV and STI prevention efforts are needed.	Hypertension Mortality
The community needs nutrition education opportunities.	Liver Disease Mortality
Schools should offer better sexual health education.	Kidney Disease Mortality
Prevention efforts need to be focused on specific populations in the community (e.g. youth, Spanish-speaking residents, the elderly, LGBTQ individuals, immigrants).	Suicide Mortality
	Unintentional Injuries Mortality
Patients need to be better connected to service providers (e.g. case management, patient navigation, or centralized service provision).	COVID19 Mortality
	COVID19 Case Fatality
	Alzheimer's Disease Mortality
	Diabetes Prevalence
	Low Birthweight
	HIV Prevalence
	Poor Mental Health Days
	Frequent Mental Distress
	Frequent Physical Distress
	Poor or Fair Health
	COVID19 Cumulative Incidence
	Asthma ED Rates
	Asthma ED Rates for Children
	Excessive Drinking
	Drug Induced Death
	Adult Obesity

Primary Data Themes	Secondary Indicators
	Physical Inactivity
	Chlamydia Incidence
	Teen Birth Rate
	Adult Smoking
	COVID19 Cumulative Full Vaccination Rate
	Firearm Fatalities Rate
	Juvenile Arrest Rate
	Motor Vehicle Crash Death
	Disconnected Youth
	Third Grade Reading Level
	Third Grade Math Level
	Income Inequality
	Homelessness Rate

Increased Community Connections

Table 40: Primary themes and secondary indicators associated with PHN11

Primary Data Themes	Secondary Indicators
Health and social service providers operate in silos; we need cross-sector connection.	Infant Mortality
Building community connections doesn't seem like a focus in the area.	Child Mortality
Relations between law enforcement and the community need to be improved.	Life Expectancy
The community needs to invest more in the local public schools.	Premature Age-Adjusted Mortality
There isn't enough funding for social services in the county.	Premature Death
People in the community face discrimination from local service providers.	Stroke Mortality
City and county leaders need to work together.	Diabetes Mortality
	Heart Disease Mortality
	Hypertension Mortality
	Suicide Mortality
	Unintentional Injuries Mortality
	Diabetes Prevalence
	Low Birthweight
	Poor Mental Health Days
	Frequent Mental Distress
	Poor Physical Health Days
	Frequent Physical Distress
	Poor or Fair Health
	Excessive Drinking
	Drug Induced Death
	Physical Inactivity
	Access to Exercise Opportunities
	Teen Birth Rate
	Primary Care Shortage Area
	Mental Health Care Shortage Area
	Medically Underserved Area
	Mental Health Providers
	Psychiatry Providers
	Specialty Care Providers
	Primary Care Providers

Primary Data Themes	Secondary Indicators
	Preventable Hospitalization
	COVID19 Cumulative Full Vaccination Rate
	Homicide Rate
	Firearm Fatalities Rate
	Violent Crime Rate
	Juvenile Arrest Rate
	Some College
	High School Completion
	Disconnected Youth
	Unemployment
	Children in Single-Parent Households
	Social Associations
	Residential Segregation (Non-White/White)
	Income Inequality
	Homelessness Rate
	Households with no Vehicle Available
	Long Commute - Driving Alone
	Access to Public Transit

System Navigation

Table 41: Primary themes and secondary indicators associated with PHN12

Primary Data 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.	There are no secondary indicators associated with this PHN.

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

Table 42: Benchmark comparisons to show indicator performance

Indicator	Benchmark Comparison Indicating Poor Performance
Infant Mortality	Higher

Indicator	Benchmark Comparison Indicating Poor Performance
Child Mortality	Higher
Life Expectancy	Lower
Premature Age-Adjusted Mortality	Higher
Premature Death	Higher
Stroke Mortality	Higher
Chronic Lower Respiratory Disease Mortality	Higher
Diabetes Mortality	Higher
Heart Disease Mortality	Higher
Hypertension Mortality	Higher
Cancer Mortality	Higher
Liver Disease Mortality	Higher
Kidney Disease Mortality	Higher
Suicide Mortality	Higher
Unintentional Injuries Mortality	Higher
COVID19 Mortality	Higher
COVID19 Case Fatality	Higher
Alzheimer's Disease Mortality	Higher
Influenza and Pneumonia Mortality	Higher
Diabetes Prevalence	Higher
Low Birthweight	Higher
HIV Prevalence	Higher
Disability	Higher
Poor Mental Health Days	Higher
Frequent Mental Distress	Higher
Poor Physical Health Days	Higher
Frequent Physical Distress	Higher
Poor or Fair Health	Higher
Colorectal Cancer Prevalence	Higher
Breast Cancer Prevalence	Higher
Lung Cancer Prevalence	Higher
Prostate Cancer Prevalence	Higher
COVID19 Cumulative Incidence	Higher
Asthma ED Rates	Higher
Asthma ED Rates for Children	Higher
Excessive Drinking	Higher
Drug Induced Death	Higher
Adult Obesity	Higher
Physical Inactivity	Higher
Limited Access to Healthy Foods	Higher
Food Environment Index	Lower
Access to Exercise Opportunities	Lower
Chlamydia Incidence	Higher
Teen Birth Rate	Higher
Adult Smoking	Higher
Primary Care Shortage Area	Present
Dental Care Shortage Area	Present
Mental Health Care Shortage Area	Present
Medically Underserved Area	Present
Mammography Screening	Lower
Dentists	Lower
Mental Health Providers	Lower

Indicator	Benchmark Comparison Indicating Poor Performance
Psychiatry Providers	Lower
Specialty Care Providers	Lower
Primary Care Providers	Lower
Preventable Hospitalization	Higher
COVID19 Cumulative Full Vaccination Rate	Lower
Homicide Rate	Higher
Firearm Fatalities Rate	Higher
Violent Crime Rate	Higher
Juvenile Arrest Rate	Higher
Motor Vehicle Crash Death	Higher
Some College	Lower
High School Completion	Lower
Disconnected Youth	Higher
Third Grade Reading Level	Lower
Third Grade Math Level	Lower
Unemployment	Higher
Children in Single-Parent Households	Higher
Social Associations	Lower
Residential Segregation (Non-White/White)	Higher
Children Eligible for Free Lunch	Higher
Children in Poverty	Higher
Median Household Income	Lower
Uninsured Population under 64	Higher
Income Inequality	Higher
Severe Housing Problems	Higher
Severe Housing Cost Burden	Higher
Homeownership	Lower
Homelessness Rate	Higher
Households with no Vehicle Available	Higher
Long Commute - Driving Alone	Higher
Access to Public Transit	Lower
Pollution Burden Percent	Higher
Air Pollution - Particulate Matter	Higher
Drinking Water Violations	Present

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

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

For this report, a PHN was selected as a preliminary quantitative SHN if 50% 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 survey SHN if it was identified by at least 50% of survey respondents. Finally, a PHN was selected as a SHN if it was included as a preliminary SHN in two of these three categories.

Significant Health Need Prioritization

The final step in the analysis was to prioritize the identified SHNs. To reflect the voice of the community, SHN prioritization was based solely on primary data. Key informants and focus group participants were asked to identify the three top 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 number of times each health need was selected as one of the top health needs by survey respondents was also included.

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

Detailed List of Resources to Address Health Needs

Table 43: Resources potentially available to meet health needs

Organization Information			Significant Health Needs												
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance-	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	System Navigation	Injury and Disease Prevention and Management	Health Equity: Equal Access to Opportunities	Active Living and Healthy Eating	Safe and Violence-Free Environment	Increased Community Connections	Access to Specialty and Extended Care	Access to Functional Needs	Access to Dental Care and Preventive Services	Healthy Physical Environment
3 Strands Global	95762	www.3strandsglobalfoundation.org								x	x				
African American Perinatal Health – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/African-American-Perinatal-Health-Program/SP-African-American-Perinatal-Health-Program				x						x			
Agency on Aging Area 4	95815	agencyonaging4.org		x			x			x	x	x			
Alchemist Community Development Corporation	95814	alchemistcdc.org	x		x				x		x				
All Nations Church of God in Christ	95817	www.ancogic.org		x							x				
ALS Association– Greater Sacramento Chapter	95825	websac.alsa.org				x	x				x				
Alternatives Pregnancy Center	95825	alternativespc.org	x		x							x			
Alzheimer's Association	95815	www.alz.org/norcal	x								x				
American Cancer Society	95815	www.cancer.org/about-us/local/california					x		x		x	x			
American Heart Association – Sacramento	95811	www.heart.org/en/affiliates/california/sacramento					x		x		x	x			
American Lung Association - Sacramento	95814	www.lung.org/research/sota/city-rankings/states/california/sacramento					x				x	x			x
American Red Cross -	95815	www.redcross.org/local/california/gold-country/about-us/locations/sierra-delta-chapter		x	x						x				

Organization Information			Significant Health Needs												
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance-	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	System Navigation	Injury and Disease Prevention and Management	Health Equity: Equal Access to Opportunities	Active Living and Healthy Eating	Safe and Violence-Free Environment	Increased Community Connections	Access to Specialty and Extended Care	Access to Functional Needs	Access to Dental Care and Preventive Services	Healthy Physical Environment
American River Park Foundation program-Health and Recreation	95608	arpf.org/what-we-do/programs/health-recreation/							x		x				
Another Choice Another Chance	95823	www.acacsac.org	x								x				
Antioch Progressive Baptist Church	95832	www.antiochprogressivechurch.org		x							x				
Anti Recidivism Coalition	95816	www.antirecidivism.org/our-programs/		x											
Arcade Community Center	95821	www.mutualassistance.org/arcade-community-center	x				x		x		x				
Arcohe Union School District	95638	www.arcohe.net		x					x						
ARTZ Artists for Alzheimer's	95826	www.imstillhere.org/artz/artz-program					x								
Asian Community Center	95831	www.accsv.org	x	x			x		x		x		x		
Asian Pacific Community Counseling (APCC)	95820	apccounseling.org	x								x				
Asian Resources, Inc.	95824, 95814, 95610	asianresources.org		x							x				
Bayanihan Clinic	95827	www.bayanihanclinic.com			x	x	x								
Big Brothers Big Sisters of the Greater Sacramento Area	95825	bbbs-sac.org	x							x	x				
Bike Lab	95630	www.bikelabsac.org/about							x	x	x				
Birth and Beyond Home Visitation – WellSpace Health	95660	www.wellspacehealth.org/location/north-highlands-community-health-center-birth-and-beyond	x	x	x	x								x	

Organization Information			Significant Health Needs												
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance-	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	System Navigation	Injury and Disease Prevention and Management	Health Equity: Equal Access to Opportunities	Active Living and Healthy Eating	Safe and Violence-Free Environment	Increased Community Connections	Access to Specialty and Extended Care	Access to Functional Needs	Access to Dental Care and Preventive Services	Healthy Physical Environment
Bishop Gallegos Maternity Home	95763	bgmhsacramento.org		x						x			x		
Black Child Legacy Campaign	95833	blackchildlegacy.org		x			x								
Black Infant Health Program – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/Black-Infant-Health-Program/SP-Black-Infant-Health-Program				x	x								
Boys and Girls Clubs of Greater Sacramento	95824	bgcsac.org	x	x					x	x	x				
Breathe California of Sacramento Region	95814	sacbreathe.org			x		x				x				x
Brother To Brother	95838	www.brother2brothermentoring.org/our-leadership	x								x				
Building Healthy Communities	95820	sacbhc.org							x	x	x				
C.O.R.E. Medical Clinic	95816	www.coremedicalclinic.com	x		x	x									
California Bridge Program	94607	cabridge.org/solution/our-work	x			x									
California Children's Services – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/California-Childrens-Services/SP-California-Childrens-Services					x					x			
California Emergency Food Link	95828	www.foodlink.org		x											
California Endowment Building Health Communities	Sacramento County	www.calendow.org			x					x				x	x

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California Health Collaborative-STAAND-Gold County Rural Regional Project	93711	healthcollaborative.org/staand-gold-country-rural-regional-project	x		x	x						x			
California Youth Connection	95814	calyouthconn.org		x							x				
Camp ReCreation	95662	www.camprecreation.org							x		x				
Cal Voices	95825	www.calvoices.org									x				
Capital City AIDS Fund	95816	www.capcityaidsfund.org					x				x				
Capital Star Community Services- Sacramento County	95821	www.starsinc.com/sacramento-county	x	x											
Carrington College – Dental Hygiene Clinic (916) 361-5168	95826	carrington.edu/location/sacramento-dental-hygiene-clinic												x	
Catholic Charities of Sacramento, Inc.	95818	www.scd.org/catholic-charities-and-social-concerns/catholic-charities		x							x				
CCHAT Center Sacramento	95670	www.cchatsacramento.com									x	x			
Center Joint Unified School District	95843	www.centerusd.org	x	x					x						
Central Downtown Food Basket	98811	www.cdfb.og		x					x						
Chest Clinic/Tuberculosis Control – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/Communicable-Disease-Control/GI-TB-Control					x					x			
Child Abuse Prevention Center	95660	www.thecapcenter.org								x	x				

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Child and Family Institute (CFI)	95838	www.child-familyinstitute.org/home.htm	x												
Child Health & Disability Prevention – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/CHDP/Pages/CHDP-Home			x										
Children's Receiving Home of Sacramento	95821	www.crhkids.org	x	x	x				x						
Christy Cares Outreach	95758	christycaresoutreach.org		x						x					
Citrus Heights Homeless Assistance Resource Team (HART)	95610	citrusheightshart.org		x							x				
City Church of Sacramento	95817	citychurchsac.org		x							x				
City of Sacramento Community Gardens	Sacramento County	www.cityofsacramento.org/ParksandRec/Parks/Specialty-Parks/Community-Gardens									x				
Clara's House	95816	www.clarashouse.org			x						x				
Clinica Tepati (in WellSpace Clinic)	95817	clinicatepati.com			x	x	x				x	x			
Community Against Sexual Harm (CASH)	95816	cashsac.org	x							x	x				
Community Link (Community Services Planning Council)	95826	communitylinkcr.org	x								x				
Community Resources Project/WIC	95838	www.communityresourceproject.org/Services/Health/WIC		x		x			x						

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Comprehensive Perinatal Services Program – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/Comprehensive-Perinatal-Services-Program/SP-Comprehensive-Perinatal-Services-Program	x			x	x		x			x			
Consumnes Community Services District (CSD)-Elk Grove Parks and Recreation	95624	www.yourcsd.com/170/About								x	x				x
Cordova Lane Center – FCUSD	95670	www.fcusd.org/domain/993	x	x											
Cordova Recreation and Park District	95670	crpd.com	x	x					x		x				
Cottage Housing, Inc.	95811	cottagehousing.org		x							x				
Crime Victims Assistance Network (iCAN)	95811	www.ican-foundation.org	x							x					
Crisis Nursery Program – Sac Children's Home	95821	www.kidshome.org/what-we-do/crisis-nursery-program/	x		x					x	x				
Cristo Rey High School	95826	www.crhss.org								x	x				
Del Oro Caregiver Resource Center	95610	www.deloro.org	x				x				x	x			
Del Paso Union Baptist Church	95838	delpasounionbaptistchurch.org								x	x				
Dignity Health	95819, 95630, 95608, 95823	www.dignityhealth.org			x	x	x		x			x			

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Dignity Health- Interim Care Program (ICP) Sutter	95819, 95630, 95608, 95823	www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/partnerships-and-programs/interim-care-program	x	x		x				x			x		
Disease Control and Epidemiology – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/Epidemiology/SP-Epidemiology.aspx					x								
Drowning Accident Rescue Team	95759	www.dartsac.com					x				x				
Effie Yeaw Nature Center	95608	www.sacnaturecenter.net							x		x				
El Dorado Community Health Center	95667	www.edcchc.org	x		x									x	
El Hogar Community Services Inc	95811, 95834	www.elhogarinc.org	x	x						x	x				
Elica Health Centers	95825	www.elicahealth.org	x		x	x	x				x			x	
Elk Grove City Council	95758	www.elkgrovecity.org/home								x	x				
Elk Grove Fire Department	95624	www.yourcsd.com/968/Fire								x	x				
Elk Grove Food Bank	95624	elkgrovefoodbank.org		x							x				
Elk Grove Food Bank (Point Pleasant United Methodist Church)	95757	elkgrovefoodbank.org/supporters/partner-churches		x						x	x				
Elk Grove Police Department	95758	www.elkgrovepd.org								x					
Elk Grove Unified School District	95624	www.egusd.net	x	x	x				x	x					
Elverta Joint Elementary School District	95626	www.ejesd.net							x						

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Eskaton	Whole County	www.eskaton.org	x	x	x						x				
EveryOne Matters Ministries	95747	everyonemattersministries.com		x							x				
Firehouse Community Center	95838	www.mutualassistance.org/firehouse-community-center							x		x				
First 5 Sacramento Commission	95833	www.first5sacramento.net	x	x	x		x		x	x	x				
Folsom Cordova Community Partnership	95670	www.thefccp.org	x	x	x						x				
Food Literacy Center	95818	www.foodliteracycenter.org		x					x		x				
Foster Hope Sacramento	95841	fosterhopesac.org		x							x				
Francis House	95814	www.nextmovesacramento.org/francis-house-center		x							x				
Fresher Sacramento	95820	www.freshersacramento.com		x					x		x				
Fruit Ridge Community Collaborative	95820	www.fruitridgecc.org		x					x						
Galt Joint Union School District	95632	www.galt.k12.ca.us							x						
Gardenland Natomas Neighborhood Association (GNNA)	95835	www.gnna.info									x				
Gender Health Center	95817	www.thegenderhealthcenter.org/gender-health-center-2/	x	x	x	x	x			x	x				
Girls on the Run Greater Sacramento	95819	www.gotrsac.org							x		x				
Golden Rule Services	95823	sacgrs.org/			x		x				x	x			

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Goodwill – Sacramento Valley & Northern Nevada	95826	www.goodwillsacto.org		x							x				
Grace City - Formally The Grace Network	95851	gracecitysac.org/								x					
Greater Sacramento Urban League	95838	www.gsul.org		x							x				
Greater Sacramento Valley and Nevada Arthritis Foundation	95815	www.arthritis.org					x		x		x				
Guest House Homeless Clinic	95811	www.elhogarinc.org/guest-house-homelessclinic	x	x											
Harm Reduction Services (HRS)	95817	hrssac.org	x		x	x	x								
HART Carmichael	95609	carmichaelhart.org	x	x		x							x		
HART Citrus Heights	95610	citrusheightshart.org/resources/navigator		x		x							x		
HART Elk Grove	95759	www.elkgrovehart.org		x									x		
Health and Life Organization (HALO Cares) – Sacramento Community Clinic	95823 95815 95827 95834 95660	halocares.org	x		x		x					x			
Health Education Council	95831	healthedcouncil.org							x	x	x				
Health Rights Hotline	95814	lawyers.justia.com/legalservices/health-rights-hotline-11068		x		x									
Health Tech Academy – Valley High School	95838	vhs.egusd.net/programs/pathways/health-tech		x											

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Heartland Child and Family Services	95838, 95821	doingwhateverittakes.org	x			x									
Helping Hearts Foundation Inc.	95827	www.helping-hearts.org		x						x					
Heritage Oaks Hospital	95841	heritageoakshospital.com	x												
HIV/STD Prevention Program	95828, 95660, 95816, 95820, 95825, 95811, 95823, 95817, 95814	dhs.saccounty.net/PUB/SexualHealthPromotionUnit/Pages/GI-HIV-STD-Prevention-Program.aspx			x		x					x			
HIV/STD Surveillance – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/SexualHealthPromotionUnit/Pages/GI-STD-Control.aspx					x								
Hope Cooperative (aka TLCS, Inc.)	95825	hopecoop.org/	x	x	x						x				
House of Hope Ministry	95822	houseofhopeministrysacramento.org	x	x						x					
Human Services Coordinating Council (HSCC)	95823	dcfas.saccounty.net/Admin/Pages/HSCC/BC-Human-Services-Coordinating-Council-HSCC.aspx		x											
Imani Clinic	95817	www.imaniclinic.org	x		x		x								
Immunization Assistance Program – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/Immunization-Assistance-Program/Immunization-Assistance-Program-(IAP).aspx					x								
Interim HealthCare	95825	www.interimhealthcare.com/sacramentoca/home	x	x	x	x				x	x				

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International Rescue Committee	95825	www.rescue.org/united-states/sacramento-ca		x						x	x				
Iu-Mien Community Services (IMCS)	95824	www.unitediumien.org	x		x		x			x	x				
Johnston Community Center (also referred to as “Johnson” Community Center)	95815	www.mutualassistance.org/johnson-center	x	x			x		x		x				
Jubilare Evangelistic Ministries (JEM)	95834	jubilare.com								x	x				
Junior League of Sacramento	95825	www.jlsac.org									x				
Kaiser Permanente Sacramento Medical Center	95825	healthy.kaiserpermanente.org/northern-california/facilities/sacramento-medical-center-100330			x	x	x		x			x			
Kaiser Permanente South Sacramento Medical Center	95823	healthy.kaiserpermanente.org/northern-california/facilities/south-sacramento-medical-center-100320	x		x	x	x		x			x			
KidsFirst Auburn	95603	www.kidsfirstnow.org	x	x		x				x	x				
La Familia Counseling Center	95820	lafcc.org	x	x	x		x		x	x	x				
Lao Family Community Development, Inc.	95823	www.lfcd.org		x					x	x	x				
Latino Coalition for a Healthy California	95814	lchc.org			x		x								
Latino Leadership Council	95603	www.latinoleadershipcouncil.org									x				
Law Enforcement Chaplaincy Sacramento	95821	sacchaplains.com	x			x				x	x				

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Lead Poisoning Prevention Program – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/Childhood-Illness-Injury-Prevention-Program/LeadPoisoningPrevention/SP-Lead-Poisoning-Prevention.aspx					x								
Legal Services of Northern California – Health Rights	95814	lsnc.net/office/lsnc-health-program		x											
Life Matters	95842	www.lifemattersinc.org/		x							x				
Lighthouse of Hopeful Hearts	95189	www.lighthouseofhopefulhearts.org		x											
Lilliput Children's Services	95610, 95820	www.lilliput.org		x							x				
LINC Housing	95838	www.linchousing.org		x							x				
Loaves and Fishes	95811	sacloaves.org	x	x	x		x			x	x				
Lutheran Social Services	95824	www.lssnorcal.org		x							x				
Mack Road Partnership	95823	mackroadpartnership.com		x	x				x	x			x		
Mack Road Partnership Community Center	95823	mackroadpartnership.com/reimagine-foundation/programs		x	x				x		x				
MAK- Meningitis Awareness Key to Prevention	95608	makinfo.org					x								
Mary House	95811	www.sacfishes.org/programs/maryhouse	x	x						x	x				
McClellan VA Clinic	95652	www.va.gov/find-locations/facility/vha_612GH			x		x					x		x	
Meals on Wheels Sacramento	95831	www.mowsac.org		x							x				
Mental Health America of California	95811	www.mhac.org	x												

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Mercy Clinic – Loaves and Fishes	95811	sacloaves.org/programs-services			x	x	x				x				
Mercy Foundation	95670	supportmercyfoundation.org/home		x	x					x					
Mercy General Hospital (Dignity Health)	95819	www.dignityhealth.org/sacramento/locations/mercy-general-hospital			x	x	x		x			x			
Mercy Hospital Folsom	95630	www.dignityhealth.org/sacramento/locations/mercy-hospital-of-folsom			x	x	x		x			x			
Mercy Housing	95816, 95838, 95833, 95820, 95811	www.mercyhousing.org		x											
Mercy San Juan Medical Center (Dignity Health)	95608	www.dignityhealth.org/sacramento/locations/mercy-san-juan-medical-center	x		x	x	x		x			x			
Methodist Hospital of Sacramento (Dignity Health)	95823	www.dignityhealth.org/sacramento/locations/methodist-hospital-of-sacramento			x	x	x		x			x			
Mexican Consulate General in Sacramento	95834	consulmex.sre.gob.mx		x						x					
Molina Healthcare	95838, 95823	www.molinahealthcare.com			x	x									
Mutual Assistance Network	95838, 95821, 95815	www.mutualassistance.org	x	x			x		x		x				
My Sister's House	95818	www.my-sisters-house.org	x	x	x					x	x				
National Alliance on Mental Illness Sacramento (NAMI)	95827	namisacramento.org	x			x					x				

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National Multiple Sclerosis Society	95834	www.nationalmsociety.org					x								
Natomas Crossroads Clinic	95834	www.diabeteslocal.org/resource/natomas-crossroads-clinic			x										
Natomas Unified School District	95834	natomasunified.org	x	x					x						
NCADD Sacramento	95825	www.ncaddsac.org, www.ncadd.org	x												
Neighborhood Wellness Foundation	95838	neighborhoodwellness.org	x								x				x
Neil Orchard Senior Activities Center	95827	crpd.com/parks/neil-orchard-senior-activities-center							x		x				
New Testament Baptist Church	95660	www.newtestamentbaptchurch.org		x					x	x	x				
Next Move (SAEH)	95817	www.nextmovesacramento.org		x	x					x	x				
North Franklin District Business Association	95820	www.franklinblvddistrict.com/								x	x				
Nurse Family Partnership – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/Nurse-Family-Partnership/The-Nurse-Family-Partnership-Program.aspx				x	x					x			
Oak Park Community Center	95817	www.cityofsacramento.org/ParksandRec/Community-Centers/OakParkCenter							x		x				
Oak Park Neighborhood Association	95817	www.cityofsacramento.org/economic-development/community-engagement/neighborhood-directory/district5/oak-park-neighborhood-association								x					
Oak Park Sol Community Garden	95817	alchemistcdc.org/broadway-sol/							x		x				

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Obesity Prevention Program – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/Chronic-Disease-Prevention-Program/Obesity-Prevention-Program.aspx					x		x						
One Community Health	95811 95825	onecommunityhealth.com	x		x				x					x	
Opening Doors	95825	www.openingdoorsinc.org	x	x						x	x				
Oral Health Program – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/OralHealth/Pages/Oral-Health.aspx					x							x	
Orangevale Food Bank	95662	orangevalefoodbank.org		x					x		x				
Pacific Counseling and Trauma Center (Pacific Trauma Specialists)	95630	www.pacifictraumacenter.com	x								x				
Paratransit, Inc.	95822	paratransit.org											x		
Partners in Care	95603	picseniorcare.com		x											
Paul Hom Asian Clinic	95819	www.paulhomasianclinic.com/			x	x	x				x	x			
Peach Tree Health Sacramento	95834	www.pickpeach.org	x		x									x	
People Reaching Out (PRO) Youth and Families	95841	proyouthandfamilies.org	x								x				
Pioneer Congregational United Church of Christ	95816	pioneerucc.org		x							x				
Planned Parenthood B Street Health Center	95816	www.plannedparenthood.org/health-center/california/sacramento/95816/b-street-health-center-2200-90130?utm_campaign=b-street-health-center&utm_medium=organic&utm_source=local-listing			x	x	x					x			

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Planned Parenthood Capitol Plaza Health Center	95814	www.plannedparenthood.org/health-center/california/sacramento/95814/capitol-plaza-health-center-2199-90130?utm_campaign=capitol-plaza-health-center&utm_medium=organic&utm_source=local-listing			x	x	x					x			
Planned Parenthood Fruitridge Health Center	95820	www.plannedparenthood.org/health-center/california/sacramento/95820/fruitridge-health-center-2198-90130?utm_campaign=fruitridge-health-center&utm_medium=organic&utm_source=local-listing			x	x	x					x			
Planned Parenthood North Highlands Health Center	95660	www.plannedparenthood.org/health-center/california/north-highlands/95660/north-highlands-health-center-2201-90130?utm_campaign=north-highlands-health-center&utm_medium=organic&utm_source=local-listing			x	x	x					x			
Prevent Alcohol and Risk Related Trauma in Youth (P.A.R.T.Y.)	95763	partyprogram.com					x			x	x				
PRIDE Industries	95660, 95826, 95834	www.prideindustries.com		x											
Project TEACH	95826	www.scoe.net/divisions/ed_services/project_teach/		x						x					

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Public Health Division – Sacramento County Department of Health and Human Services	Entire county	dhs.saccounty.net/PUB/Pages/PUB-Home.aspx			x	x	x		x						x
Public Health Emergency Preparedness – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Emergency-Preparedness/Pages/SP-Emergency-Preparedness.aspx					x								
Public Health Laboratory – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Laboratory/Pages/Laboratory-Home.aspx					x								
radKIDS Childrens's Safety Education	27617	www.radkids.org								x	x				
Rebuilding Together - Sacramento	95826	rebuildingtogethersacramento.org								x	x				
River City Food Bank	95816, 95821	rivercityfoodbank.org		x					x		x				
River Delta Unified School District	94571	www.riverdelta.org							x		x				
River Oak Center for Children	95841	www.riveroak.org	x								x				
River Oak Family Resource Center	95820	www.riveroak.org/programs/	x				x		x		x				
Roberts Family Development Center	95815	www.robertsfdc.org		x					x		x				
Robla School District	95838	www.robla.k12.ca.us			x				x						
Roseville Unified School District	95661	www.rjuhsd.us								x					

Organization Information			Significant Health Needs												
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance-	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	System Navigation	Injury and Disease Prevention and Management	Health Equity: Equal Access to Opportunities	Active Living and Healthy Eating	Safe and Violence-Free Environment	Increased Community Connections	Access to Specialty and Extended Care	Access to Functional Needs	Access to Dental Care and Preventive Services	Healthy Physical Environment
Ryan White HIV Care & Treatment – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/SexualHealthPromotionUnit/Pages/RyanWhiteProgram/Ryan-White-Program.aspx	x		x	x	x					x			
Sacramento Children's Home - Meadowview Family Resource Centers	95822	www.kidshome.org/what-we-do/family-resource-center	x				x		x		x				
Sacramento Area Congregations Together (ACT)	95818	www.sacact.org	x	x							x				
Sacramento Children's Home	95820	www.kidshome.org	x	x					x	x	x				
Sacramento Chinese Community Services Center (SCCS)	95814	sccsc.org	x						x		x				
Sacramento City College – Dental Health Clinic	95822	scc.losrios.edu/dentalhealthclinic												x	
Sacramento City Unified School District	95824	www.scusd.edu	x	x	x										
Sacramento County Dental Health Program	Whole county	dhs.saccounty.net/PUB/OralHealth/Pages/Oral-Health.aspx												x	
Sacramento County Department of Health and Human Services	Whole county	dhs.saccounty.net/Pages/DHS-Home.aspx	x		x		x		x	x					x
Sacramento County Department of Human Assistance	Whole county	ha.saccounty.net/Pages/default.aspx		x											
Sacramento County Office of Education SCOE: Project TEACH	95826	www.scoe.net/divisions/ed_services/project_teach/about		x		x									

Organization Information			Significant Health Needs												
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance-	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	System Navigation	Injury and Disease Prevention and Management	Health Equity: Equal Access to Opportunities	Active Living and Healthy Eating	Safe and Violence-Free Environment	Increased Community Connections	Access to Specialty and Extended Care	Access to Functional Needs	Access to Dental Care and Preventive Services	Healthy Physical Environment
Sacramento County Women, Infants and Children (WIC)	95822, 95838, 95820, 95670, 95624	dhs.saccounty.net/PRI/WIC/Pages/Women-Infants-and-Children-Home.aspx		x		x									
Sacramento Countywide Foster Youth Services	95826	www.scoe.net/divisions/ed_services/fys		x											
Sacramento Court Appointed Special Advocates (CASA)	95827	sacramentocasa.org								x	x				
Sacramento Covered	95811	www.sacramentocovered.org			x	x									
Sacramento District Dental Foundation	95825	www.sdds.org/foundation/												x	
Sacramento Emergency Rental Assistance Program (SERA2)	95825	www.shra.org/about-shra		x											
Sacramento Employment and Training Agency (SETA)	95815	www.seta.net		x											
Sacramento Food Bank and Family Services	95817, 95838	www.sacramentofoodbank.org		x					x		x				
Sacramento Habitat for Humanity	95811	habitatgreatersac.org		x							x				
Sacramento Homeless Union	95825	www.sacramentohomelessunion.org	x												
Sacramento Housing Alliance	95814	sachousingalliance.org		x							x				

Organization Information			Significant Health Needs												
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Sacramento Housing and Redevelopment Agency (SHRA)	95814	www.shra.org		x											
Sacramento Junior Giants	95811	www.cityofsacramento.org/ParksandRec/Youth-Division/Youth-Sports-and-Summer-Programs/JR-Giants							x		x				
Sacramento Kindness Campaign	95864	www.sackindnesscampaign.org		x						x	x		x		
Sacramento LGBT Community Center	95811	saccenter.org		x		x				x	x				
Sacramento Life Center (SLC)	95825	saclife.org			x		x				x	x			
Sacramento Native American Health Center, Inc.	95811	www.snahc.org	x		x		x		x	x		x			
Sacramento Police Foundation	95822	sacpolicefoundation.org/wordpress									x				
Sacramento Regional Coalition to End Homelessness	95833	www.srceh.org		x											
Sacramento Self Help Housing	95818	www.sacselfhelp.org		x							x				
Sacramento Steps Forward	95833	sacramentostepsforward.org		x							x				
Sacramento Tree Foundation	95815	www.sactree.com									x				x
Sacramento County Unified School District	95824	www.scusd.edu	x	x					x	x					

Organization Information			Significant Health Needs												
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Sacramento Violence Intervention Program (SVIP) (WellSpace Health)	95828	www.wellspacehealth.org/services/behavioral-health-prevention/sac-violence-intervention-program				x				x	x				
Sacramento Women's Health	95825	sacwomenshealth.com			x	x	x					x			
Sacramento Works Job Centers	95817, 95610, 95670, 95823, 95632, 95838, 95842, 95820, 95824, 95817, 95655, 95828	sacramentoworks.org		x											
Safer Alternatives Thru Networking and Education (SANE)	95815	www.cleanneedles.org	x			x									
Safety Center	95827	safetycenter.org					x			x	x				
Saint John's Program for Real Change	95825	saintjohnsprogram.org	x	x							x				
Sam & Bonnie Pannell Community Center	95832	www.cityofsacrametno.org/ParksandRec/Community-Centers/SamBonniePannellCenter							x		x				
San Juan Unified School District	95608	www.sanjuan.edu	x	x					x	x				x	

Organization Information			Significant Health Needs												
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance-	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	System Navigation	Injury and Disease Prevention and Management	Health Equity: Equal Access to Opportunities	Active Living and Healthy Eating	Safe and Violence-Free Environment	Increased Community Connections	Access to Specialty and Extended Care	Access to Functional Needs	Access to Dental Care and Preventive Services	Healthy Physical Environment
San Juan Unified School District (FACE) Department	95608	www.sanjuan.edu/Page/525								x	x				
SeniorCare PACE	95823, 95818	www.sutterhealth.org/services/senior-geriatric/senior-pace			x		x		x			x			
SETA Head Start	95815	headstart.seta.net		x					x		x				
Sherriff Community Impact Program	95825	www.sacscip.org	x						x	x					
Shifa Community Clinic	95818	www.shifaclinic.org	x		x				x					x	
Shiloh Baptist Church	95817	www.shilohbaptistchurch-sacramento.org		x							x				
Shingle Springs Tribal TANF Program	95825	www.shinglespringsrancheria.com/tribal-tanf/		x											
Shriner's Hospital for Children	95817	www.shrinerschildrens.org/locations/northern-california			x	x	x					x			
Sierra Health Foundation	95833	www.sierrahealth.org	x		x		x		x	x	x				
Sierra Vista Hospital	95823	sierravistahospital.com	x												
Slavic Assistance Center	95825	www.slaviccenter.us		x											
Society for the Blind	95811	societyfortheblind.org					x				x	x			
Soil Born Farms	95670	soilborn.org/our-story		x					x	x	x				
South County Services	95632	southcountyservices.net		x									x		
South Natomas Community Center	95833	www.cityofsacramento.org/ParksandRec/Community-Centers/SouthNatomasCenter							x		x				
South Sacramento Interfaith Partnership Food Closet	95822	www.ssipfoodcloset.org		x											

Organization Information			Significant Health Needs												
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Southeast Asian Assistance Center	95822	teamsclc.org/	x								x				
St. Marks United Methodist Church	95864	stmarksumc.com		x						x	x				
St. Paul Missionary Baptist Church	95820	stpaulsac.org							x		x				
St. Vincent De Paul Good Shepard Catholic Church	95758	gscceg.org								x	x				
St. Vincent de Paul Sacramento Council	95816	www.svdp-sacramento.org		x							x				
Stanford Settlement	95833	www.stanfordsettlement.org		x					x		x		x		
Stanford Sierra Youth and Families	95826	www.ssyaf.org/	x	x						x	x				
Stop Stigma Sacramento Speakers Bureau	Whole county	www.stopstigmasacramento.org	x				x								
Su Familia- The National Hispanic Family Health Helpline	20036	www.healthyamericas@org/help-line			x										
Sunburst Projects	95825	sunburstprojects.org	x				x				x	x			
Sutter Center for Psychiatry	95826	www.sutterhealth.org/find-location/facility/sutter-center-for-psychiatry	x			x									
Sutter Health in Collaboration with WellSpace Health Street Nurse Program	Sacramento County	www.sutterhealth.org/about/street-nurse		x		x	x								
Sutter Medical Center, Sacramento	95616	www.sutterhealth.org/smcs	x		x	x	x					x			
Terra Nova Counseling	95628	www.terranovacounseling.org	x												

Organization Information			Significant Health Needs												
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The Cup With Love Project	95758	www.cupwithlove.org									x				
The Gardens – A Family Care Community Center	95822	thegardensfamily.org	x	x			x				x				
The Keaton Raphael Memorial	95661	childcancer.org					x				x				
The Mental Health Association	95825	www.mhac.org	x												
The Place Within Folsom	95830	www.theplacewithinfolsom.com	x												
The Salvation Army	95814, 95670, 95817	www.salvationarmyusa.org		x	x					x	x				
The Salvation Army – Adult Rehabilitation Center	95814	sacramento.salvationarmy.org/	x								x				
The SOL Project – Saving Our Legacy, African Americans for Smoke-Free Safe Places	95814	www.thesolproject.com	x								x				
Tobacco Education Program – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/Tobacco-Education-Program/SP-Tobacco-Education-Program.aspx					x								x
Triple-R Adult Day Centers - City of Sacramento	95816	www.cityofsacramento.org/ParksandRec/Recreation/older-adult-services/Programs/TripleR									x				
Turning Point Community Programs	95827	www.tpcp.org	x	x											
Twin Lakes Food Bank	95630	www.twinlakesfoodbank.org/		x							x				

Organization Information			Significant Health Needs												
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance-	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	System Navigation	Injury and Disease Prevention and Management	Health Equity: Equal Access to Opportunities	Active Living and Healthy Eating	Safe and Violence-Free Environment	Increased Community Connections	Access to Specialty and Extended Care	Access to Functional Needs	Access to Dental Care and Preventive Services	Healthy Physical Environment
Twin Rivers Unified School District	95660	www.twinriversusd.org	x	x					x						
U.S. Department of Veterans Affairs – Sacramento Vet Center	95825	www.va.gov/directory/guide/facility.asp?ID=521	x	x											
UC Davis Medical Center	95817	health.ucdavis.edu/medicalcenter/	x		x	x	x					x			
United Cerebral Palsy of Sacramento and Northern California	95841	ucpsacto.org					x				x				
VA Northern California Health Care System	95655	www.va.gov/northern-california-health-care/	x	x	x	x	x					x			
Valley Hi Family Resource Center	95823	valleyhifrc.com/	x								x				
Visions Unlimited	95823	www.vuinc.org	x												
Vital Records – Sacramento County Public Health	Whole county	dhs.saccounty.net/PUB/Pages/Birth-and-Death-Certificates/Sacramento-County-Vital-Records.aspx					x								
Volunteers of America – Northern California & Northern Nevada	95821	www.voa-ncnn.org/		x							x				
Waking the Village	95816	www.wakingthevillage.org		x					x	x					
WALK Sacramento	95814	www.walksacramento.org							x						
Warmline Family Resource Center	95818	www.warmlinefrc.org					x				x				
WEAVE	95811	www.weaveinc.org	x	x						x	x				
Wellness and Recovery Center – Consumers Self Help	95608, 95823	www.consumersselfhelp.org/wrc-north, www.consumersselfhelp.org/wrc-sourth-1	x								x				
Wellness Within	95678	www.wellnesswithin.org					x		x		x				

Organization Information			Significant Health Needs												
Name	Primary ZIP Code	Website	Access to Mental/Behavioral Health and Substance-	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Quality Primary Care Health Services	System Navigation	Injury and Disease Prevention and Management	Health Equity: Equal Access to Opportunities	Active Living and Healthy Eating	Safe and Violence-Free Environment	Increased Community Connections	Access to Specialty and Extended Care	Access to Functional Needs	Access to Dental Care and Preventive Services	Healthy Physical Environment
WellSpace Health	95632 95823 95826 95841 95828 95610 95621 95827 95834 95817 95660 95811 95820 95630 95821 95814	www.wellspacehealth.org	x		x	x	x			x		x		x	
WellSpace Health Residential Treatment Center	95815	www.wellspacehealth.org/services.counseling-prevention/addictions-counseling	x			x									
Wellspring Women's Center	95817	www.wellspringwomen.org	x			x			x		x				
Wind Youth Services	95817	www.windyouth.org	x	x							x				
Women's Empowerment	95811	womens-empowerment.org	x	x											
World Relief Sacramento	95660	worldrelief.org/sacramento		x		x					x				
YMCA of Superior California	95818	www.ymcasuperiorcal.org		x					x	x	x				
Yoga Seed Collective	95814	theyogaseed.org							x						
YWCA	95811	www.ywcaccc.org/sacramento	x	x			x				x				

Limits and Information Gaps

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

Related to primary data collection, gaining access to participants that best represented the populations needed for this assessment was a challenge for the key informant interviews, focus groups and CSP survey. The COVID-19 pandemic made it more difficult to recruit community members to participate in focus groups. Though an effort was made to verify all resources (assets) through a web search, ultimately some resources that exist in the service area may not be listed.

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 readily available as those data that detail the resulting health disparities. Having a clearer picture of early-in-life opportunity differences, as experienced by various populations, that result in later-in-life disparities can help direct community health improvement efforts for maximum impact.

Appendix A – Impact of Actions Taken

ACCESS TO MENTAL/BEHAVIORAL/SUBSTANCE-ABUSE SERVICES

Name of program/activity/initiative	**Area Wide Mental Health Strategy**
Description	The need for mental health services and resources, especially for the underserved, has reached a breaking point across the Sutter Health Valley Operating Unit. This is why we are focused on building a comprehensive mental health strategy that integrates key elements such as policy and advocacy, county specific investments, stigma reduction, increased awareness and education, with tangible outreach such as expanded mental health resources to professionals in the workplace and telepsych options to the underserved.
Goals	By linking these various strategies and efforts through engaging in statewide partnerships, replicating best practices, and securing innovation grants and award opportunities, we have the ability to create a seamless network of mental health care resources so desperately needed in the communities we serve.
Outcomes	In 2020, the mental health strategy helped with the following initiatives: • Advance legislation that expands the California Mental Health Parity Act and ensures that medical necessity coverage determinations are consistent with generally accepted standards of care. This legislation -- Senate Bill 855 – passed in June 2020. • Additionally, based on parity advocacy, the Governor publicly touted parity enforcement as a priority on a number of occasions and the enacted budget for California includes over $2.7 million in additional resources for the Department of Managed Health Care (DMHC) to enforce parity this year with $4.7 million annually thereafter. In 2021, the mental health strategy helped with the following initiatives: • Launch the 988 crisis line going live on July 26, 2022 • Pass SB803 for peer certification. • Secure funding for SB71/Bring CA Home in amount of $2 billion over two years and an unspecified amount future funding. • Advocate for funding for board and care with the County Behavioral Health Directors Association and other organizations serving people living with severe mental illness and/or substance use disorder. Resulting in securing $803 million, with program details still to be fleshed out. Propose Children and Youth Initiative and assist Secretary Ghaly to develop what became one of the Governor's signature budget achievements: $4.5 billion over five years to meet the behavioral health needs of children.

Name of program/activity/initiative	**Suicide Prevention ED Follow-Up Program**
Description	The Emergency Department Suicide Prevention Follow Up Program is designed to prevent suicide during a high-risk period, and post discharge, provide emotional support, and continue evidence based risk assessment and monitoring for ongoing suicidality. That includes personalized safe plans, educational and sensitive outreach materials about surviving a

	suicide attempt and recovery, 24-hour access to crisis lines, and referrals to community-based resources for ongoing treatment and support.
Goals	The goal of the Suicide Prevention program is to wrap patients with services and support following a suicide attempt or suicidal ideation.
Outcomes	In 2019, 18 patients received supportive services. In 2020, 33 patients received supportive services. In the first half of 2021,12 patients received supportive services.

Name of program/activity/initiative	**Triage Navigator Program**
Description	The Triage Navigator has become an important part of the ED and Psych Response Team and a vital resource for patients suffering from a mental health crisis. The Triage Navigator connects with complex patients who are not only battling mental health issues, but also have countless other challenges around substance abuse, homelessness, poverty and other health problems. The Triage Navigator, through the offering of specialized, wrap-around services, is making a positive impact on the lives of patients.
Goals	The goal of the Triage Navigator is to provide a linkage between our underserved population and behavioral/mental health resources.
Outcomes	Between July 2019-June 2020, 302 individuals were referred, and 215 individuals were screened and linked to behavioral/mental health resources. Between July 2020-June 2021, 286 individuals were referred, and 161 individuals were screened and linked to behavioral/mental health resources.

ACCESS TO QUALITY PRIMARY HEALTHCARE SERVICES

Name of program/activity/initiative	**Emergency Department Navigator (ED Navigator)**
Description	The ED Navigator serves as a visible ED-based staff member. Upon referral from a Sutter employee (and after patient agreement), ED Navigators attend to patients in the ED and complete an assessment for T3 case-management services. Upon assessment, the ED Navigator determines and identifies patient needs for community-based resources and/or case-management services, such as providing a patient linkage to a primary care provider and establishing a medical home.
Goals	The goal of the ED Navigator is to connect patients with health and social services, and ultimately a medical home, as well as other programs (like T3) when appropriate.
Outcomes	In 2019, 309 individuals were served, with a total of 563 service referrals to community resources. In 2020, 289 individuals were served and provided 245 service referrals to community resources. From Jan-June 2021, 142 individuals were served and provided 267 service referrals to community resources.

Name of program/activity/initiative	**Health Navigation: Reducing Barriers to Care**
Description	The Sacramento Health Navigator Program expands health navigation services in Sacramento 11 County and connects thousands of low-income residents to affordable health care coverage.

Goals	The overall goal of the project is to establish medical homes, thereby reducing dependence on emergency room systems of care.
Outcomes	The community needs addressed by this project, all of which support the under-insured and uninsured, include: 1) access to primary care, 2) access to preventive care, and 3) access to dental care. In 2019, 8,233 individuals were served, and 16,971 services were provided. In 2020, 7,979 individuals were served, and provided 19,741 services. Between Jan-June 2021, 2,723 individuals were served and provided 1,308 services.

Name of program/activity/initiative	**Interim Care Program (ICP)**
Description	A collaborative of the four health care systems and WellSpace Health, Volunteers of America and Sacramento County, the Sacramento Interim Care Program (ICP) is a respite-care shelter for homeless patients discharged from hospitals. The ICP wraps people with health and social services, while giving them a place to heal. Started in 2005, the ICP links people in need to vital community services while giving them a place to heal. The clients who are enrolled in the ICP are homeless adult individuals who otherwise would be discharged to the street or cared for in an inpatient setting only. The program is designed to offer clients up to six weeks during which they can focus on recovery and developing a plan for their housing and care upon discharge. This innovative community partnership provides temporary respite housing that offer homeless men and women a place to recuperate from their medical conditions, link them to vital community services, and provide them a place to heal.
Goals	The ICP seeks to connect patients with a medical home, social support and housing.
Outcomes	In 2019, ICP served 83 individuals with 13,112 services provided. In 2020, ICP served 96 individuals with 8,477 services provided. From Jan-June 2021, ICP served 63 individuals, providing 10,786 services. ICP helped people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care, shelter and other social support services.

Name of program/activity/initiative	**Interim Care Program Plus (ICP+)**
Description	SMCS offers an “expanded ICP” ICP+ aimed to meet the needs of patients with more complex needs and acute health issues. The program offers short-term (60-90 days) respite center serving homeless individuals post-hospitalization. Caters to individuals with higher medical acuity. Offers intensive case mgmt., access to LVNs & CNAs, medication educ., transportation, & referrals.
Goals	ICP+ seeks to connect patients with a medical home, social support and housing.
Outcomes	In 2019, ICP+ served 169 individuals with 137,558 services provided. In 2020, ICP+ served 191 individuals with 205,559 services provided. From Jan-June 2021, ICP+ served 92 individuals, providing 71,331 services. ICP+ helped people improve their overall health by wrapping them with services and treating the whole person through linkage to appropriate health care, shelter and other social support services.

Name of program/activity/initiative	**Triage, Transport, Treatment (T3)**
Description	T3 provides case management services for people who frequently access the SMCS EDs for inappropriate and non-urgent needs, by connecting vulnerable patients to vital resources such as housing, primary care, mental and behavioral health services, transportation, substance abuse treatment and other key community resources. By linking these patients to the right care, in the right place, at the right time and wrapping them with services, we see a drastic improvement to the health and overall quality of life for this often underserved, patient population.
Goals	The goal of T3 is to wrap patients with health and social services, and ultimately a medical home.
Outcomes	In 2019, T3 served 342 individuals with 1,370 services provided. In 2020, T3 served 387 individuals with 628 services provided. From Jan-June 2021, T3 served 326 individuals, providing 353 services to community resources.

Name of program/activity/initiative	**Triage, Transport, and Treatment Plus (T3+)**
Description	T3+ is similar to T3, except patients are identified in an inpatient setting and are often more complex. The T3+ navigator follows patients after discharge and works with Sutter Health staff to provide a follow-up health plan, tele-health, pain management, etc. All of this occurs while the T3+ navigators address the patient's other needs (including housing, insurance enrollment, etc.) and ensure a connection is made to primary and preventive care to reduce further hospitalization.
Goals	The goal of T3+ is to wrap patients with health and social services, and ultimately a medical home.
Outcomes	In 2019, T3+ served 89 individuals with 313 services provided. In 2020, T3+ served 133 individuals with 265 services provided. From Jan-June 2021, T3+ served 84 individuals, providing 90 services to community resources. T3+ program helped successfully connect patients with a medical home and social services, in turn, managing any long term health ailments and making the patient healthier overall.

Name of program/activity/initiative	**Street Nurse**
Description	Street Nurse works alongside our local community navigators. This increases opportunities to connect more homeless individuals to immediate medical care, necessary follow-up treatment and eventually a primary and behavioral health home to address the long-term healthcare needs for this underserved population. The Street Nurse has become a direct conduit from the community navigators to programs like ICP and ED Navigators.
Goals	The goal of the street nurse is to connect with patients in their environment (often homeless patients, on the street) provide them with health advice and certain services, then work with community partners to wrap patients with health and social services, and ultimately a medical home.
Outcomes	In 2019, Street Nurse served 497 individuals with 2,213 services provided. In 2020, the program served 479 individuals with 6,503 services provided. From Jan-June 2021, 250 individuals were served, providing 2,739 services. The street nurse successfully connected

	patients with a medical home and social services, in turn, getting patients off the street and making the patient healthier overall.
Name of program/activity/initiative	**Violence Prevention Navigator**
Description	WEAVE provides culturally responsive, trauma-informed, and survivor-centered case management, emergency shelter, transitional housing, counseling, and legal services. The program has grown, responding to more providers and survivors, providing training and outreach, and developing referral protocols.
Goals	Victims at highest risk of continued or escalating violence will be offered safe alternatives, including emergency shelter, transitional housing, legal intervention, advocacy, and support with their health, housing, and economic stability.
Outcomes	In 2019, 287 individuals were served, with 115 services provided and 348 referrals to community services. In 2020, 333 individuals were served, with 1,012 services provided and 742 referrals to community resources. Between Jan-June 2021, 79 individuals were served, with 315 services provided and 154 referrals to community resources.

Name of program/activity/initiative	**Ongoing Clinic Investments**
Description	With access to care, including primary, mental health and specialty care continuing to be a major priority area in the SMCS health service area, we will continue to make strategic investments in our local FQHC partners to increase clinic capacity and services offered. Creative collaborations and innovative opportunities with our clinic partners will continue to evolve with the needs of the community.
Goals	The goal is to expand access to care, especially for underserved populations who have barriers to receiving proper medical care.
Outcomes	From 2019 – June 2021 Sutter Health's partnership with WellSpace Health has served 2,858 individuals with primary care, behavioral/mental health care, and dental and other specialty services.

ACCESS TO BASIC NEEDS SUCH AS HOUSING, JOBS, AND FOOD

Name of program/activity/initiative	**Short-Term Medical Housing**
Description	Provide free short-term housing for patients and families who must leave their own community to seek medical care at Sutter Healthcare Centers and other medical facilities. This unique home-away-from-home experience has brought a compassionate response as well as emotional and financial relief to guests in need. These programs help families to access specialized medical treatment by providing a place to stay at little or sometimes no cost.
Goals	Keeping families with a sick family member together and near the care and resources they need.
Outcomes	Families are stronger when they are together. By staying at a short-term medical housing establishment, families can better communicate with their loved ones medical team and keep up with complicated treatment plans when needed. They can also focus on the health of their family member, rather than grocery shopping, cleaning or cooking meals.

	In 2019, 3,409 adults and youth were served. In 2020, 1,352 adults and youth were served with 4,634 bed nights provided. Between Jan-June 2021, 900 adults and youth were served with 4,539 bed nights provided.
Name of program/activity/initiative	**Serial Inebriate Program**
Description	The Serial Inebriate Program (SIP) addresses the health, safety, and housing needs of intoxicated, chronically homeless adults living on the streets of Sacramento. To qualify for SIP, individuals must have been admitted to local EDs, the Comprehensive Alcohol Treatment Center 16 (also known as the "detox" program) or arrested at least 25 times within the previous 12 months, and who pose a danger to themselves or others due to excessive alcohol consumption. During the 90-day stay, clients receive alcohol addiction counseling, and are offered permanent housing through Sacramento Self Help Housing. SIP clients are not only placed in a safe housing environment, but they are also wrapped with services to get on the road to sobriety and connect to health resources they were not aware of during their time on the streets. Additionally, SIP clients are connected with primary and mental health services, to help address their long-term medical needs and place these at-risk patients in permanent medical homes.
Goals	The goal is to get serial inebriates off the streets and into housing and alcohol and drug treatment.
Outcomes	Between 2019-2020, 28 individuals were served and obtained permanent housing.
Name of program/activity/initiative	**Community College Promise Scholarship Program**
Description	The Promise Scholarship is targeted to the neediest of these students attending full-time and gives flexible support that can help meet their most important needs. In addition to tuition fees, community college students have other attendance costs that stand in the way of postsecondary success (books, transportation, housing, student fees, lab equipment, supplies, childcare expenses, etc.), but they have less access to financial aid. 56% of Los Rios students are low income (approx. 40,000) nearly 32% live below the poverty line, and 13% are homeless.
Goals	The Promise Scholarship aims to remove the barriers that prevent students from achieving college success. By removing barriers, students have a greater chance of completing their degrees and entering the workforce ready to succeed.
Outcomes	In 2020, 180 students were awarded a promise scholarship. Between Jan-June 2021,100 students were awarded the promise scholarship.
Name of program/activity/initiative	**Food Factory Program**
Description	The Food Factory is a neighborhood incubator project and manufacturing facility that will provide a multitude of critical services for food entrepreneurs, including kitchen space, storage, distribution, marketing and business services.
Goals	The long-term goal of the project is to foster community investment and reduce health and economic inequities.

Outcomes	Due to COVID-19, the Food Factory project has halted. Once up and running, the Food Factory will provide space which can used for healthy food retail and farmer's market space. In addition, will provide residents an opportunity to improve their employment, educational, and health outcomes through supportive services including job training, connection to jobs, entrepreneurship, and increased access to food.

Name of program/activity/initiative	**Jr. Robotic Program**
Description	Jr. Robotic Program is designed to meet the 21st Century Science Standards and provide students with the opportunity to learn, technology and engineering and math concepts (STEM) in after school programs.
Goals	Encourage at-risk, underserved, and socio-economically disadvantaged children to further develop their education in the sciences and mathematics, as well as to encourage the development of partnerships between education and the industrial partners.
Outcomes	Due to COVID 19, Sacramento City Unified School District has paused the program and will continue in 2022. Through this program, students will develop critical thinking and team-building skills, core values, practices, basic STEM application and presentation skills.

Name of program/activity/initiative	**Clean Air Partnership (CAP)**
Description	CAP is a joint project of Breathe California Sacramento Region, the Sacramento Metro Chamber of Commerce, Valley Vision, and others to help the Sacramento region meet clean air standards that protect health, promote economic growth, and support equity.
Goals	CAP provides regional leadership to influence public policy centered on air quality and greenhouse gases. CAP's work centers on programs that help minimize smog-forming emissions from vehicles, which are the dominant source of the capital region's air pollution.
Outcomes	CAP has expanded and maintained a regional air quality coalition of business, public health, government, transportation and community leaders focused on reducing air emissions and advancing air quality and health benefits, providing policy work at the local, state and federal levels. In addition, the CAP has reached 3,834 individuals by event and outreach to support their work.

ACCESS TO SPECIALTY AND EXTENDED CARE

Name of program/activity/initiative	**SPIRIT**
Description	The Sacramento Physicians' Initiative to Reach out, Innovate and 14 Teach (SPIRIT) program recruits and places physician volunteers in community clinics to provide free medical services to our region's uninsured. The SPIRIT program also provides physician volunteers and case management for surgical procedures, including hernia and cataract repair, at local hospitals and ambulatory surgery centers that wish to donate services.
Goals	The overall goal of the project is to provide uninsured patients with outpatient surgeries they otherwise couldn't afford.
Outcomes	In 2019, 496 individuals were served, providing 122 surgical procedures. In 2020, 300 individuals were served, providing 93 surgical procedures. Between Jan-June 2021, 246 individuals were served, providing 77 surgical procedures.

Name of program/activity/initiative	**Society for the Blind**
Description	Society for the Blind is a comprehensive rehabilitative teaching center that provides low vision eye care and blindness skills education and services.
Goals	Provide low vision evaluations to low income, under and/or un-insured patients, provide OrCam Readers, Electronic Magnifiers or other assistive devices, provide transportation to low vision clinics
Outcomes	In 2019, 106 individuals were served, providing 96 services to community resources. In 2020, 93 individuals were served, providing 127 services to community resources. Between Jan-June 2021, 48 individuals were served, providing 118 services to community resources.

ACCESS TO ACTIVE LIVING AND HEALTHY EATING

Name of program/activity/initiative	**Midtown Parks**
Description	To provide safety and maintenance services including outreach to homeless individuals, place making including health-focused free park activations and improvements such as lighting and business development in parks and public spaces, and advocacy related to infill development, alternative transportation, investment in infrastructure, and reducing homelessness.
Goals	To establish and maintain the quality of life in a community, ensuring the health of families and youth, and contributing to the economic and environmental well-being of the community.
Outcomes	Outcomes of this program is continued support of the well-being of the community by creating centrally-located public spaces designed to provide opportunities for recreation, leisure, and to build relationships with neighbors. In 2019, 11,903 people were reached through evets/outreach and provided health education services. In 2020, 98,504 people were reached through events/outreach and provided health education services.

Name of program/activity/initiative	**Food Literacy Program**
Description	To teach elementary children in low-income schools cooking and nutrition to improve our health, environment, and economy.
Goals	To reach 700 elementary students during free 14-week afterschool programs. Provide hands-on cooking & nutrition classes covering topics such as fiber, sugar, and fruit & vegetable appreciation. Improve children's attitude through repeated exposure to new foods through tasting education. Improve children's behavior by repeating skills until they become habits, including sending recipes home to replicate with their families and training them to ask for veggies.
Outcomes	In 2019, 2,343 children and youth were served and distributed 2,859 pounds of food. In 2020, 1,945 children and youth were served, 9600 pounds of food distributed. This program helped improved children's knowledge toward healthy food to improve their attitude and develop the habit of eating healthy.

Name of program/activity/initiative	**Sacramento Food Bank & Family Services (SFBFS)**
Description	Sacramento Food Bank & Family Services (SFBFS) is the largest nonprofit provider of basic human needs in Sacramento County. Food Bank provides healthy emergency food, assistance and referrals to promote self-sufficiency through a variety of programs in Sacramento.
Goals	SFBFS has evolved from a food pantry to a provider of services for lifelong Sacramento residents—as well as immigrants and refugees who have chosen to make Sacramento their home. Each client we serve comes to us with a unique set of circumstances. Each also comes with a collective hope: to step out of poverty and into a future that allows them to flourish.
Outcomes	In 2019, 308,000 adults and youth were served, providing 27,304,440 pounds of food distributed. In 2020, 1,414,877 adults and youth were served, providing 40,470,533 pounds of food distributed.

ACCESS TO MEETING FUNCTIONAL NEEDS (TRANSPORTATION AND PHYSICAL MOBILITY)

Name of program/activity/initiative	**Evaluating Fare-Free Transit**
Description	RydeFreeRT waives youth fares on bus, light rail, and SmaRT Ride microtransit service across SacRT's service area, which includes the cities of Sacramento, Folsom, Citrus Heights, and Rancho Cordova and parts of Sacramento County. Approximately 220,000 students in grades TK through 12, home-schooled students, and foster and homeless youth are all eligible.
Goals	The program aims to decrease truancy and eliminate obstacles for young people to get to school, after-school activities, sports, clubs, and jobs.
Outcomes	Program found a significant increase in the share of students who reported using SacRT to get to and from school, as well as a corresponding statistically significant decrease in the share of students reporting traveling to and from school in an automobile Students who reported using SacRT also reported that they can more easily access important non-school destinations because of the RydeFreeRT program. The RydeFreeRT program was well received, pre-COVID-19, by February 2020, student ridership increased by 127%. Even during the COVID-19 pandemic, students took advantage of the fare-free program as SacRT provided more than 1 million rides in 2020.

SYSTEM NAVIGATION

Name of program/activity/initiative	**Community Navigator**
Description	The Community Navigator connects with homeless individuals. The Community Navigator slowly builds relationships with these people and helps wrap them with services, such as housing, a medical home, a PCP/mental health provider, alcohol 15 and drug treatment and other social services. The Community Navigator is integrated with both the Street Nurse and the SMCS ED, Case Management and Social Work staff, to ensure a continuum of care for homeless patients both within the walls of the hospital and out in the community.

Goals	This effort seeks to provide homeless individuals with a medical home, linkages to health and social resources and a successfully connection to housing/shelter.
Outcomes	In 2019, 107 individuals were served and provided 114 services to community resources. In 2020, 45 individuals were served and provided 6 services to community resources.

Name of program/activity/initiative	**Pediatric/Health Patient Navigation**
Description	Pediatric/Health navigation provides health navigation services, including but not limited to assistance with scheduling timely discharge appointments of newborns, adding newborns to Medi-Cal case, plan selection/changes to assigned provider or health plan, primary dental or vision care appointments, transportation services, interpreting services, education on health coverage and nutrition program, and referrals to other resources.
Goals	The goal of Pediatric Navigation is to provide newborns with health and social services. The priority goal for a Patient Navigator is to find healthcare homes for uninsured and underinsured patients, where they can receive appropriate levels of care with the desired outcome being improved health for designated patient populations.
Outcomes	In 2019, 8,233 individuals were served, with 1,6971 services provided and connected to 1138 community resources. In 2020, 7,979 individuals were served, with 19,741 services provided and connected to 1,373 community resources. Between Jan-June 2021, 2,723 individuals were served, with 1,308 services provided and connected to 438 community resources.

CULTURAL COMPETENCE

Name of program/activity/initiative	**World Relief Refugee Women's Integration Program**
Description	Over 13,000 refugees have arrived in northern California in the past five years. An especially vulnerable subset of this group are women, many of whom are not literate in any language. The health literacy-based English classes will address the issues around social isolation, language barriers, health access among refugee women, and create a scalable model to serve this population, thus creating healthier communities.
Goals	The goal of this program is to have 120 refugee women enroll in Women's Education programs and complete a health literacy curriculum over a 12-month period.
Outcomes	In 2019, 48 individuals were served, with 46 services provided and 28 referrals to community services. In 2020, 98 individuals were served, with 119 services provided and 240 referrals to community resources. Between Jan-June 2021, 39 individuals were served, with 56 services provided and 168 referrals to community resources.

Name of program/activity/initiative	**LGBTQ**
Description	The Sacramento LGBT Community Center works to create a region where LGBTQ people thrive. It supports the health and wellness of the most marginalized, advocates for equality and justice, and works to create a culturally rich LGBTQ community.

Goals	The goals of this organization will support increased access for LGBTQ+ people to preventive sexual health and mental health support, homeless and at-risk LGBTQ+ youth support services, youth development activities, and cultural competency education.
Outcomes	In 2019, 2,338 individuals were served, with 2,158 services provided and 663 referrals to community services. In 2020, 1,107 individuals were served, with 13,614 services provided and 629 referrals to community resources. Between Jan-June 2021, 1,686 individuals were served, with 13,226 services provided and 2,171 referrals to community resources.

Name of program/activity/initiative	**Gender Health Center**
Description	The Gender Health Center provides counseling/therapy services to anyone who expresses the need as well as anyone who self identifies or is perceived to be gender variant. The services embrace the psychological well-being and self-fulfillment of individuals coming out and/or beginning or in the transition process in a safe, supportive and welcoming environment.
Goals	The Gender Health Center aims to affect change that alleviates the systematic oppression of transgender people- especially those at intersections of identities- through advocacy and direct services, while using a mental health-centered model and social justice lens
Outcomes	In 2019, 394 individuals were served, with 4,755 services provided and 220 referrals to community services. In 2020, 499 individuals were served, with 7,156 services provided and 623 referrals to community resources. Between Jan-June 2021, 1,686 individuals were served, with 13,226 services provided and 2,171 referrals to community resources.