2016 Community Health Needs Assessment

Kaiser Foundation Hospital Sacramento
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Approved by KFH Board of Directors
September 21, 2016

To provide feedback about this Community Health Needs Assessment, email CHNA-communications@kp.org

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Acknowledgements

This report was prepared by Valley Vision on behalf of Kaiser Foundation Hospital-Sacramento and the Sacramento Region CHNA Collaborative. Through the course of the CHNA project, many organizations and individuals contributed input on the health issues and conditions impacting their communities or the communities they serve. We gratefully acknowledge the contributions of all these participants, many of whom shared deeply personal challenges and experiences with us. We hope that the contents of this report serve to accurately represent their voices.

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I. EXECUTIVE SUMMARY

A. Community Health Needs Assessment (CHNA) Background

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf).

While Kaiser Permanente has conducted CHNAs for many years to identify needs and resources in our communities and to guide our Community Benefit plans, these new requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhancing compliance and transparency and leveraging emerging technologies. The CHNA process undertaken in 2016 and described in this report was conducted in compliance with current federal requirements.

B. Summary of Prioritized Needs

The following significant health needs were identified through the CHNA Process and are presented in order of priority according to a set of criteria detailed in section VI-B:

1. **Access to behavioral health services (mental health & substance abuse)** is a significant health need in the Kaiser Foundation Hospital (KFH)-Sacramento Hospital Service Area (HSA). Eight of 13 indicators (62%) pertaining to mental health perform poorly compared to state benchmarks, and eight of 12 indicators (67%) pertaining to substance abuse also compare unfavorably to the benchmarks. The issue of mental health is marked by high rates of suicide, a shortage of mental health providers, high rates of emergency department (ED) visits and hospitalization (H) for mental health conditions and self-inflicted injury. Substance use issues are evident from high percentages of alcohol consumption and expenditures, and high rates of ED and H for substance abuse. Of 47 key informant interviews and community member focus groups, 46 mention health issues or drivers related to access to behavioral health services as a health need. Input from service providers and community members indicates that the need for behavioral health services far outweighs the resources currently available in the HSA.

2. **Healthy Eating and Active Living (HEAL)** is a significant health need in the KFH-Sacramento HSA. Sixteen of 30 indicators (53%) pertaining to HEAL compare unfavorably to the state benchmarks. The lack of healthy eating and/or active living is marked by high rates of obesity and diabetes mortality in adults, physical inactivity among youth and ED visits for osteoporosis. There is a higher rate of fast food restaurants per capita, and a lower rate of Women, Infant, Children (WIC) authorized food stores. Of 47 key informant interviews and community member focus groups, 45 mention health issues or drivers related to healthy eating and active living as a health need. Input from service providers and community members indicates that HEAL opportunities are greatly needed. Particular populations of high concern include those who are low-income or rely on CalFresh or WIC benefits.

3. **Safe, crime and violence-free communities** is a significant health need in the KFH-Sacramento HSA. Twenty-one of 26 indicators (81%) pertaining to safe, crime and violence-free communities perform poorly compared to state benchmarks. The lack of safe communities is marked by high rates of major crimes (assault, rape, and robbery), youth intentional injuries, domestic violence, pedestrian accident mortalities, and high rates of ED visits and H for assault and unintentional injuries. Of 47 key informant interviews and community member focus groups, 45 mention health issues or drivers related to safe, crime and violence-free communities as a health need. Vulnerable populations include those experiencing homelessness, women, children and youth, people of color, those with substance abuse issues, and undocumented individuals. Significant issues include substance abuse, domestic violence and sexual assault, child abuse and trauma, and gang violence.

4. **Basic needs (food, housing, employment, education)** are a significant health need in the KFH-Sacramento HSA. Upstream health determinants (e.g. housing, employment and education) have the potential to impact downstream health determinants such as diabetes, heart disease and mental health. Fifteen of 25 indicators (60%) pertaining to basic needs compare unfavorably to the state benchmarks. The lack of basic needs being met are marked by high poverty percentages (population below 100% Federal Poverty Level [FPL], population below 200% FPL, and children below 100% FPL), a high percentage of people receiving Supplemental Nutrition Assistance Program (SNAP) benefits and those living within a food desert, and a high percentage of children in grade four reading below the proficient level. Of 47 key informant interviews and community member focus groups, 46 mention health issues or drivers related to basic needs as a health need. Input from service providers and community members indicates that basic needs are a significant concern within the service area. Vulnerable populations include those experiencing homelessness, those living on a limited income or working minimum wage jobs, low-income seniors and children, recent immigrants, and undocumented individuals. Noteworthy issues raised include the lack of economic security, few affordable housing options, food insecurity and low educational attainment.

5. **Access to high quality health care and services** is a significant health need in the KFH-Sacramento HSA. Thirteen of 32 indicators (41%) pertaining to access to care perform poorly compared to the state benchmarks. Issues related to access to care are marked by a lack of prenatal care, a low rate of access to dentists and recent dental exams for youth, and high rates of ED visits and H for dental/oral diseases. Of 47 key informant interviews and community member focus groups, 45 mention health issues or drivers related to access to high quality health care and services as a health need. Input from service providers and community members indicates that the need for high quality health care services far outweighs the resources currently available in the HSA. Populations of high concern include: those on Medi-Cal, ethnic groups with distinct language or cultural differences, refugees and recent immigrants, undocumented individuals, those identifying as LGBT, those experiencing homelessness, and seniors on restricted incomes.

6. **Disease prevention, management and treatment** is a significant health need in the KFH-Sacramento HSA. Forty-eight of 64 indicators (75%) pertaining to disease prevention and management of cancer, cardiovascular disease and stroke (CVD/Stroke), asthma, and HIV/AIDS/STDs compare unfavorably compared to the state benchmarks. Issues related to cancer are marked by a high all cause cancer mortality rate and an elevated incidence of breast, colon and rectum, prostate, and lung cancers as compared to the state benchmarks, as well as high rates of ED visits for lung, prostate, colorectal,

and breast cancers. Issues related to CVD/Stroke are evidenced by the high rate of mortality from ischemic heart disease and stroke, and high rates of visits ED and H for heart diseases and stroke. Issues related to asthma are marked by high prevalence and high rates of ED visits and H for asthma. Issues related to HIV/AIDS and Sexually Transmitted Infections (STIs) are discernable from high rates of chlamydia and gonorrhea, ED visits for sexually transmitted infections and a high prevalence of HIV. Of 47 key informant interviews and community member focus groups, 35 mention health issues or drivers related to disease prevention, management and treatment as a health need.

7. **Pollution free living and work environments** are a significant health need in the KFH-Sacramento HSA. Fifteen of 26 indicators (58%) pertaining to pollution-free living and work environments perform poorly compared to the state benchmarks. The issue of pollution is marked by high rates of particulate matter, a high prevalence of asthma, and a higher pollution burden score in the communities of West Sacramento, Davis (southeast), Midtown Sacramento, and Rancho Cordova. Of 47 key informant interviews and community member focus groups, 23 mention health issues or drivers related to pollution free living and work environments as a health need. Input from service providers and community members indicates that poor air quality and asthma are significant concerns within the service area. Particular populations of concern include children, seniors in poor health, farm workers, and those exposed to second hand smoke.

C. Summary of Needs Assessment Methodology and Process

The Community Healthy Needs Assessment (CHNA) was completed as a collaboration of the four major health systems in the Greater Sacramento region: Dignity Health, Kaiser Permanente, Sutter Health and UC Davis Health System. Together, the CHNA Collaborative represented 15 hospitals in the Sacramento Region including three Kaiser Permanente hospitals: KFH-Sacramento, KFH-South Sacramento, and KFH-Roseville.
The CHNA Collaborative served to collectively conduct the 2016 CHNA and to support a coordinated approach to community benefit planning and activities. Building on federal and state requirements, the objective of the 2016 CHNA was:

To identify and prioritize community health needs and identify resources available to address those health needs, with the goal of improving the health status of the community at large with a particular focus on specific locations and/or populations experiencing health disparities.

From this objective the following research questions were used to guide the 2016 CHNA:

1. What is the community or hospital service area (HSA) served by each hospital in the CHNA Collaborative?
2. What specific geographic locations within the community are experiencing social inequities that may result in health disparities?
3. What is the health status of the community at large as well as of particular locations or populations experiencing health disparities?
4. What factors are driving the health of the community?
5. What are the significant and prioritized health needs of the community and requisites for the improvement or maintenance of health status?
6. What are the potential resources available in the community to address the significant health needs?

To meet the project objective, a defined set of data collection and analytic stages were developed. Data collected and analyzed included both primary or qualitative data, and

secondary or quantitative data. To determine geographic locations affected by social inequities, data were compiled and analyzed at the census tract and ZIP code levels as well as mapped by GIS systems. From this analysis as well as an initial preview of the primary data, Focus Communities were identified within the HSA. These were defined as geographic areas (ZIP codes) within the HSA that had the greatest concentration of social inequities (e.g. poverty, educational attainment and health disparities) that may result in poor health outcomes. Focus Communities were important to the overall CHNA methodology because they allowed for a place-based lens with which to consider health disparities in the HSA.

To assess overall health status and disparities in health outcomes, indicators were developed from a variety of secondary data sources. Data on gender and race/ethnicity breakdowns were analyzed when available. Overall, more than 180 indicators were included in the CHNA. For details on specific sources and dates of the data used, please see Appendix A.

Community input and primary data on health needs were obtained via interviews with service providers and community key informants and through focus groups with medically underserved, low-income, and minority populations. Transcripts and notes from interviews and focus groups were analyzed to look for themes and to determine if a health need was identified as significant and/or a priority to address. Primary data for KFH-Sacramento included 37 interviews with 48 key informants and 15 focus groups conducted with 152 participants including community members and service providers. A complete list of primary data sources is available in Appendix B.

In order to assess the health needs of the community, eight potential health need categories were identified based upon a) the needs identified in the 2013 CHNA, b) the grouping of indicators in the Kaiser Permanente CHNA data platform (CHNA-DP), and c) a preliminary review of primary data. The quantitative and qualitative data were then organized by these eight categories and then analyzed to identify the significant health needs for each hospital according to the following criteria: 1) indicators that performed poorly compared to the State benchmark and/or demonstrated racial/ethnic disparities and 2) health needs identified as significant in key informant interviews and focus groups. Of the eight potential health needs, seven were validated as significant for the KFH-Sacramento service area (Appendix C). As a final step, the resources available to address the significant health needs were compiled by using the community assets listed in the KFH-Sacramento 2013 CHNA report as a foundation. This list was then verified and expanded upon to include those referenced through community input.

II. INTRODUCTION/BACKGROUND

A. About Kaiser Permanente (KP)

Founded in 1942 to serve employees of Kaiser Industries and opened to the public in 1945, Kaiser Permanente is recognized as one of America's leading health care providers and nonprofit health plans. We were created to meet the challenge of providing American workers with medical care during the Great Depression and World War II, when most people could not afford to go to a doctor. Since our beginnings, we have been committed to helping shape the future of health care. Among the innovations Kaiser Permanente has brought to U.S. health care are:

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick

- An organized coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 10.2 million members in eight states and the District of Columbia. Our mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Care for members and patients is focused on their Total Health and guided by their personal physicians, specialists, and team of caregivers. Our expert and caring medical teams are empowered and supported by industry-leading technology advances and tools for health promotion, disease prevention, state-of-the-art care delivery, and world-class chronic disease management. Kaiser Permanente is dedicated to care innovations, clinical research, health education, and the support of community health.

B. About Kaiser Permanente Community Benefit

For more than 70 years, Kaiser Permanente has been dedicated to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve. We believe good health is a fundamental right shared by all and we recognize that good health extends beyond the doctor's office and the hospital. It begins with healthy environments: fresh fruits and vegetables in neighborhood stores, successful schools, clean air, accessible parks, and safe playgrounds. These are the vital signs of healthy communities. Good health for the entire community, which we call Total Community Health, requires equity and social and economic well-being.

Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Historically, we've focused our investments in three areas—Health Access, Healthy Communities, and Health Knowledge—to address critical health issues in our communities.

For many years, we've worked side-by-side with other organizations to address serious public health issues such as obesity, access to care, and violence. And we've conducted Community Health Needs Assessments to better understand each community's unique needs and resources. The CHNA process informs our community investments and helps us develop strategies aimed at making long-term, sustainable change—and it allows us to deepen the strong relationships we have with other organizations that are working to improve community health.

C. Purpose of the Community Health Needs Assessment (CHNA) Report

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document. Both the CHNA Report and the IS for each Kaiser Foundation Hospital facility are available publicly at kp.org/chna.

D. Kaiser Permanente's Approach to Community Health Needs Assessment

Kaiser Permanente has conducted CHNAs for many years, often as part of long standing community collaboratives. The new federal CHNA requirements have provided an opportunity to revisit our needs assessment and strategic planning processes with an eye toward enhanced compliance and transparency and leveraging emerging technologies. Our intention is to develop and implement a transparent, rigorous, and whenever possible, collaborative approach to understanding the needs and assets in our communities. From data collection and analysis to the identification of prioritized needs and the development of an implementation strategy, the intent was to develop a rigorous process that would yield meaningful results.

Kaiser Permanente's innovative approach to CHNAs include the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of approximately 150 publicly available indicators to understand health through a framework that includes social and economic factors; health behaviors; physical environment; clinical care; and health outcomes.

In addition to reviewing the secondary data available through the CHNA data platform, and in some cases other local sources, each KFH facility, individually or with a collaborative, collected primary data through key informant interviews, focus groups, and surveys. Primary data collection consisted of reaching out to local public health experts, community leaders, and residents to identify issues that most impacted the health of the community. The CHNA process also included an identification of existing community assets and resources to address the health needs.

Each hospital/collaborative developed a set of criteria to determine what constituted a health need in their community. Once all of the community health needs were identified, they were all prioritized, based on identified criteria. This process resulted in a complete list of prioritized community health needs. The process and the outcome of the CHNA are described in this report.

In conjunction with this report, KFH Sacramento will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, www.kp.org/chna.

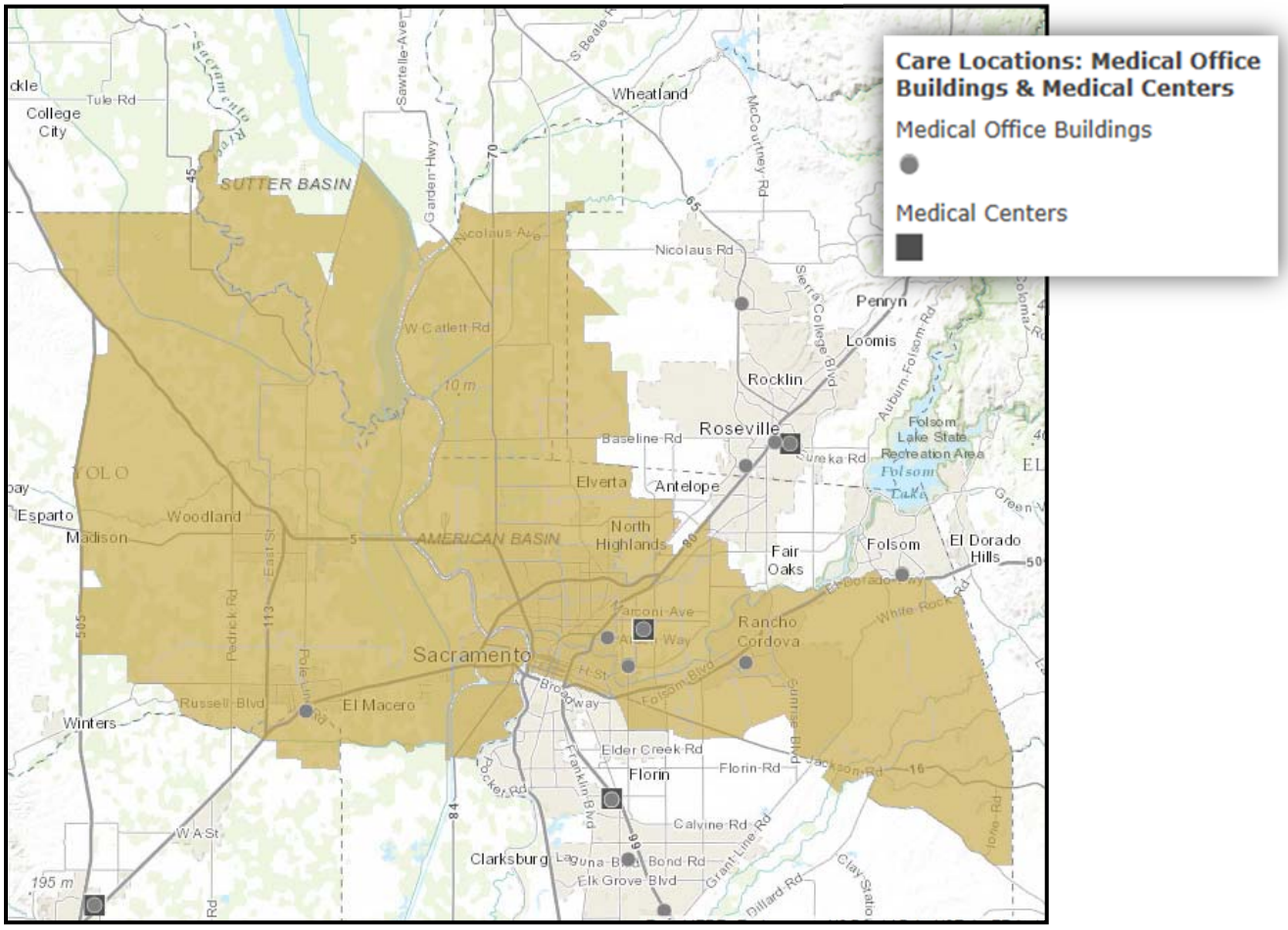
III. COMMUNITY SERVED

A. Kaiser Permanente's Definition of Community Served

Kaiser Permanente defines the community served by a hospital as those individuals residing within its hospital service area. A hospital service area includes all residents in a defined geographic area surrounding the hospital and does not exclude low-income or underserved populations.

B. Map and Description of Community Served

i. Figure 1. Map of the KFH-Sacramento Hospital Service Area (HSA)



ii. Geographic description of the community served

The KFH-Sacramento service area comprises Sacramento and Yolo counties. Cities in this area include Citrus Heights, Davis, Sacramento, Rancho Cordova, West Sacramento, and Woodland.

iii. Demographic profile of community served : KFH-Sacramento

Table 1. Demographic Data of KFH-Sacramento	
Total Population	762,192
White	64.12%
Black	7.87%
Asian	11.54%
Native American/ Alaskan Native	0.93%
Pacific Islander/ Native Hawaiian	0.71%
Some Other Race	8.55%
Multiple Races	6.28%
Hispanic/Latino	24.16%

Table 2. Socio-economic Data	
Living in Poverty (<200% FPL)	39.95%
Children in Poverty	25.31%
Unemployed	8.5%
Uninsured	13.75%
No High School Diploma	12.8%

Figure 2. Map of the KFH-Sacramento Hospital Service Area (HSA) by ZIP code

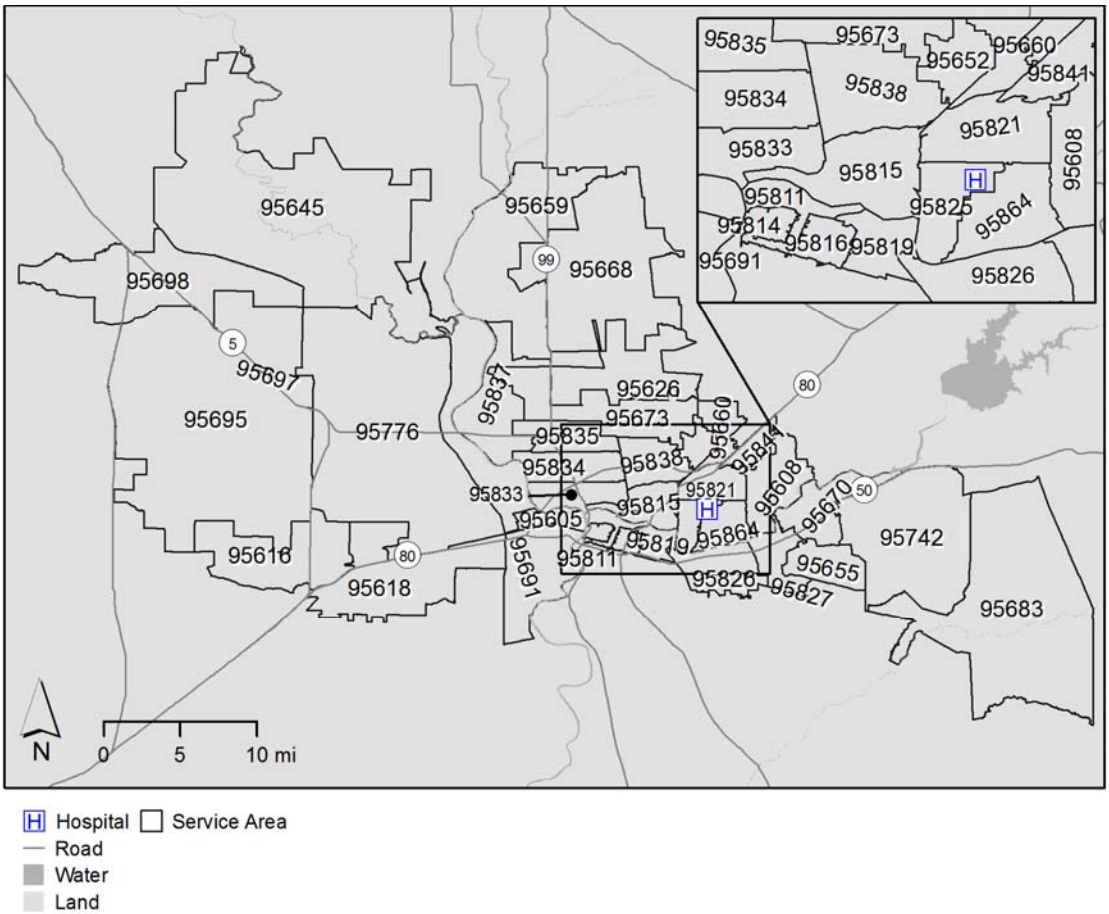


Table 3. Population, Median Age, Median Income and Percent Minority for All ZIP Codes in the HSA **Source:** 2013 American Community Survey 5-year Estimate				
ZIP	**Population**	**Median Age**	**Med. Income**	**% Minority**
95605	14160	30.4	38791	56.23
95608	60255	43.4	54322	26.32
95616	47995	23	44741	45.34
95618	27262	29.5	82313	41.76
95626	5979	37	58333	26.65
95645	1962	32.9	44954	57.59
95652	836	24.4	29583	37.91
95655	4802	32.8	80865	55.78
95659	760	38.4	42109	33.68
95660	32835	31.3	41036	46.04
95668	844	45.7	72422	18.12
95670	53259	36.1	54915	44.41
95673	15430	36.4	53429	34.14
95683	6354	51.5	96165	24.81
95691	35485	33.9	63559	52
95695	37686	37.8	51158	49.65
95697	307	36.4	60469	86.97
95698	177	51.1	47857	0
95742	8873	31.5	96278	56.99
95776	22083	30.6	61599	66.63
95811	7370	32.5	36421	46.67
95814	9802	35.5	34085	49.55
95815	25627	31.7	31274	66.06
95816	16624	35.3	49953	32.04
95819	17705	38.6	81076	24.69
95821	33190	39.6	38750	38.08
95825	31505	31.8	37605	50.17
95826	37215	33.9	53432	48.36
95827	20120	36.2	51981	45.43
95833	38264	31.1	56280	68.56
95834	24201	29.8	55177	72.15
95835	38606	33.6	79528	63.71
95837	240	47	42500	15
95838	35584	28.9	38271	72.97
95841	18612	33.3	36967	35.45
95864	21554	46.8	79778	21.81
SACRAMENTO	1435207	35.1	55064	52.05
YOLO	202288	30.7	55918	50.62
CALIFORNIA	37659181	35.4	61094	60.33

IV. WHO WAS INVOLVED IN THE ASSESSMENT

A. Identity of hospitals that collaborated on the assessment

The Sacramento Region Community Healthy Needs Assessment Collaborative (CHNA Collaborative) included four health systems that represent 15 hospitals in the Sacramento region. The CHNA Collaborative served to collectively conduct the 2016 CHNA and to support a coordinated approach to community benefit planning and activities. CHNA Collaborative participants included the following hospitals:

- **Dignity Health**: Mercy General Hospital, Mercy Hospital of Folsom, Mercy San Juan Medical Center, Methodist Hospital of Sacramento, Sierra Nevada Memorial Hospital, Woodland Memorial Hospital
- **Kaiser Permanente of Greater Sacramento**: KFH Sacramento, KFH South Sacramento, KFH Roseville
- **Sutter Health Sacramento Sierra Region**: Sutter Auburn Faith Hospital, Sutter Center for Psychiatry, Sutter Davis Hospital, Sutter Medical Center – Sacramento, Sutter Sacramento Medical Center)
- **UC Davis Health System**

B. Other partner organizations that collaborated on the assessment

Numerous partner organizations contributed to the CHNA. In particular, the following local health departments contributed data that were used in the CHNA reports: El Dorado County Health and Human Services Agency; Placer County Health and Human Services; Sacramento County Health and Human Services; and Yolo County Health and Human Services. Over 40 organizations assisted the KFH-Sacramento CHNA process through participation in key informant interviews or focus groups, as outlined in Appendix B.

C. Identity and qualifications of consultants used to conduct the assessment

The 2016 CHNA was facilitated by Valley Vision, a regional leadership organization committed to making the Sacramento region a great place to live, work and recreate. The CHNA Collaborative contracted with Valley Vision in 2016 and 2013 to conduct the CHNA process and reports, as well as in 2010 and 2007 to conduct their statewide CNA. The collaborative process has built and strengthened partnerships between hospitals and other stakeholders, providing a coordinated approach to identifying priority health needs as well as developing plans to improve the health of the Sacramento region.

Valley Vision was selected to conduct the 2016 CHNAs in the Sacramento Region given its history of working with the CHNA Collaborative, mixed methods research skills and strong commitment to drawing attention to critical unmet health needs. Valley Vision has been a leading social enterprise and nonprofit consultancy for the Sacramento region since 1994 with the ability to deliver trusted research, design and drive multi-stakeholder initiatives and access a set of powerful leadership networks across the region.

The Valley Vision team conducted primary qualitative data collection, analyzed primary and secondary data, synthesized these data to determine the significant and prioritized health needs, documented findings and wrote the draft and final CHNA reports. This CHNA report was primarily completed by Sarah Underwood, MPH, Project Manager for the CHNA project. Additional CHNA team members included: Amelia Lawless, CHES, ASW, MPH, Alan Lange, MPA, Giovanna Forno, BS, Anna Rosenbaum, MPH, MSW, and Katie Strautman, MSW. The CHNA team brought a rich skill-set from years of experience working in public health, health care, social service and other public sectors.

Valley Vision also contracted with Community Health Insights (CHI) to assist with the CHNA. Community Health Insights is a Sacramento based research-oriented consulting firm dedicated to improving the health and wellbeing of communities across Northern California. Dr. Heather Diaz, Dr. Mathew C. Schmidtlein and Dr. Dale Ainsworth assisted with project design, research methodology, data processing and GIS mapping for the CHNA.

V. PROCESS AND METHODS USED TO CONDUCT THE CHNA

CHNA Process Model

The CHNA collaborative project was conducted over a period of fifteen months, beginning in January 2015 and concluding in March 2016. The overall process to conduct the CHNA is outlined below in Figure 3, the CHNA Process Model. Additional details on the process are provided in subsequent sections of the report.

The project began with confirming the HSA for KFH-Sacramento according to the geographic area defined by Kaiser Permanente. Once the broader HSA was identified, geographic areas within the HSA that were facing the greatest risk of both social and health inequities were identified. These Focus Communities were defined at the ZIP code level following an analysis of: 1) social determinants of health and inequities (e.g., poverty and educational attainment), 2) values from the Community Health Vulnerability Index (CHVI), 3) initial input from key informant interviews and 4) consideration of Focus Communities in the 2013 CHNA (previously called Communities of Concern).

The collaborative then used the Focus Communities to target additional primary data collection in order to understand the specific health issues facing those particular high risk communities. This second round of data collection and analysis included additional community input from high risk populations within the Focus Communities as well as a review of morbidity, mortality, health behavior and living conditions data. Based on the analysis of the second round of primary and secondary data, a list of significant community health needs were identified for the KFH-Sacramento service area. Finally, resources available to address the significant health needs were compiled and the final report was written.

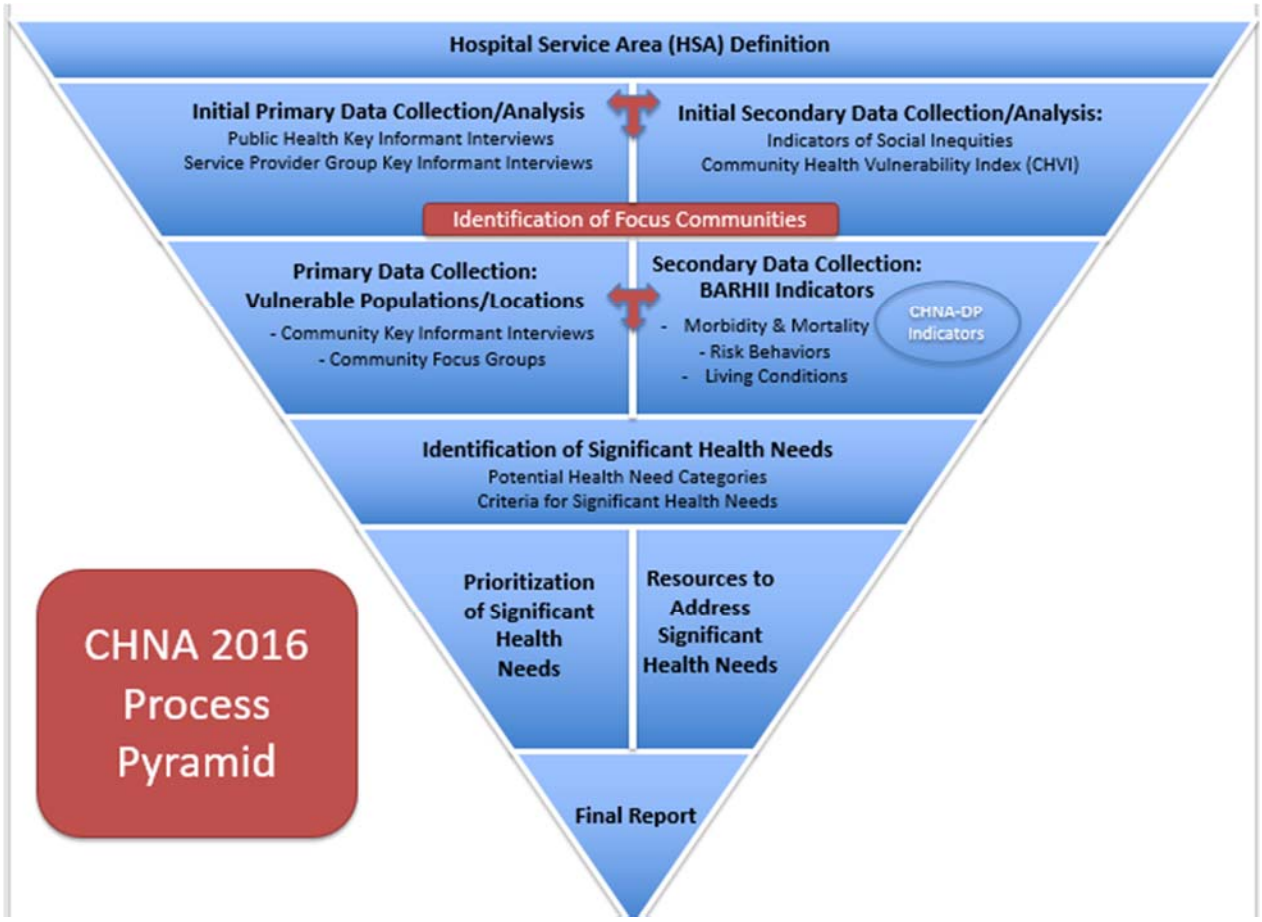


Figure 3. CHNA Process Model

The Focus Communities determined for KFH-Sacramento are noted in Table 4, followed by a map of the Focus Communities (Figure 4). Detailed methodology and socio-demographic information for these communities can be found in Appendix E.

Table 4. Focus Communities for KFH-Sacramento	
Community	**ZIP Code**
West Sacramento/Broderick	95605
McClellan Park	95652
North Highlands	95660
Rancho Cordova	95670
West Sacramento/Broderick	95691
West Woodland	95695
Downtown/Midtown Sacramento	95811
Downtown/Midtown Sacramento	95814
North Sacramento	95815
Watt/Marconi	95821
Arden-Arcade	95825
South Natomas	95833
West and North Natomas	95834
Del Paso Heights	95838
Old Foothill Farms	95841

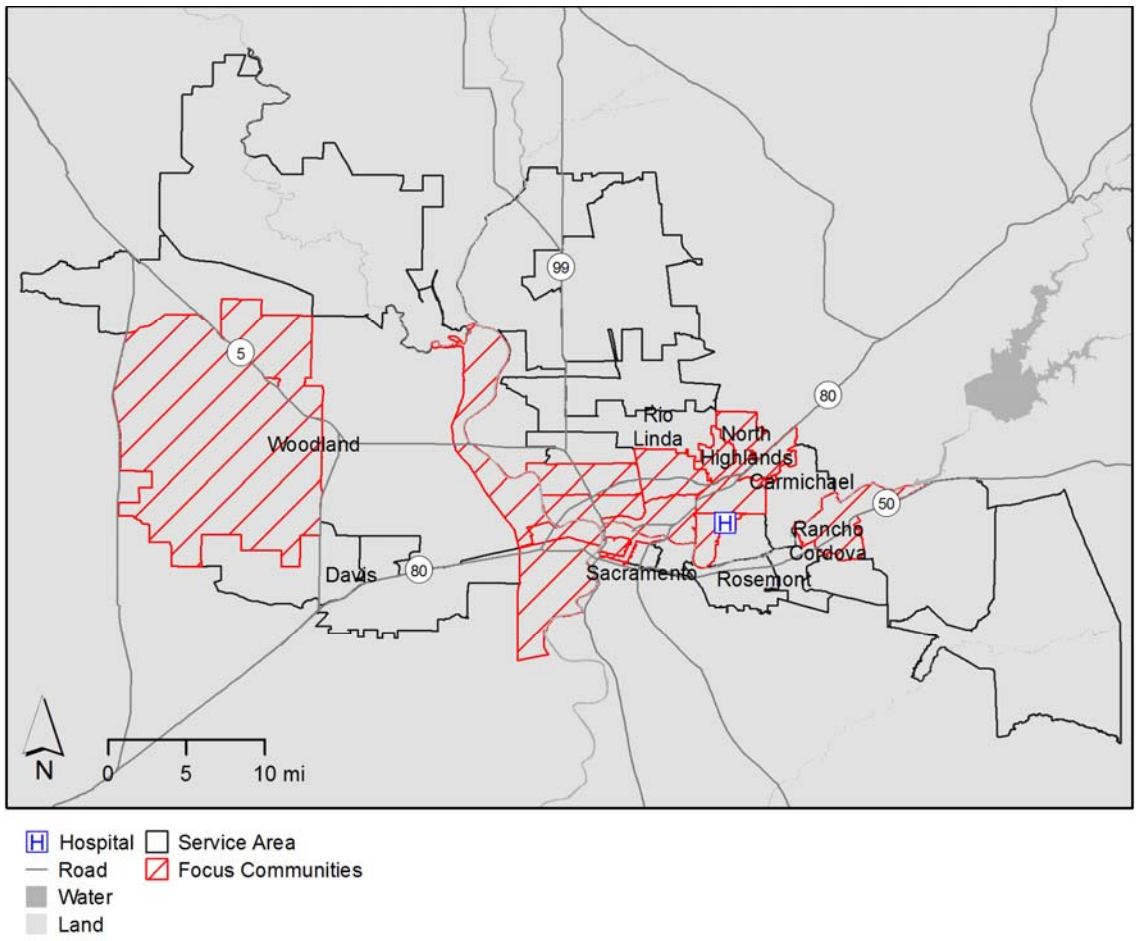


Figure 4. Map of Focus Communities

A. Secondary data

i. Sources and dates of secondary data used in the assessment

KFH-Sacramento used the Kaiser Permanente CHNA Data Platform (www.chna.org/kp) to review over 150 indicators from publically available data sources. Data on gender and race/ethnicity breakdowns were analyzed when available. Additional secondary data for the CHNA were collected from a variety of sources and processed in multiple stages before being used for analysis. The majority of these additional secondary variables were collected from three main data sources: (1) the US Census Bureau (Census) 2011, 2012 and 2013 American Community Survey 5-year Estimates; (2) the California Office of Statewide Health Planning and Development (OSHPD) 2011-2013; and (3) the California Department of Public Health (CDPH) 2010-2012. For details on specific sources and dates of the data used, please see Appendix A.

ii. Methodology for collection, interpretation and analysis of secondary data

This section serves to provide a brief overview of the secondary data collection, processing

and analysis approaches used to support the CHNA. For additional information, including detailed project methodology, please refer to Appendix A.

Initial social inequities data were compiled and analyzed at the census tract and ZIP code levels as well as mapped by GIS. These indicators, with support from the initial findings from the primary data, was used to identify Focus Communities. See Appendix E for a list of social inequities indicators that were collected and analyzed to identify these Focus Communities.

Quantitative indicators used in this assessment were guided by a conceptual framework developed by the Bay Area Regional Health Inequities Initiative (BARHII) (Figure 6 in Appendix A). The BARHII Framework demonstrates the connection between social inequalities and health and focuses attention on measures that had not characteristically been within the scope of public health departments. Valley Vision used the BARHII framework to organize quantitative indicators, as well as frame the primary data collection tool, to capture both “upstream” and “downstream” factors influencing health in the HSA.

The secondary data supporting the CHNA was collected from a variety of sources. The foundation for selection of secondary data indicators to identify the significant health needs was guided by the Kaiser Permanente CHNA Data Platform (CHNA-DP). Mortality data were also obtained from CDPH and morbidity data were obtained from OSHPD to compliment the indicators already collected from the CHNA-DP. Additional collected indicators were only selected for inclusion and analysis if they did not duplicate indicators that were pulled from the CHNA-DP. The data were organized into the eight potential health need categories to better understand the health conditions of the HSA.

During the analysis, indicators were flagged that compared unfavorably to state benchmarks or had evident racial/ethnic disparities. Indicators from the CHNA-DP were flagged if the HSA value performed (a) poorly (>2% or 2 percentage point difference) or (b) moderately (between 1-2% or 1-2 percentage point difference) compared to the state benchmark. Additional indicators sourced by Valley Vision were flagged if they compared unfavorably to benchmark by any amount as presented in Appendix A.

The secondary data was processed in multiple stages before it was analyzed. The three basic processing steps include rate smoothing, age-adjustment, and obtaining benchmark rates. A detailed description of this process is outlined in Appendix A, Data Dictionary and Processing.

B. Community input

i. Description of the community input process

Community input was provided by a broad range of community members through the use of key informant interviews and focus groups. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from the local public health department as well as leaders, representatives, and members of medically underserved, low-income, and minority populations. Additionally, where applicable, other individuals with expertise of local health needs were consulted. For a complete list of individuals who provided input, see Appendix B.

Primary data collection began with group key informant interviews with hospital service representatives and interviews of area health experts such as public health and social service representatives. The primary data collected from the first phase of interviews, including initial analysis of socio-demographic data, identified Focus Communities within the KFH-Sacramento service area. These identified Focus Communities were then used to help inform a second phase of data collection which included additional key informant interviews and Focus Groups with medically-underserved, low-income and minority populations where additional data collection was needed.

Primary data were collected from May 2015-November 2015.

ii. Methodology for collection and interpretation

Key Informant Interviews

Key informant interviews were conducted with area health experts and service providers familiar with health issues, places and populations experiencing health disparities within the HSA. Primary data collection began with group key informant interviews of hospital service providers including nursing managers, medical directors, social workers, case managers, patient coordinators/navigators, Emergency Department providers, and administrative leadership. Early interviews were also conducted with county Public Health Officers and other public health and social service experts. Initial findings from the service provider informants were used along with the Community Health Vulnerabilities Index and indicators of social inequities, to identify locations (i.e., Focus Communities) and populations vulnerable to poor health outcomes, which directed additional primary data collection activities.

A total of 38 key informant interviews were completed with a cumulative total of 55 service providers participating in these interviews, which are listed in Appendix B. Primary data collection began with key informant interviews with hospital service experts, followed by interviews with service providers and focus groups with community members.

Key informant interviewees represented the following sectors: academic research (3%), community based organizations (54%), health care (33%) public health (5%), and social services (18%), with some interviewees representing multiple sectors. These 55 key informants reported working with the following populations: low-income (93%), medically underserved (93%), and racial and/or ethnic minorities (86%). The racial and ethnic minority groups specified by interviewees included: Latino/Hispanic, African American, Asian Pacific Islander, Hmong, Khmer, Vietnamese, Lao, Mien Punjabi, Arabic, Afghan, Slavic, Russian, and refugees from the former Soviet Union. In addition, key informants specified working with the following vulnerable sub-populations: migrant farm workers, individuals experiencing homelessness, individuals diagnosed with a developmental disability, individuals with serious mental illness and/or substance abuse disorders, pregnant women, individuals identifying as lesbian, gay, bisexual and/or transgender (LGBT), youth, children and seniors who have experienced abuse and/or neglect, and those utilizing public assistance programs.

Community Focus Groups

Focus group interviews were conducted with community members representing vulnerable

populations and locations identified through the initial analysis of key informant input. Recruitment consisted of referrals from designated service providers as well as direct outreach from the Valley Vision CHNA Team to acquire input from special population groups. The identification of Focus Communities (see Focus Communities below) was another input that was considered when identifying vulnerable populations and locations to conduct community focus groups.

Within the KFH-Sacramento HSA, 12 focus groups were conducted with 134 participants representing medically underserved, minority and low-income populations and/or community members living in vulnerable locations. Of the approximately 129 people who completed demographic data cards, the median age was 40, 76% identified as female, 21% as male, and 5% as other. Additionally, 23% indicated they were not high school graduates, 16% indicated they were not covered by health insurance and 67% received some form of public assistance. The racial breakdown of focus group participants is as follows:

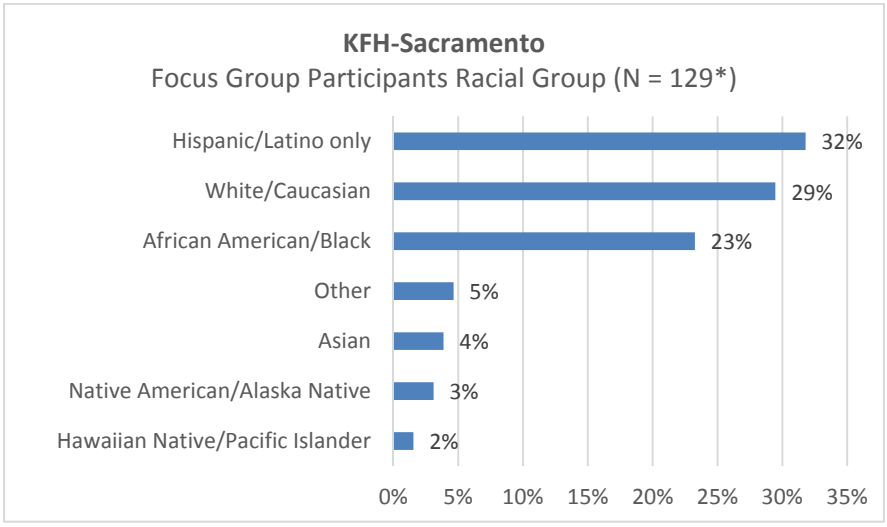


Figure 5. Participant Race/Ethnicity

* Demographic surveys were not completed by all participants

Processing Primary Data

After each interview or focus group was completed, the recording and any notes were uploaded to a secure server for future analysis. A significant portion of key informant interviews and focus group recordings were sent to a transcription service, with a smaller portion transcribed by Valley Vision staff or converted into notes corresponding to the order of questions in the interview guides. A small portion of the key informant interviews and focus groups were conducted in Spanish only.

Content analysis was done on the key informant and focus group transcripts utilizing NVivo 10 Qualitative Analytical Software. This analysis was completed in a two phase approach. In the first phase of analysis the qualitative data were coded based on the Bay Area Regional Health Inequities Initiative (BARHII) Framework categories and other organically arising thematic areas. Further analysis was then conducted with thematic coding to the eight potential health needs categories detailed later in this report and in Appendix D, with additional nodes for vulnerable populations and locations and resource identification.

Results were aggregated to inform the determination of prioritized significant health needs as further detailed in Section 6.

C. Written comments

KP provided the public an opportunity to submit written comments on the facility's previous CHNA Report through *CHNA-communications@kp.org.* This website will continue to allow for written community input on the facility's most recently conducted CHNA Report.

As of the time of this CHNA report development, KFH Sacramento had not received written comments about previous CHNA Reports. Kaiser Permanente will continue to track any submitted written comments and ensure that relevant submissions will be considered and addressed by the appropriate Facility staff.

D. Data limitations and information gaps

The KP CHNA data platform (CHNA-DP) includes approximately 150 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

For primary data collection, it often proved to be a challenge to gain access to participants in communities that disproportionately experience health disparities. Measures were taken to reach out to vulnerable populations and locations through the process of Focus Community identification and the recommendations of early key informants. However, recruitment was variable and several key contacts expressed the issue of research fatigue from repeated needs assessments. Community members also frequently mentioned distrust of the research process or concerns that their input would lead to change in their communities. As best as possible, the research team attempted to address these concerns and to be open and transparent about the full CHNA process. All participants were given contact information of the staff that conducted their interviews and were encouraged to reach out with any additional questions; key informants were also assured that they would receive notification once the CHNA reports become available.

Another challenge was reconciling the primary and secondary data. A large share of the primary or qualitative data was deliberately sourced from low-income, minority and medically underserved populations and locations within the KFH-Sacramento service area. Alternately, the secondary or quantitative data was collected for all populations within the service area. At times, this caused for there to be significant disparities between the primary and secondary data for the health need. Owing to this discrepancy, significant health need categories were validated by either the quantitative or qualitative data, rather than by both of these data sources.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

A. Identifying community health needs

i. Definition of "health need"

For the purposes of the CHNA, Kaiser Permanente defines a "health need" as a health outcome and/or the related conditions that contribute to a defined health need. Health needs are identified by the comprehensive identification, interpretation, and analysis of a robust set of primary and secondary data.

ii. Criteria and analytical methods used to identify the community health needs

Significant health needs were identified through an integration of both qualitative and quantitative data. The process began with generating a list of eight broad potential health needs (PHN categories) that could exist within the HSA as well as subcategories of these broad needs as applicable. The PHN categories and subcategories were identified through consideration of the following inputs: the health needs identified in the 2013 CHNA process; the categories in the KP CHNA data platform (CHNA-DP) - preliminary health needs identification tool; and a preliminary review of primary data. Once the PHN categories were created, quantitative and qualitative indicators associated with each category and subcategory were identified in a crosswalk table. The potential health need categories, subcategories and associated indicators were then vetted and finalized by members of the CHNA Collaborative prior to identification of the significant health needs. The PHN categories and subcategories are listed below in Table 5; a full list of the indicators associated with each PHN category is available in Appendix D.

Table 5. Overview of Potential Health Need (PHN) Categories and Subcategories

Potential Health Need Category	Subcategories	Abbreviation
Access to High Quality Health Care and Services	Access to Care (General); Oral Health; Maternal/Infant Health	Access to Care
Access to Behavioral Health Services	Mental Health; Substance Abuse	Behavioral Health
Affordable and Accessible Transportation	N/A	Transportation
Basic Needs	Food, Housing, Employment, Education	Basic Needs
Disease Prevention, Management and Treatment	Cancer; Asthma; CVD/Stroke; HIV/AIDS/STIs	Disease Prevention
Healthy Eating and Active Living	N/A	HEAL
Pollution Free Living and Work Environments	N/A	Pollutant Free
Safe, Crime and Violence-Free Communities	N/A	Safe Communities

While all of these needs exist within the HSA to a greater or lesser extent, the purpose

was to identify those that were most significant. The results from the primary and secondary data analysis were then merged to create a final set of significant health needs. The full results of these analyses are available in Appendix D.

A health need was determined to be significant if:

(1) At least 50% of secondary data (quantitative) indicators within PHN category compared unfavorably to benchmarks or demonstrated racial/ethnic groups disparities, or
(2) At least 75% of primary data (qualitative) sources mentioned a health outcome or related condition associated with the potential health need category. Primary data was mainly sourced from Focus Communities.

B. Process and criteria used for prioritization of the health needs

Once significant health needs were identified, they were prioritized through the following process. First, health needs were given a score based upon the degree to which they met the criteria outlined above. Health needs that met or exceeded the thresholds for both the primary and secondary data categories were given a score of two (2 points); health needs that met or exceeded the thresholds for only one of the categories were given a score of one (1 point). The health needs were then ranked so that those with two points were put into a higher tier for prioritization than those with one point.

Secondly, health needs were further ranked within their tiers based upon further analysis of the primary data. As previously mentioned, the interview guide for primary data collection prompted participants to identify the health issues in their communities that were most urgent or important to address. Thematic analysis was conducted on the responses to this question and matched with the significant health need categories. The percentage of sources referring to each health need as a priority was calculated from this analysis, and then used for further prioritization of the health needs within tiers. Health needs with a higher percentage of sources identifying the need as important were ranked above those with a lower percentage of sources identifying that health need as a priority. The full results of these analyses are available in Appendix D.

Table 6. Prioritization of significant health needs within tiers by percentage of importance from community input

PHN Category	QUANT	QUAL	SCORE	IMPORTANCE
	50%	75%		25%
1. Behavioral Health	64%	98%	**2**	**55%**
2. HEAL	53%	96%	**2**	**47%**
3. Safe Communities	81%	96%	**2**	**30%**
4. Basic Needs	60%	98%	**2**	**28%**
5. Access to Care	41%	96%	**1**	**45%**
6. Disease Prevention and Management	75%	74%	**1**	**28%**
7. Pollution Free Communities	58%	49%	**1**	**3%**

C. Prioritized description of all the community health needs identified through the CHNA

The following are summarized descriptions of the prioritized significant health needs that were identified through the CHNA process. The data supporting these health needs are available in the Health Need Profiles in Appendix C.

1. Access to Behavioral Health Services (Mental Health & Substance Abuse)

Access to behavioral health services (mental health & substance abuse) is a significant health need in the Kaiser Foundation Hospital (KFH)-Sacramento Hospital Service Area (HSA). Eight of 13 indicators (62%) pertaining to mental health perform poorly compared to state benchmarks, and eight of 12 indicators (67%) pertaining to substance abuse also compare unfavorably to the benchmarks. The issue of mental health is marked by high rates of suicide, a shortage of mental health providers, high rates of emergency department (ED) visits and hospitalization (H) for mental health conditions and self-inflicted injury. Suicide rates among non-Hispanic Whites and Native Hawaiian/Pacific Islanders are high compared to other racial/ethnic groups and the overall HSA rate; a higher percentage of Hispanic/Latinos of all races also reported needing mental health services compared to other groups and the HSA as a whole. Substance use issues are evident from high percentages of alcohol consumption and expenditures, and high rates of ED and H for substance abuse.

Of 47 key informant interviews and community member focus groups, 46 mention health issues or drivers related to access to behavioral health services as a health need. Input from service providers and community members indicates that the need for behavioral health services far outweighs the resources currently available in the HSA; barriers to treatment and recovery include long wait times for services, stigma, lack of preventative education and complications from co-morbid conditions. Particular issues and populations of high concern include: those experiencing severe mental illness particularly if they are homeless, women or people of color; those using substances (alcohol, meth, cocaine, pain meds, marijuana and tobacco use) especially by youth; and depression and anxiety related to the stresses of living in poverty. Providers and community members suggest that more opportunities for social engagement, support services for seniors, culturally sensitive behavioral health services (available in languages other than English), and peer education and harm reduction approaches are needed to address to mental health/substance abuse issues.

2. Healthy Eating and Active Living

Healthy Eating and Active Living (HEAL) is a significant health need in the KFH-Sacramento HSA. Sixteen of 30 indicators (53%) pertaining to HEAL compare unfavorably to the state benchmarks. The lack of healthy eating and/or active living is marked by high rates of obesity and diabetes mortality in adults, physical inactivity among youth and ED visits for osteoporosis. There is a higher rate of fast food restaurants per capita, and a lower rate of Women, Infant, Children (WIC) authorized food stores. Overweight and obesity rates among youth are high among Blacks and Hispanic/Latinos compared to other racial/ethnic groups and the overall HSA rate.

Of 47 key informant interviews and community member focus groups, 45 mention health issues or drivers related to healthy eating and active living as a health need. Input from service providers and community members indicates that HEAL opportunities are greatly needed; particular populations of high concern include: those who are low-income or rely on CalFresh or WIC benefits. Barriers to healthy eating include lack of access to healthy food, lack of

financial resources, lack of knowledge for food preparation, lack of time, lack of motivation and access to unhealthy, cheap food options. Providers and community members suggest an increase in healthy food outlets and/or farmers markets that are affordable and culturally relevant to the area. Barriers to active living include lack of recreational opportunities, lack of properly designed roadways for safe walking or biking, lack of personal safety due to real and perceived threats of violence, cultural attitudes towards exercise, and high rates of time spent using a device such as a computer, television, or games console. Suggestions include more recreation opportunities via recreation centers, parks, and gyms; improved street design to facilitate safe and active transportation.

3. Safe, Crime and Violence-Free Communities

Safe, crime and violence-free communities is a significant health need in the KFH-Sacramento HSA. Twenty-one of 26 indicators (81%) pertaining to safe, crime and violence-free communities perform poorly compared to state benchmarks. The lack of safe communities is marked by high rates of major crimes (assault, rape, and robbery), youth intentional injuries, domestic violence, pedestrian accident mortalities, and high rates of ED visits and H for assault and unintentional injuries. Homicide mortality rates among Blacks are high compared to other racial/ethnic groups and the overall HSA rate.

Of 47 key informant interviews and community member focus groups, 45 mention health issues or drivers related to safe, crime and violence-free communities as a health need. Vulnerable populations include those experiencing homelessness, women, children and youth, people of color, those with substance abuse issues, and undocumented individuals. Significant issues include substance abuse, domestic violence and sexual assault, child abuse and trauma, and gang violence. Providers and community members suggest an increase in the number of substance abuse treatment options, as well as child abuse prevention and youth development programs.

4. Basic Needs (Food, Housing, Employment, Education)

Basic needs (food, housing, employment, education) are a significant health need in the KFH-Sacramento HSA. Fifteen of 25 indicators (60%) pertaining to basic needs compare unfavorably to the state benchmarks. The lack of basic needs being met are marked by high poverty percentages (population below 100% Federal Poverty Level [FPL], population below 200% FPL, and children below 100% FPL), a high percentage of people receiving Supplemental Nutrition Assistance Program (SNAP) benefits and those living within a food desert, and a high percentage of children in grade four reading below the proficient level. Poverty is higher among Blacks, Native American/Alaskan Natives, and Hispanic/Latinos compared to other racial/ethnic groups and the overall HSA rate.

Of 47 key informant interviews and community member focus groups, 46 mention health issues or drivers related to basic needs as a health need. Input from service providers and community members indicates that basic needs are a significant concern within the service area. Vulnerable populations include those experiencing homelessness, those living on a limited income or working minimum wage jobs, low-income seniors and children, recent immigrants, and undocumented individuals. Noteworthy issues raised include the lack of economic security, few affordable housing options, food insecurity and low educational attainment. Providers and community members suggest more job training and assistance programs, as well as more affordable housing options.

5. Access to High Quality Health Care and Services

Access to high quality health care and services is a significant health need in the KFH-Sacramento HSA. Thirteen of 32 indicators (41%) pertaining to access to care perform poorly compared to the state benchmarks. Issues related to access to care are marked by a lack of prenatal care, a low rate of access to dentists and recent dental exams for youth, and high rates of ED visits and H for dental/oral diseases. A lack of consistent source of primary care is higher among Hispanic/Latinos compared to other racial/ethnic groups and the overall HSA rate, and a higher percentage of Hispanic/Latinos and Whites reported needing dental exams for youth compared to other groups and the HSA as a whole.

Of 47 key informant interviews and community member focus groups, 45 mention health issues or drivers related to access to high quality health care and services as a health need. Input from service providers and community members indicates that the need for high quality health care services far outweighs the resources currently available in the HSA. Barriers to quality care include: long wait times for services especially for those on Medi-Cal, lack of health education and literacy for navigating the healthcare system, lack of transportation to access services, and a lack of culturally sensitive care. Populations of high concern include: those on Medi-Cal, ethnic groups with distinct language or cultural differences, refugees and recent immigrants, undocumented individuals, those identifying as LGBT, those experiencing homelessness, and seniors on restricted incomes. Providers and community members suggest more health education for the prevention and treatment of chronic diseases, more cultural sensitivity training for providers working with diverse populations, more bilingual and bicultural providers, and more primary care providers, especially those that accept Medi-Cal.

6. Disease Prevention, Management and Treatment

Disease prevention, management and treatment is a significant health need in the KFH-Sacramento HSA. Forty-eight of 64 indicators (75%) pertaining to disease prevention and management of cancer, cardiovascular disease and stroke (CVD/Stroke), asthma, and HIV/AIDS/STDs compare unfavorably compared to the state benchmarks. Issues related to cancer are marked by a high all cause cancer mortality rate and an elevated incidence of breast, colon and rectum, prostate, and lung cancers as compared to the state benchmarks, as well as high rates of ED visits for lung, prostate, colorectal, and breast cancers. The “all cause cancer mortality rate" is higher among Whites, Blacks, and Native Hawaiian/Pacific Islanders, the incidence of breast cancer is higher among Whites, the incidence of lung cancer is higher among Whites and Blacks, and the incidence of colorectal and prostate cancers are higher among Blacks as compared to other racial/ethnic groups and the overall HSA rate. Issues related to CVD/Stroke are evidenced by the high rate of mortality from ischemic heart disease and stroke, and high rates of visits ED and H for heart diseases and stroke. Mortality from ischemic heart disease is higher for Whites, Blacks, and Native Hawaiian/Pacific Islanders, and mortality from stroke is higher for Blacks and Native Hawaiian/Pacific Islanders as compared to other racial/ethnic groups and the overall HSA rate. Issues related to asthma are marked by high prevalence and high rates of ED visits and H for asthma. Issues related to HIV/AIDS/STIs are discernable from high rates of chlamydia and gonorrhea, ED visits for sexually transmitted infections and a high prevalence of HIV. The prevalence of HIV is higher for Whites and Blacks as compared to other racial/ethnic groups and the overall HSA rate.

Of 47 key informant interviews and community member focus groups, 35 mention health issues or drivers related to disease prevention, management and treatment as a health need. Input from service providers and community members indicates that disease prevention, management and treatment of CVD/stroke, cancer, asthma and HIV/AIDS/Sexually

Transmitted Infections (STIs) are significant health needs in the KHF-South Sacramento HSA. The need for proper CVD diagnosis, management, health education and affordable medication were discussed frequently and increases in CVD incidence among youth were discussed. Various types of cancer were discussed including lung, breast, colon, prostate, cervical and stomach cancers. Asthma was discussed as a problematic health condition for many people (both youth and adults) due to the inhalation of contaminated air and smoke. STIs are also of concern to individuals, and community members discussed that there is still stigma around this subject and that those identifying as LGBT and individuals using substances suffer disproportional burdens of these diseases. Providers and community members suggest more screening, testing and education programs, affordable medications for management and treatment of diseases, and more regulations around tobacco use.

7. Pollution Free Living and Work Environments

Pollution free living and work environments are a significant health need in the KFH-Sacramento HSA. Fifteen of 26 indicators (58%) pertaining to pollution-free living and work environments perform poorly compared to the state benchmarks. The issue of pollution is marked by high rates of particulate matter, a high prevalence of asthma, and a higher pollution burden score in the communities of West Sacramento, Davis (southeast), Midtown Sacramento, and Rancho Cordova.

Of 47 key informant interviews and community member focus groups, 23 mention health issues or drivers related to pollution free living and work environments as a health need. Input from service providers and community members indicates that poor air quality and asthma are significant concerns within the service area. Particular populations of concern include children, seniors in poor health, farm workers, and those exposed to second hand smoke. Geographic areas of concern include areas affected with industrial activity, areas with high roadway density, and agricultural areas where pesticides are used. Providers and community members suggest more enforcement of anti-smoking laws and smoking cessation programs.

D. Community resources potentially available to respond to the identified health needs

An extensive process was used to identify the resources available to address the significant health needs and catalog them for inclusion in the final CHNA report. First, all resources identified in the 2013 CHNA report were included for consideration in a working comprehensive list of resources. Secondly, qualitative data from key informant interviews and focus groups were analyzed to include the resources identified by community input. Resources from community input were added to the list and all resources were then verified to assure that they were current and actively available. Once all resources on the list had been confirmed, each resource was considered in relation to the significant health needs for the HSA. As best as possible, each resource was assessed to determine which of the health needs it most closely addressed.

Through this process, a total of 161 resources were identified pertaining to the significant health needs for KHF-Sacramento. The final list of health resources is available in Appendix I, and the methodology for resource identification is further detailed in Appendix D.

VII. KFH-Sacramento 2013 implementation strategy Evaluation of Impact

A. Purpose of 2013 Implementation Strategy evaluation of impact

KFH-Sacramento's 2013 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2013 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-Sacramento's Implementation Strategy Report, including the health needs identified in the facility's 2013 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit www.kp.org/chna. For reference, the list below includes the 2013 CHNA health needs that were prioritized to be addressed by KFH-Sacramento in the 2013 Implementation Strategy Report.

1. Access to Care
2. Healthy Eating Active Living
3. Limited Mental Health Services/Lack of Access to Mental Health Services
4. Broader Health Care System Needs in our Communities (Workforce & Research)

KFH-Sacramento is monitoring and evaluating progress to date on their 2013 Implementation Strategies for the purpose of tracking the implementation of those strategies as well as to document the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH Sacramento tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA Report in March 2016, KFH-Sacramento had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH-Sacramento will continue to monitor impact for strategies implemented in 2016.

B. 2013 Implementation Strategy Evaluation Of Impact Overview

In the 2013 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2014 and 2015, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

- **KFH Programs:** From 2014-2015, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

- Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.

- Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.

- Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.

- Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.

- Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research, health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

- **Grantmaking:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, KFH Sacramento awarded 232 grants totaling $4,583,438 in service of 2013 health needs. Additionally, KFH in Northern California has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the KFH-Sacramento service area. During 2014-2015, a portion of money managed by this foundation was used to award 38 grants totaling $541,558 in service of 2013 health needs.

- **In-Kind Resources:** Kaiser Permanente's commitment to Total Community Health means reaching out far beyond our membership to improve the health of our communities. Volunteerism, community service, and providing technical assistance and expertise to community partners are critical components of Kaiser Permanente's

approach to improving the health of all of our communities. From 2014-2015, KFH Facility Name donated several in-kind resources in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

- **Collaborations and Partnerships:** Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2014-2015, KFH Facility Name engaged in several partnerships and collaborations in service of 2013 Implementation Strategies and health needs. An illustrative list of in-kind resources is provided in each health need section below.

C. 2013 Implementation Strategy Evaluation of Impact by Health Need

PRIORITY HEALTH NEED I: ACCESS TO CARE

Long Term Goal:

- Increase number of individuals who have access to and receive appropriate health care services in the KFH-Sacramento service area

Intermediate Goal:

- Increase the number of low-income people who enroll in or maintain health care coverage
- Increase access to culturally competent, high-quality health care services for low-income, uninsured individuals

KFH-Administered Program Highlights

KFH Program Name	KFH Program Description	Results to Date
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	• *2014: 27,260 Medi-Cal members* • *2015: 27,683 Medi-Cal members*
Medical Financial Assistance (MFA)	MFA provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	• *2014: KFH - Dollars Awarded By Hospital - $2,775,168* • *2014: 4,319 applications approved* • *2015: KFH - Dollars Awarded By Hospital - $2,558,209* • *2015: 3,937applications approved*
Charitable Health Coverage (CHC)	CHC programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.	• *2014: 3,177 members receiving CHC* • *2015: 3,001 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 122 active KFH grants totaling $1,952,560 addressing Access to Care in the KFH-Sacramento service area.[1] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 19 grants totaling $307,467 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date

[1] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

Winters Health Centers (WHC)	$125,000 in 2015 This grant impacts two KFH hospital service areas in Northern California Region.	WHC will build team-based approach to care, develop care plans, and train staff on motivational interviewing to develop self-management goals that can be monitored and tracked through an electronic health record (EHR) for patients who have diabetes.	• care plan function in EHR improves ability to track patient progress on health goals • WHC's health education department implemented a patient satisfaction survey that increased ability to design-test services to meet patient needs; early results indicate most patients are motivated-extremely motivated and satisfied with their care plan • patients with controlled A1c improved from 39% to 54%
CARES Community Health	$125,000 over 2 years $62,500 in 2014 & 2015 This grant impacts two KFH hospital service areas in Northern California Region.	CARES will expand clinical capacity by focusing on improving health outcomes for specific patient groups and develop processes to improve specific outcomes for all patients, with a focus on hypertension in African Americans, diabetes in Latinos, and chlamydia screening for young people.	• Completed blood pressure competency training of all staff • Created patient outreach and education strategy including a "Heart Smart" hypertension education initiative. • Completed four community outreach events where they discussed hypertension with over 400 patients and community members • % of hypertensive patients with blood pressure under control rose from a baseline of 54% to 60%
Sacramento Native American Health Centers (SNAHC)	$125,000 over 2 years $65,500 in 2014 & 2015 This grant impacts two KFH hospital service areas in Northern California Region.	Proposed project will increase QI culture and expand process improvement skills through participation in a collaborative learning environment. SNAHC will focus on improving specialty service referrals using a high-level of care coordination and a team-based approach.	• improved EHR systems to include alerts when a foot exam is due that prompts medical assistants to conduct the exam; rate of annual foot exams improved from 38% to 52% • improvement strategies increased efficacy of team huddle meetings • patients with HbA1c </ = 8, rate of controlled blood sugar improved from 39% to 59%

Chapa-De Indian Health Program	$125,000 over 2 years $65,500 in 2014 & 2015 This grant impacts two KFH hospital service areas in Northern California Region.	Chapa-De plans to increase clinical capacity to care for patients with chronic illness by educating and training highly functioning teams and instituting team based care.	• developed electronic tool-registry to track diabetes patients • developed protocols for efficient phone care management and group education classes for diabetic patients • created standing orders for nurses to lead case management and reduce physician workload • hired a diabetes care manager nurse
Elica Health Centers (EHC)	$125,000 over 2 years $65,500 in 2014 & 2015 This grant impacts two KFH hospital service areas in Northern California Region.	EHC will advance its clinical capacity by sustainably integrating preventive and primary care, chronic disease management, and behavioral health services to increase process improvement skills and create a QI environment.	• updated cervical care screening guideline (based on the evidence) and reviewed changes with all physicians • improved eight processes related to improving cancer screening rates (e.g., developed checklists-algorithms to remind staff of the importance of cancer screenings and to flag patients who need screening) • substantially reduced notification time for abnormal lab results from 89 minutes to 55 minutes
WellSpace Health Centers	$125,000 over 2 years $65,500 in 2014 & 2015 This grant impacts two KFH hospital service areas in Northern California Region.	Project allows Sacramento FQHC Wellspace to increase quality of care and outcomes for chronic disease patients by providing regular health education and supporting behavior change to control blood pressure and diabetes, and to reduce emergency department use.	• launched group health education classes targeting Latino patients with diabetes and will spread classes to two new sites. • prepared for deployment of a sophisticated technology tool-disease registry in early 2016

*Sacramento Native American Health Center, Inc. (SNAHC)	$250,000 in 2015 This grant impacts three KFH hospital service areas in Northern California Region.	This project will allow SNAHC to provide primary, mental health, vision and dental services to 15,000 low-income patients annually, double its current capacity	Anticipated outcomes include: • increased access to medical services by adding 13 exam and procedure rooms • increased access to dental services by adding seven operatories

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Sacramento Region Health Care Partnership	Launched in 2011, in response to the Affordable Care Act and an anticipated influx of 227,500 newly insured residents, the Partnership works to improve the safety net health care system in El Dorado, Placer, Sacramento, and Yolo counties. Its Safety Net Learning Institute helps community health centers build skills and expertise in key staff members to help leverage internal system transformation.	Greater Sacramento CB Manager is a Partnership member. Nearly $1.4 million in grants were awarded to five community health centers and the Safety Net Learning Institute was offered to all community health centers staff in the Sacramento Region and drew 30 to 45 attendees at each meeting.
Yolo Community Health Initiative (CHI)	Working to strategically reach target groups throughout the county, Yolo CHI's mission is to connect children and families with low- and no-cost health care coverage and to educate and advocate for access to health care.	Greater Sacramento CB Manager is a Yolo CHI member. KFH-Sacramento provided guidance and support, including connecting member organizations (clinics and family resource centers) with Kaiser Permanente Child Health Program liaisons.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Roberts Family Development Center	Greater Sacramento Area pediatrician spoke to parents on the importance of childhood vaccinations.
Community-at-large	On December 11, Greater Sacramento Area held a no-cost flu clinic for the community and 44 flu shots were provided to non-Kaiser Permanente members.
All PHASE Grantees	To increase clinical expertise in the safety net, Quality and Operations Support (QOS), a Kaiser Permanente Northern California Region TPMG (The Permanente Medical Group) department, helped

	develop a PHASE data collection tool. QOS staff provided expert consultation on complex clinical data issues, such as reviewing national reporting standards, defining meaningful data, and understanding data collection methodology. This included: • conducting clinical training webinars • wireside/webinar on PHASE clinical guidelines • presentation at convening on Kaiser Permanente's approach to PHASE • presentation to various clinical peer groups through CHCN, SFCCC, etc. • individual consultation to staff at PHASE grantee organizations • individual consultation to Community Benefit Programs staff Kaiser Permanente Northern California Region's Regional Health Education (RHE) also provided assistance to PHASE grantees: • conducted two seven-hour Motivating Change trainings (24 participants each) to enable clinical staff who implement (or will) PHASE to increase their skills with regard to enhancing patients' internal motivations to make health behavior changes • provided access to patient education documents related to PHASE
Safety Net Institute (SNI)	With a goal to increase SNI's understanding of what it means to be a data-driven organization, a presentation and discussion about Kaiser Permanente's use and development of cascading score cards – a methodology leadership uses to track improvement in clinical, financial, operations, and HR – was shared with this longtime grantee.

Impact of Regional Initiatives

PHASE:

PHASE (Prevent Heart Attacks And Strokes Everyday) is a program developed by Kaiser Permanente to advance population-based, chronic care management. Using evidence-based clinical interventions and supporting lifestyle changes, PHASE enables health care providers to provide cost-effective treatment for people at greatest risk for developing coronary vascular disease. By implementing PHASE, Kaiser Permanente has reduced heart attacks and stroke-related hospital admissions among its own members by 60%. To reach more people with this life saving program, Kaiser Permanente began sharing PHASE with the safety net health care providers in 2006. KP provides grant support and technical assistance to advance the safety net's operations and systems required to implement, sustain and spread the PHASE program. By sharing PHASE with community health providers, KP supports development of a community-wide standard of care and advances the safety net's capacity to build robust population health management systems and to collectively reduce heart attacks and strokes across the community.

PRIORITY HEALTH NEED II: HEALTHY EATING, ACTIVE LIVING

Long Term Goal:

- Reduce obesity among at-risk populations in the KFH-Sacramento service area

Intermediate Goals:

- Increase healthy eating and physical activity among vulnerable populations with a focus on communities of concern

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 62 active KFH grants totaling $1,646,798 addressing Healthy Eating, Active Living in the KFH-Sacramento service area.[2] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 8 grants totaling $56,548 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Soil Born Farms Urban Agriculture Project	$69,939 over 2 years $35,000 in 2014 $34,939 in 2015	The project educates diverse, low-income populations about healthy eating through nutrition information, food tasting, recipes, cooking demonstrations, food distribution, and incentives to buy local produce.	Over 2 years, Soil Born reached 4,660 people through: cooking demonstrations, wellness-themed community dinners, 2 Birth and Beyond Family Nights, and participation in other community events.
San Juan Unified School District (SJUSD)	$23,000 in 2014	Implement Fire up Your Feet (FUYF) at one middle and four elementary schools to boost physical activity among staff, students, and their families with an emphasis on nutrition and pedestrian/bicyclist safety education.	SJUSD implemented pedestrian and bicyclist safety education, including on-bike lessons using its fleet of bikes. In addition, SJUSD focused on nutrition education by including the Dairy Council's Common Core-aligned curriculum and implementing Food Literacy Center's 13-week program.
Folsom Cordova Unified School District	$21,443 in 2015	Supports two HEAL programs. One is a partnership with Soil Born Farms to continue the school-based garden program for students at six sites with active school gardens. Students participate in Soil Born Farms' Explorer program and experience local agriculture resources through four seasonal field trips and hands on	As of December 1: • 175 students attended 1 or 2 of the 4 scheduled trips to Soil Born Farms • students experienced food harvest, food tasting, the American River (life cycle discussions), and prepping/cleaning the fields for planting the next set of crops • An average of 80 youth and 40 adults received lunch and dinner and

[2] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

		learning. The second is a summer lunch program that provides a four-week, no-cost family day camp experience.	participated in 20 hours of physical activity during the summer lunch program
Health Education Council (HEC)	$68,465 over 2 years $51,450 in 2014 (even split with So. Sac and Roseville) $17,015 in 2015	Supports Don't Buy The Lie, a program to reduce tobacco initiation and use among youth.	During 2014 and 2015, 17,504 students at 27 different primary, secondary and continuation schools were reached with this program. Activities included 'Don't Buy The Lie' poster contest, and hundreds of students designed anti-tobacco messages as part of a region-wide billboard and poster contest to raise awareness among youth.
*The Trust for Public Land	$100,000 in 2015 This grant impacts six KFH hospital service areas in Northern California Region.	The Trust for Public Land will lead a replicable assessment and planning process to help city government, community partners, and other stakeholders improve the City of Fresno's parks and recreation system. The Trust for Public Land will also provide assistance to Oakland, Sacramento, San Jose, and Stockton.	Expected reach is 135 community leaders and expected outcomes include: • community and government engagement in Fresno leads to identification of new park projects and potential park renovation sites • a local advisory committee of stakeholders, including park managers, health practitioners, and engaged citizens is formed to identify programming and funding opportunities for park improvements • tools and resources are provided to help five other Northern California communities identify and develop park resources

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
San Juan Unified School District (SJUSD) Coordinated School Health Council (CSHC)	SJUSD's CSHC is a stakeholder group of students, staff, health-related community-based organizations, and parents who are committed to the health and wellness of students, families, and staff.	Greater Sacramento CB Manager is a member of CSHC, which meets on a quarterly basis to discuss pertinent health topics and to make recommendations to the SJCUSD school board.

Folsom Cordova Unified School District (FCUSD) School Health Advisory Council (SHAC)	FCUSD's SHAC is a stakeholder group of students, staff, health-related community-based organizations, and parents who are committed to the health and wellness of students, families, and staff.	Greater Sacramento CB Manager is a member of SHAC, which meets on a quarterly basis to discuss pertinent health topics and to make recommendations to the FCUSD school board.
Healthy Sacramento Coalition (HSC), Sierra Health Foundation	HSC's goal is to improve the health and wellness of Sacramento County residents.	Former Greater Sacramento CB Specialist was a HSC committee member and chair of the tobacco work-group. Health and social service providers worked to develop a plan to address tobacco use and to create healthy eating and active living opportunities for Sacramento residents.
In-Kind Resources Highlights		
Recipient	**Description of Contribution and Purpose/Goals**	
Roberts Family Development Center (RFDC)	In partnership with the NBA, 75 students from RFDC's MLK technology academy afterschool program participated in the FIT Clinic. Led by Sacramento Kings player Ray McCallum, participants engaged in activities that taught them how to be active and eat healthy.	
San Juan Unified School District (SJUSD)	Together with a Kaiser Permanente physician, the Sacramento Kings led a series of fun physical activities, including Get Fit clinics and PE Takeover days, at Greer, Starr King, and Kingswood elementary schools and San Juan High School. Approximately 1,000 students participated. SJUSD was chosen to participate in a three-year Alliance for a Healthier Generation (AHG) program to institute specific changes to create healthier school environments that support healthy eating and physical activity. Ten schools were identified for AHG participation.	
Thomas Edison Language Institute	A performance of KPET's *The Best Me*, a production about health eating and active living for fifth and sixth graders, and a related family night workshop.	
Impact of Regional Initiatives		
Parks Initiative: The physical and mental health benefits of experiencing nature and outdoor physical activity are well-documented. Kaiser Permanente's investments in parks focus on increasing access to and use of safe parks and open spaces by low-income, underserved populations that have historically faced significant obstacles in accessing parks. By connecting people to parks, creating infrastructure enhancements in parks, and supporting policies to advance sustainability and improve culturally available services within park departments, we also aim to increase the competencies of local, regional, state, and national parks to effectively engage diverse communities. In addition to our monetary contributions, we are expanding volunteer opportunities in parks for Kaiser Permanente physicians and employees.		

PRIORITY HEALTH NEED III: LIMITED ACCESS TO MENTAL HEALTH CARE SERVICES

Long Term Goals:

- Improve mental health and behavioral health among high-risk populations in the KFH-Sacramento service area

Intermediate Goals:

- Increase access to mental health care services to improve the management of mental health symptoms among high-risk populations (e.g., the uninsured and underinsured, residents engaging in unsafe behavior, etc.)
- Decrease risks for mental, emotional, and behavioral disorders among people at risk for engaging in unsafe behaviors

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 29 active KFH grants totaling $373,088 addressing Limited Access to Mental Health Care Services in the KFH-Sacramento service area.[3] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 3 grants totaling $108,095 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Elica Health Centers	$71,500 over 2 years $41,500 in 2014 $30,000 in 2015	Supports Elica's integrated behavioral health program	During 2014 and 2015, The program treated 597 new and returning patients; 65% of whom had individual therapy; the remaining 35% participated in group therapy. Approximately 6,250 unduplicated patients were screened for depression and substance abuse.
Sacramento Loaves and Fishes	$35,000 over 2 years $10,000 in 2014 $25,000 in 2015	Supports the Genesis Project, which provides one-on-one counseling for homeless adults, and increased the street outreach program to four days per week.	In 2014 and 2015, 4,124 homeless and low-income people received mental health counseling services at the center. In addition, street outreach helped 146 people receive counseling and referral services to health care providers.
Transitional Living and Community Support (TLCS), Inc.	$55,163 over 2 years $27,503 in 2014 $27,660 in 2015	Supports providing transportation to appointments for clients with serious, ongoing mental illness.	253 clients received transportation to 2,248 psychiatric, housing, therapy, and other needed appointments.
WellSpace Health	$147,652	Supports T3 (triage, transport, and treat) Foothills, a program designed to	The program served 100 individuals with intensive case management services,

[3] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

	$99,000 in 2014 (split with Roseville) $48,652 in 2015	meet the complex medical, behavioral, and psychosocial needs of homeless high-utilizers of emergency health services.	including housing and transportation support and assistance with completing required documentation to facilitate coordination of care. Clients receive referrals to primary care, mental health, and alcohol and other drug providers; are connected to housing, food banks, and other services; and get help with SSI, SDI, and General Assistance benefits, as needed.

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
Creating Community Solutions (CCS)	Part of the national dialogue on mental health, the CCS initiative aims to get communities and people talking about mental health. CCS has resources to help communities organize events and to guide participants in discussions about mental health and how to take local action.	Greater Sacramento CB Manager is a member of the Action Team for Integration of Behavioral Health and Primary and Health Care for Sacramento County that developed an advocacy paper on integrating behavioral health and primary health care in youth.
Mental Health Improvement Coalition	Comprising four local health systems, Sierra Sacramento Valley Medical Society, Northern and Central California Hospital Council, Sacramento Metro Fire, area clinics, and an array of community and business stakeholders, the coalition aims to enable a coordinated response to restore and rebalance Sacramento County's system of behavioral health care.	Greater Sacramento public affairs directors, Sacramento/Roseville and South Sacramento, are Coalition members. Funds were approved to expand access to the county's crisis stabilization unit; expand in-patient, outpatient, and respite care; and utilize innovative patient-centered approaches, including patient navigators and mobile crisis teams.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Thomas Edison Language Institute (SJUSD)	Greater Sacramento clinical staff mentor fifth graders at Thomas Edison. Each of the 35 participating providers mentored one child. Activities included email and face-to-face contact.
Roberts Family Development Center	As part of a Shop with a Doc event, Greater Sacramento physicians shopped with 30 RFDC youth each year. Each child received $125 worth of clothing, along with a book and a stuffed animal from Kohls.

(RFDC)	
RFDC; Rancho Cordova PAL; Sheriff's Community Impact Program; and Mutual Assistance Network Women's Empowerment	KFH-Sacramento helped provide tickets for underserved youth and their families (70 each year) to attend the California State Fair and receive a healthy lunch. For many of the children, their family's financial situation meant they would not have been able to attend the fair otherwise. Some shared that this was their first visit.

Impact of Regional Initiatives

Youth and Trauma Informed Care:

Research has established the connection between childhood trauma and significant, long-term health issues in adulthood. Kaiser Permanente's Youth and Trauma-Informed Care (YTIC) initiative aims to cultivate trauma-informed environments in schools and community-based organizations to prioritize the relationships, trust, safety, and mindful interactions that are essential to helping youth heal from trauma and go on to lead healthy, productive lives. Grantees are supported to increase screening for trauma exposure among youth 12 to 18, provide mental health support and services onsite, strengthen referrals for long-term care, and increase awareness among teachers and staff of trauma signs and symptoms. Teacher and staff training also addresses how to manage their own stress, burnout, and even vicarious trauma and how to minimize the risks of re-traumatizing youth.

PRIORITY HEALTH NEED IV: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – WORKFORCE

KFH Workforce Development Highlights

Long Term Goal:

- To address health care workforce shortages and cultural and linguistic disparities in the health care workforce

Intermediate Goal:

- Increase the number of skilled, culturally competent, diverse professionals working in and entering the health care workforce to provide access to quality, culturally relevant care

Summary of Impact: During 2014 and 2015, Kaiser Foundation Hospital awarded 19 Workforce Development grants totaling $610,992 that served the KFH-Sacramento service area.[4] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 6 grants totaling $38,106 that address this need. In addition, KFH Sacramento provided trainings and education for 271 residents in their Graduate Medical Education program in 2014 and 228 in 2015, 32 nurse practitioners or other nursing beneficiaries and 2014 in 54 in 2015 , and 98 other health (non-MD) beneficiaries as well as internships for 36 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.

Grant Highlights

[4] This total grant amount may include grant dollars that were accrued (i.e., awarded) in a prior year, although the grant dollars were paid in 2015.

Grantee	Grant Amount	Project Description	Results to Date
*Vision Y Compromiso	$98,093 This grant impacts 16 KFH hospital service areas in Northern California Region	The Promotoras and Community Health Worker (CHW) Network will engage 40 to 60 more promotores (from the current 220); expand the Network to Fresno and Sacramento counties; provide 4 to 6 trainings per region to build professional capacity and involve 20 to 40 workforce partners to better integrate the promotor model.	Anticipated outcomes include: • increased promotores leadership as measured by an increased number of promotores who participate in regional Network activities • increased knowledge of community health issues as measured by pre- and post-surveys completed by promotores participating in training, conferences, and other activities • increased knowledge of community resources, increased networking, and social support as measured by an increased number of agencies involved in the regional Networks
*Public Health Institute (PHI)	$149,889 (over 2 years) This grant impacts four KFH hospital service areas in Northern California Region	PHI's FACES for the Future Coalition is a program that works with at-risk, underrepresented high-school students to increase their presence in the health professions through academic support, internships in hospitals and community clinics, youth leadership development, and wellness training that includes psychosocial intervention as needed.	Anticipated outcomes include: • FACES is implemented in San Francisco Unified School District • FACES tracks students' individual progress through changes in GPA, attendance and cause of absence, internship supervisor feedback, case management documentation, and pre/post surveys and testing that measure learning outcomes • Plan for and pilot FACES at South Sacramento's Health Professions and Hiram Johnson high schools • to further expand the program, FACES electronically disseminates a newly developed replication toolkit to a wide number of interested groups
*Physicians Medical Forum (PMF)	$150,000	PMF's Doctors On Board (DOB) Pipeline and Community Health Ambassadors (CHA) programs aim to	Anticipated outcomes include: • 250 DOB students mentored annually by faculty, physicians, medical students,

	This grant impacts 16 KFH hospital service areas in Northern California Region	increase the pipeline of African American and other under-represented minority medical students, residents, and physicians in Northern California who want to pursue careers in medicine. Through DOB, health care professionals mentor students and workshops help students prepare for the process of working towards a health care career. Through CHA, students work in teams with community-based organizations to design and help implement health education programs to improve the health of their communities and better prepare them for health care careers.	residents, and other health care professionals • 250 DOB students participate in workshops to prepare them for SAT/MCAT tests, essay/ writing skills, and interviewing/communication skills • 25 CHA students work with medical students, residents, and physicians to become prepared for medical school and with community-based organizations to develop multimedia community service/learning projects on a health-related topic

PRIORITY HEALTH NEED IV: BROADER HEALTH CARE SYSTEM NEEDS IN OUR COMMUNITIES – RESEARCH

KFH Research Highlights

Long Term Goal:

- To increase awareness of the changing health needs of diverse communities

Intermediate Goal:

- **I**ncrease access to, and the availability of, relevant public health and clinical care data and research

Grant Highlights

Grantee	Grant Amount	Project Description	Results to Date
UCLA Center for Health Policy Research	$2,100,000 over 4 years 1,158,200 over 2014 & 2015 This grant impacts all KFH	Grant funding during 2014 and 2015 has supported The California Health Interview Survey (CHIS), a survey that investigates key public health and health care policy issues, including health insurance coverage and access to health services, chronic health conditions and their prevention and	CHIS 2013-2014 was able to collect data and develop files for 48,000 households, adding Tagalog as a language option for the survey this round. In addition 10 online AskCHIS workshops were held for 200 participants across the state. As of February 2016, progress on the 2015-2016 survey included completion of the

	hospital service areas in Northern California Region.	management, the health of children, working age adults, and the elderly, health care reform, and cost effectiveness of health services delivery models. In addition, funding allowed CHIS to support enhancements for AskCHIS Neighborhood Edition (NE). New AskCHIS NE visualization and mapping tools will be used to demonstrate the geographic differences in health and health-related outcomes across multiple local geographic levels, allowing users to visualize the data at a sub-county level.	CHIS 2015 data collection that achieved the adult target of 20,890 completed interviews. CHIS 2016 data collection began on January 4, 2016 and is scheduled to end in December 2016 with a target of 20,000 completed adult interviews. In addition, funding has supported the AskCHIS NE tool which has allowed the Center to: • Enhance in-house programming capacity for revising and using state-of-the-science small area estimate (SAE) methodology. • Develop and deploy AskCHIS NE. • Launch and market AskCHIS NE. • Monitor use, record user feedback, and make adjustments to AskCHIS NE as necessary.

In addition to the CHIS grants, two research programs in the Kaiser Permanente Northern California Region Community Benefit portfolio – the Division of Research (DOR) and Northern California Nursing Research (NCNR) – also conduct activities that benefit all Northern California KFH hospitals and the communities they serve.

DOR conducts, publishes, and disseminates high-quality research to improve the health and medical care of Kaiser Permanente members and the communities we serve. Through interviews, automated data, electronic health records (EHR), and clinical examinations, DOR conducts research among Kaiser Permanente's 3.9 million members in Northern California. DOR researchers have contributed over 3,000 papers to the medical and public health literature. Its research projects encompass epidemiologic and health services studies as well as clinical trials and program evaluations. Primary audiences for DOR's research include clinicians, program leaders, practice and policy experts, other health plans, community clinics, public health departments, scientists and the public at large. Community Benefit supports the following DOR projects:

DOR Projects	Project Information

Central Research Committee (CRC)	Information on recent CRC studies can be found at: **http://insidedorprod2.kp-dor.kaiser.org/sites/crc/Pages/projects.aspx**
Clinical Research Unit (CCRU)	CCRU offers consultation, direction, support, and operational oversight to Kaiser Permanente Northern California clinician researchers on planning for and conducting clinical trials and other types of clinical research; and provides administrative leadership, training, and operational support to more than 40 regional clinical research coordinators. CCRU statistics include more than 420 clinical trials and more than 370 FDA-regulated clinical trials. In 2015, the CCRU expanded access to clinical trials at all 21 KPNC medical centers.
Research Program on Genes, Environment and Health (RPGEH)	RPGEH is working to develop a research resource linking the EHRs, collected bio-specimens, and questionnaire data of participating KPNC members to enable large-scale research on genetic and environmental influences on health and disease; and to utilize the resource to conduct and publish research that contributes new knowledge with the potential to improve the health of our members and communities. By the end of 2014, RPGEH had enrolled and collected specimens from more than 200,000 adult KPNC members, had received completed health and behavior questionnaires from more than 430,000 members; and had genotyped DNA samples from more than 100,000 participants, linked the genetic data with EHRs and survey data, and made it available to more than 30 research projects

A complete list of DOR's 2015 research projects is at **http://www.dor.kaiser.org/external/dorexternal/research/studies.aspx**. Here are a few highlights:

Research Project Title	Alignment with CB Priorities
Risk of Cancer among Asian Americans (2014)	Research and Scholarly Activity
Racial and Ethnic Disparities in Breastfeeding and Child Overweight and Obesity (2014)	Healthy Eating, Active Living
Transition from Healthy Families to Medi-Cal: The Behavioral Health Carve-Out and Implications for Disparities in Care (2014)	Access to Care Mental/Behavioral Health
Health Impact of Matching Latino Patients with Spanish-Speaking Primary Care Providers (2014)	Access to Care
Predictors of Patient Engagement in Lifestyle Programs for Diabetes Prevention – Susan Brown	Access to care
Racial Disparities in Ischemic Stroke and Atherosclerotic Risk Factors in the Young – Steven Sidney	Access to care
Impact of the Affordable Care Act on prenatal care utilization and perinatal outcomes – Monique Hedderson	Access to care
Engaging At-Risk Minority Women in Health System Diabetes Prevention Programs – Susan	HEAL

Brown	
The Impact of the Affordable Care Act on Tobacco Cessation Medication Utilization – Kelly Young-Wolff	HEAL
Prescription Opioid Management in Chronic Pain Patients: A Patient-Centered Activation Intervention – Cynthia Campbell	Mental/Behavioral Health
Integrating Addiction Research in Health Systems: The Addiction Research Network – Cynthia Campbell	Mental/Behavioral Health

RPGEH Project Title	Alignment with CB Priorities
Prostate Cancer in African-American Men (2014)	Access to Care Research and Scholarly Activity
RPGEH high performance computing cluster. DOR has developed an analytic pipeline to facilitate genetic analyses of the GERA (Genetic Epidemiology Research in Adult Health and Aging) cohort data. Development of the genotypic database is ongoing; in 2014, additional imputed data were added for identification of HLA serotypes. (2014)	Research and Scholarly Activity

The main audience for NCNR-supported research is Kaiser Permanente and non-Kaiser Permanente health care professionals (nurses, physicians, allied health professionals), community-based organizations, and the community-at-large. Findings are available at the Nursing Pathways NCNR website: https://nursingpathways.kp.org/ncal/research/index.html,

Alignment with CB Priorities	Project Title	Principal Investigator
Serve low-income, underrepresented, vulnerable populations located in the Northern California Region service area	**1.** *A qualitative study: African American grandparents raising their grandchildren: A service gap analysis.* **2.** *Feasibility, acceptability, and effectiveness of Pilates exercise on the Cadillac exercise machine as a therapeutic intervention for chronic low back pain and disability.*	**1.** Schola Matovu, staff RN and nursing PhD student, UCSF School of Nursing **2.** Dana Stieglitz, Employee Health, KFH-Roseville; faculty, Samuel Merritt University
Reduce health disparities.	**1.** *Making sense of dementia: exploring the use of the markers of assimilation of problematic experiences in dementia scale to understand how couples process a diagnosis of dementia.* **2.** *MIDAS data on elder abuse reporting in KP NCAL.*	**1.** Kathryn Snow, neuroscience clinical nurse specialist, KFH-Redwood City **2.** Jennifer Burroughs, Skilled Nursing Facility, Oakland CA **3.** Tracy Trail-Mahan, et al., KFH-Santa Clara

	3. *Quality Improvement project to improve patient satisfaction with pain management: Using human-centered design.* **4.** *Transforming health care through improving care transitions: A duty to embrace.* **5.** *New trends in global childhood mortality rates.*	**4.** Michelle Camicia, KFH-Vallejo Rehabilitation Center **5.** Deborah McBride, KFH-Oakland
Promote equity in health care and the health professions.	**1.** *Family needs at the bedside.* **2.** *Grounded theory qualitative study to answer the question, "What behaviors and environmental factors contribute to emergency department nurse job fatigue/burnout and how pervasive is it?"* **3.** *A new era of nursing in Indonesia and a vision for developing the role of the clinical nurse specialist.* **4.** *Electronic and social media: The legal and ethical issues for health care.* **5.** *Academic practice partnerships for unemployed new graduates in California.* **6.** *Over half of U.S. infants sleep in potentially hazardous bedding.*	**1.** Mchelle Camicia, director operations KFH-Vallejo Rehabilitation Center **2.** Brian E. Thomas, Informatics manager, doctorate student, KP-San Jose ED. **3.** Elizabeth Scruth, critical care/sepsis clinical practice consultant, Clinical Effectiveness Team, NCAL **4.** Elizabeth Scruth, et al. **5.** Van et al. **6.** Deborah McBride, KFH-Oakland

VIII. Appendices

A. **Secondary Data Dictionary and Processing**

B. **Community Input Tracking Form**

C. **Health Need Profiles**

D. **Detailed Analytic Methodology for Identifying Significant Health Needs**

E. **Focus Communities**

F. **Informed Consent**

G. **Demographic Forms**

H. **Interview Guides**

I. **Project Summary Sheet**

J. **Resources**

APPENDIX A: Secondary Data Dictionary and Processing

Kaiser Permanente (KP) CHNA Data Platform

The CHNA Data Platform is a web-based platform designed to assist hospitals, non-profit organizations, state and local health departments, financial institutions and other organizations seeking to better understand the needs and assets of their communities (http://www.communitycommons.org/groups/community-health-needs-assessment-chna/).The Kaiser Permanente Data Platform was used to collect additional indicators, including indicators by race and ethnicity, in order to better understand what is driving health in the community and prioritize issues that require the most urgent attention. The list of KP Data Platform indicators used is detailed in Table 7.

Table 7. CHNA Data Platform Indicators

Variable	Year	Definition	Reporting Unit	Data Source
Absence of Dental Insurance Coverage	2009	Percent Adults Without Dental Insurance	County (Grouping)	University of California Center for Health Policy Research, California Health Interview Survey
Access to Dentists	2013	Dentists, Rate per 100,000 Population	County	US Department of Health and Human Services, Health Resources and Services Administration, Areas Health Resource File
Access to Mental Health Providers	2014	Mental Health Care Provider Rate (Per 100,000 Population)	County	University of Wisconsin Population Health Institute, County Health Rankings
Access to Primary Care	2012	Primary Care Physicians, Rate per 100,000 Population	County	US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File
Alcohol – Excessive Consumption	2006 – 2012	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	County	Center for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. U.S. Department of Health and Human Services, Health Indicators Warehouse

Variable	Year	Definition	Reporting Unit	Data Source
Alcohol – Expenditures	2014	Alcoholic Beverage Expenditures, Percentage of Total Food-At-Home Expenditures	Tract	Nielsen, Nielsen SiteReports
Air Quality - Ozone (O3)	2008	Percentage of Days Exceeding Standards, Population Adjusted Average	Tract	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network
Air Quality - Particulate Matter 2.5	2008	Percentage of Days Exceeding Standards, Pop. Adjusted Average	Tract	Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network
Asthma - Hospitalizations	2011	Age-Adjusted Discharge Rate (Per 10,000 Population)	ZIP Code	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES
Asthma – Prevalence	2011 – 2012	Percent Adults with Asthma	County	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES
Breastfeeding (Any)	2012	Percentage of Mothers Breastfeeding (Any)	County	California Department of Public Health (CDPH) – Breastfeeding Statistics
Breastfeeding (Exclusive)	2012	Percentage of Mothers Breastfeeding (Exclusively)	County	California Department of Public Health, CDPH - Breastfeeding Statistics
Cancer Incidence - Breast	2008-2012	Annual Breast Cancer Incidence Rate (Per 100,000 Population)	County	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles
Cancer Incidence (Cervical)	2010 – 2012	Total Aggregated Incidence of Cervical Cancers from 2010 - 2012, Rate per 100,000 Population	County	California Cancer Registry

Variable	Year	Definition	Reporting Unit	Data Source
Cancer Incidence - Colon and Rectum	2008-2012	Annual Colon and Rectum Cancer Incidence Rate (Per 100,000 Population)	County	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles
Cancer Incidence - Lung	2008-2012	Annual Lung Cancer Incidence Rate (Per 100,000 Population)	County	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles
Cancer Incidence - Prostate	2008-2012	Annual Prostate Cancer Incidence Rate (Per 100,000 Population)	County	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles
Cancer Screening - Mammogram	2008 - 2012	Annual Cervical Cancer Incidence, Rate per 100,00 Population	County	National Institutes of Health, National Cancer Institute, Surveillance, Epidemiology, and End Results Program. State Cancer Profiles
Cancer Screening – Pap Test	2012	Percent Adults Females Age 18+ with Regular Pap Test (Age Adjusted)	County	Dartmouth College Institute for Health Policy & Practice, Dartmouth Atlas of Health Care
Cancer Screening – Sigmoid and Colonoscopy	2006 – 2012	Percent Adults Screened for Colon Cancer (Age Adjusted)	County	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse
Children Eligible for Free/Reduced Price Lunch	2013 - 2014	Percent Students Eligible for Free or Reduced Price Lunch	Address	National Center for Education Statistics, NCES – Common Core of Data

Variable	Year	Definition	Reporting Unit	Data Source
Climate & Health - Canopy Cover	2011	Population Weighted Percentage of Report Area Covered by Tree Canopy	Tract	Multi-Resolution Land Characteristics Consortium, National Land Cover Database 2011. Additional data analysis by CARES
Commute to Work – Alone in Car	2009 – 2013	Percentage of Workers Commuting by Car, Alone	Tract	US Census Bureau, American Community Survey
Commute to Work – Walking/Biking	2009-2013	Percentage Walking or Biking/Work	Tract	US Census Bureau, American Community Survey
Dental Care - Lack of Affordability (Youth)	2009	Percent Population Age 5-17 Unable to Afford Dental Care	County (Grouping)	University of California Center for Health Policy Research, California Health Interview Survey
Dental Care - No Recent Exam (Adult)	2006-2010	Percent Adults Without Recent Dental Exam	County	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES
Dental Care - No Recent Exam (Youth)	2013-2014	Percent Youth Without Recent Dental Exam	County (Grouping)	University of California Center for Health Policy Research, California Health Interview Survey
Diabetes Hospitalizations	2011	Age-Adjusted Discharge Rate (Per 10,000 Population)	ZIP Code	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES
Diabetes Management (Hemoglobin A1c Test)	2012	Percent Medicare Enrollees with Diabetes with Annual Exam	County	Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care
Diabetes Prevalence	2012	Percent Adults with Diagnosed Diabetes (Age Adjusted)	County	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion

Variable	Year	Definition	Reporting Unit	Data Source
Drinking Water Safety	2012-2013	Percentage of Population Potentially Exposed to Unsafe Drinking Water	County	University of Wisconsin Population Health Institute, County Health Rankings
Economic Security – Commute Over 60 Minutes	2009 - 2013	Percent of Workers Communities More than 60 Minutes	Tract	US Census Bureau, American Community Survey
Economic Security - Households with No Vehicle	2009-2013	Percentage of Households with No Motor Vehicle	Tract	US Census Bureau, American Community Survey
Economic Security - Unemployment Rate	2015	Unemployment Rate	County	US Department of Labor, Bureau of Labor Statistics
Education - Head Start Program Facilities	2014	Head Start Programs Rate (Per 10,000 Children Under Age 5)	Point	US Department of Health & Human Services, Administration for Children and Families
Education – High School Graduation Rate	2013	Cohort Graduation Rate	County	California, Department of Education
Education - Less than High School Diploma (or Equivalent)	2009-2013	Percent Population Age 25+ with No High School Diploma	Tract	US Census Bureau, American Community Survey. 2009-13.
Education – Reading Below Proficiency	2012 – 2013	Percentage of Grade 4 ELA Test Score Not Proficient	County	California, Department of Education
Education – School Enrollment Age 3-4	2009 - 2013	Percentage Population Age 3-4 Enrolled in School	Tract	US Census Bureau, American Community Survey
Federally Qualified Health Centers	2015	Federally Qualitied Health Centers, Rate per 100,000 Population	Address	U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File
Food Environment – Fast Food Restaurants	2011	Fast Food Restaurants, Rate per 100,000 Population	Tract	U.S. Census Bureau, County of Business Patterns. Additional data analysis by CARES

Variable	Year	Definition	Reporting Unit	Data Source
Food Environment – Grocery Stores	2011	Grocery Stores, Rate per 100,000 Population	Tract	U.S. Census Bureau, County of Business Patterns. Additional data analysis by CARES
Food Environment - WIC-Authorized Food Stores	2011	WIC-Authorized Food Stores, Rate (Per 100,000 Population)	County	US Department of Agriculture, Economic Research Service, USDA - Food Environment Atlas
Food Security – Food Insecurity Rate	2013	Percentage of the Population with Food Insecurity	County	Feeding America
Food Security – Population Receiving SNAP	2011	Percent Population Receiving SNAP Benefits	County	U.S. Census Bureau, Small Area Income & Poverty Estimates
Food Security - School Breakfast Program	2013	Average Daily School Breakfast Program Participation Rate	State	US Department of Agriculture, Food and Nutrition Service, USDA - Child Nutrition Program
Fruit/Vegetable Expenditures	2014	Fruit / Vegetable Expenditures, Percentage of Total Food-At-Home Expenditures	Tract	Nielsen, Nielsen SiteReports
Heart Disease Prevalence	2011 – 2012	Percent Adults with Heart Disease	County (Grouping)	University of California Center for Health Policy Research, California Health Interview Survey
High Blood Pressure - Unmanaged	2006 - 2010	Percent Adults with High Blood Pressure	County	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES
Housing – Assisted Housing	2013	HUD – Assisted Units, Rate per 10,000 Housing Units (2010)	County	U.S. Department of Housing and Urban Development
Housing - Cost Burdened Households	2009-2013	Percentage of Households where Housing Costs Exceed 30% of Income	Tract	US Census Bureau, American Community Survey
Housing – Substandard Housing	2009 – 2013	Percent Occupied Housing Units with One or More Substandard Conditions	County	U.S. Census Bureau, American Community Survey

Variable	Year	Definition	Reporting Unit	Data Source
Housing - Vacant Housing	2009-2013	Vacant Housing Units, Percent	Tract	US Census Bureau, American Community Survey
Infant Mortality	2006-2010	Infant Mortality Rate (Per 1,000 Births)	County	Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research
Insurance – Population Receiving Medicaid	2009 – 2013	Percent of Insured Population Receiving Medicaid	Tract	U.S. Census Bureau, American Community Survey
Insurance - Uninsured Population	2009-2013	Percent Uninsured Population	Tract	US Census Bureau, American Community Survey
Lack of a Consistent Source of Primary Care	2011-2012	Percentage Without Regular Doctor	County (Grouping)	University of California Center for Health Policy Research, California Health Interview Survey
Lack of Prenatal Care	2011	Percent Mothers with Late or No Prenatal Care	ZIP Code	California Department of Public Health, CDPH - Birth Profiles by ZIP Code
Lack of Social or Emotional Support	2006 – 2012	Percent Adult Without Adequate Social / Emotional Support (Age-Adjusted)	County	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse
Liquor Store Access	2012	Liquor Stores, Rate per 100,000 Population	County	U.S. Census Bureau, County Business Patterns. Additional data analysis by CARES
Low Birth Weight	2011	Percent Low Birth Weight Births	ZIP Code	California Department of Public Health, CDPH - Birth Profiles by ZIP Code

Variable	Year	Definition	Reporting Unit	Data Source
Low Fruit/Vegetable Consumption (Adult)	2005-2009	Percent Adults with Inadequate Fruit / Vegetable Consumption	County	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse
Low Fruit/Vegetable Consumption (Youth)	2011 - 2012	Percent Population Age 2-13 with Inadequate Fruit/Vegetable Consumption	County (Grouping)	University of California Center for Health Policy Research, California Health Interview Survey
Mental Health - Depression Among Medicare Beneficiaries	2012	Percentage of Medicare Beneficiaries with Depression	County	Centers for Medicare and Medicaid Services
Mental Health - Needing Mental Health Care	2013-2014	Percentage with Poor Mental Health	County (Grouping)	University of California Center for Health Policy Research, California Health Interview Survey
Mental Health – Poor Mental Health Days	2006 - 2012	Average Number of Mentally Unhealthy Days per Month	County	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse
Mortality - Cancer	2010-2012	Cancer, Age-Adjusted Mortality Rate (per 100,000 Population)	ZIP Code	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data
Mortality – Homicide	2010 - 2012	Homicide, Age-Adjusted Mortality, Rate per 100,000 Population	ZIP Code	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data

Variable	Year	Definition	Reporting Unit	Data Source
Mortality - Ischaemic Heart Disease	2010-2012	Heart Disease, Age-Adjusted Mortality Rate (per 100,000 Population)	ZIP Code	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data
Mortality – Motor Vehicle Accident	2010 - 2012	Motor Vehicle Accident, Age Adjusted Mortality, Rate per 100,000 Population	ZIP Code	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data
Mortality – Pedestrian Accident	2010 - 2012	Pedestrian Accident – Age Adjusted Mortality, Rate per 100,000 Population	ZIP Code	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data
Mortality - Stroke	2010-2012	Stroke, Age-Adjusted Mortality Rate (per 100,000 Population)	ZIP Code	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data
Mortality - Suicide	2010-2012	Suicide, Age-Adjusted Mortality Rate (per 100,000 Population)	ZIP Code	University of Missouri, Center for Applied Research and Environmental Systems. California Department of Public Health, CDPH - Death Public Use Data
Obesity (Adult)	2012	Percent Adults with BMI > 30.0 (Obese)	County	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion
Obesity (Youth)	2013 - 2014	Percent Obese	County	California Department of Education, FITNESSGRAM® Physical Fitness Testing

Variable	Year	Definition	Reporting Unit	Data Source
Overweight (Adult)	2011-2012	Percent Adults Overweight	County	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES
Overweight (Youth)	2013 - 2014	Percent Overweight	County	California Department of Education, FITNESSGRAM® Physical Fitness Testing
Physical Inactivity (Adult)	2012	Percent Population with no Leisure Time Physical Activity	County	Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion
Physical Inactivity (Youth)	2013 - 2014	Percent Physically Inactive	County	California Department of Education, FITNESSGRAM® Physical Fitness Testing
Poor Dental Health	2006-2010	Percent Adults with Poor Dental Health	County	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES
Poverty - Children Below 100% FPL	2009-2013	Percent Population Under Age 18 in Poverty	Tract	US Census Bureau, American Community Survey
Poverty - Population Below 100% FPL	2009-2013	Percent Population in Poverty	Tract	US Census Bureau, American Community Survey
Poverty - Population Below 200% FPL	2009-2013	Percent Population with Income at or Below 200% FPL	Tract	US Census Bureau, American Community Survey
Preventable Hospital Service Days	2011	Age-Adjusted Discharge, Rate per 10,000 Population	County	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES

Variable	Year	Definition	Reporting Unit	Data Source
Recreation and Fitness Facility Access	2012	Recreation and Fitness Facilities, Rate (Per 100,000 Population)	ZCTA	US Census Bureau, County Business Patterns. Additional data analysis by CARES
Soft Drink Expenditures	2014	Soda Expenditures, Percentage of Total Food-At-Home Expenditures	Tract	Nielsen, Nielsen Site Reports
STD - Chlamydia	2012	Chlamydia Infection Rate (Per 100,000 Population)	County	US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
STD – HIV Hospitalizations	2011	Age-Adjusted Discharge, Rate per 10,000 Population	County	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES
STD – HIV Prevalence	2010	Population with HIV/AIDS, Rate by 100,000 Population	County	US Department of Health & Human Services, Health Indicators Warehouse. Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
STD – No HIV Screening	2011 - 2012	Percent Adults Never Screened for HIV/AIDS	County	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Additional data analysis by CARES
Teen Births (Under Age 20)	2011	Teen Birth Rate (Per 1,000 Female Population Under Age 20)	ZIP Code	California Department of Public Health, CDPH - Birth Profiles by ZIP Code
Tobacco Expenditures	2014	Cigarette Expenditures, Percentage of Total Household Expenditures	Tract	Nielsen, Nielsen SiteReports

Variable	Year	Definition	Reporting Unit	Data Source
Tobacco Usage	2006-2012	Percent Population Smoking Cigarettes(Age-Adjusted)	County	Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse
Transit - Public Transit within 0.5 Miles	2011	Percentage of Population within Half Mile of Public Transit	Tract	Environmental Protection Agency, EPA Smart Location Database
Transit – Road Network Density	2011	Total Road Network Density (Road Miles per Acre)	County	Environmental Protection Agency, EPA Smart Location Database
Transit - Walkability	2012	Percent Population Living in Car Dependent (Almost Exclusively) Cities	City	WalkScore®
Violence - All Violent Crimes	2010-2012	Violent Crime Rate (Per 100,000 Population)	County	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research
Violence - Assault (Crime)	2010-2012	Assault Rate (Per 100,000 Population)	County	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research

Variable	Year	Definition	Reporting Unit	Data Source
Violence - Assault (Injury)	2011-2013	Assault Injuries, Rate per 100,000 Population	County	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research
Violence - Domestic Violence	2011-2013	Domestic Violence Injuries, Rate per 100,000 Population (Females Age 10+)	County	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research
Violence - Rape (Crime)	2010-2012	Rape Rate (Per 100,000 Pop.)	County	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research
Violence - Robbery (Crime)	2010-2012	Robbery Rate (Per 100,000 Pop.)	County	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research
Violence - School Expulsions	2013-2014	Expulsion Rate	Tract	California Department of Education
Violence – School Suspensions	2013-2014	Suspension Rate	County	California Department of Education. 2013-2014 school year

Variable	Year	Definition	Reporting Unit	Data Source
Violence - Youth Intentional Injury	2011-2013	Intentional Injuries, Rate per 100,000 Population (Youth Age 13 - 20)	County	Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research
Walking/Biking/Skating to School	2011-2012	Percentage Walking/Skating/Biking to School	County (Grouping)	University of California Center for Health Policy Research, California Health Interview Survey

Additional Indicators Collected

The selection of additional secondary indicators was guided by the BARHII Framework illustrated in Figure 6 below. Within the framework "upstream" social inequities and "downstream" health outcomes are organized into six principal categories: (1) social inequities; (2) institutional power; (3) living conditions; (4) risk behaviors; (5) disease and injury; and (6) mortality. Specific secondary indicators were selected to represent the concepts organized in the six categories in the BARHII model that reflect both "upstream" and "downstream" factors influencing health. A number of general principles guided the selection of secondary indicators to represent these concepts. First, only indicators associated with concepts in BARHII framework were included in the analysis. Second, indicators available at a sub-county level (such as at a ZIP code or smaller level) were preferred for their utility in revealing variations within the HSA. Third, indicators were only collected from data sources deemed reliable and reputable, with a preference for indicators that were more current than those used in the 2013 CHNA report. Finally, indicators were only selected for final analysis and inclusion if they did not duplicate those in the CHNA-DP.

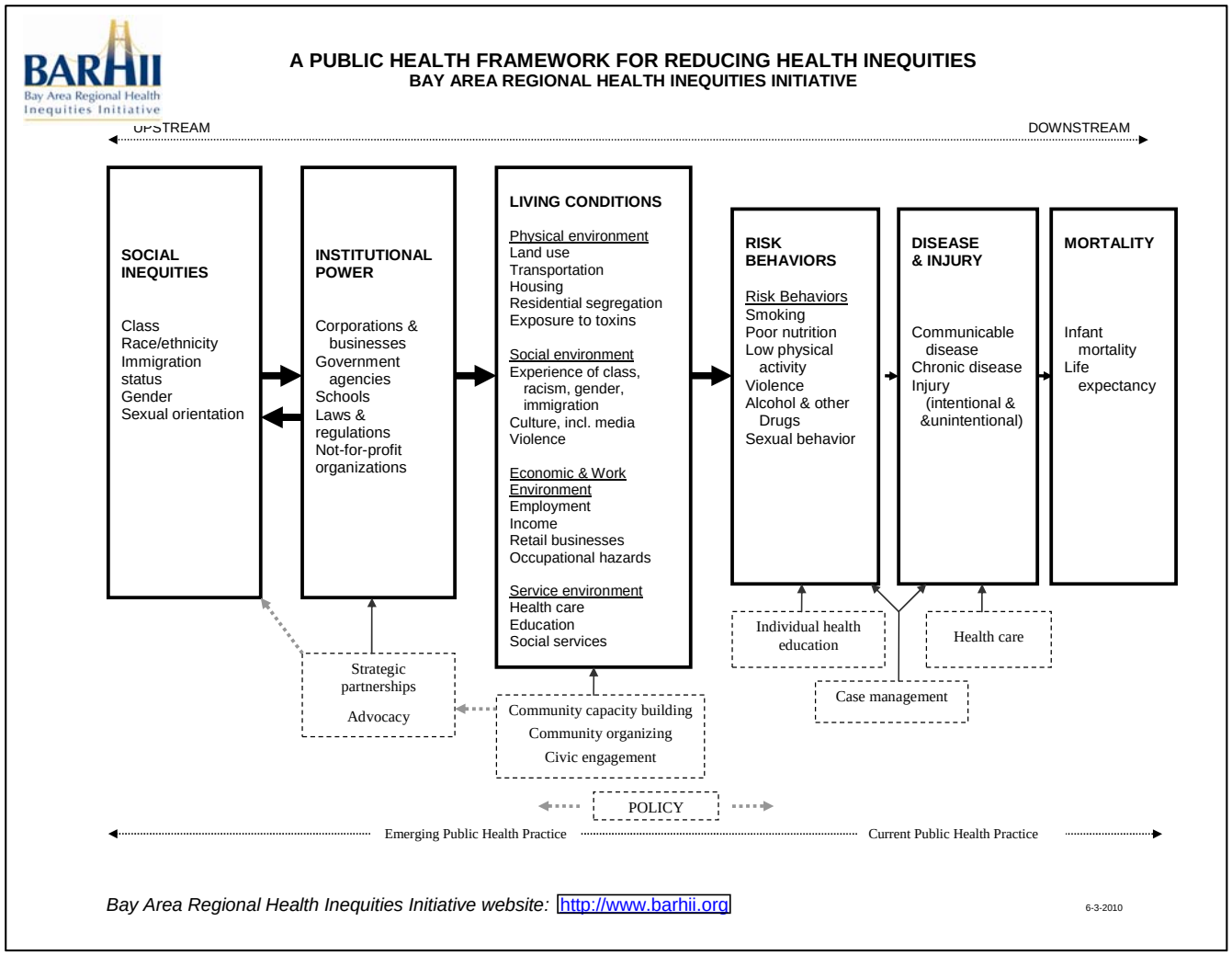


Figure 6. BARHII Framework

Mortality, Morbidity, and Socio-Economic Variables

The majority of mortality, morbidity, and socio-economic variables were collected from three main data sources: the US Census Bureau (Census), the California Office of Statewide Health Planning and Development (OSHPD), and the California Department of Public Health (CDPH). Census data was collected both to provide descriptions of population characteristics for the study area, as well as to calculate rates for morbidity and mortality variables. Table 8 below lists the 2013 population characteristic variables and sources; Table 9 lists the sources for variables used to calculate morbidity and mortality rates, which were collected for 2012, 2013, and 2014. These demographic variables were collected variously at the Census blocks and tracts, ZCTA, county, and state levels. In urban areas, Census blocks are roughly equivalent to a city block, and tracts to a neighborhood.

Table 8. Demographic Variables Collected from the US Census Bureau[5]

Derived Indicator Name	Source Indicator Names	Source
Percent Minority (Hispanic or Non-White)	Total Population: Not Hispanic or Latino (White Alone)	2013 American Community Survey 5-year Estimate Table B03002
Population 5 Years or Older Who Speak Limited English	For age groups 5 to 17; 18 to 64; and 65 years and over: Speak Spanish: Speak English "not well"; Speak Spanish: Speak English "not at all"; Speak other Indo-European languages: Speak English "not well"; Speak other Indo-European languages: Speak English "not at all"; Speak Asian and Pacific Island languages: Speak English "not well"; Speak Asian and Pacific Island languages: Speak English "not at all"; Speak other languages: Speak English "not well"; Speak other languages: Speak English "not at all"	2013 American Community Survey 5-year Estimate Table B16004
Percent Households 65 Years or Older in Poverty	Income in the past 12 months below poverty level: - Family households: Married-couple family: - Householder 65 years and over; Income in the past 12 months below poverty level: - Family households: - Other family: - Male householder, no wife present: - Householder 65 years and over; Income in the past 12 months below poverty level: - Family households: - Other family: - Female householder, no husband present: - Householder 65 years and over; Income in the past 12 months below poverty level: - Nonfamily households: - Male householder: - Householder 65 years and over; Income in the past 12 months below poverty level: - Nonfamily households: - Female householder: - Householder 65 years and over; Total Households	2013 American Community Survey 5-year Estimate Table B17017
Median Income	Estimate; Median household income in the past 12 months (in 2013 inflation-adjusted dollars)	2013 American Community Survey 5-year Estimate Table B19013
GINI Coefficient	Gini Index	2013 American Community Survey 5-year Estimate Table B19083
Average Population per Housing Unit	Total population in Occupied Housing Units	2013 American Community Survey 5-year Estimate Table B25008

[5] U.S. Census Bureau. (2015). *2013 American Community Survey 5-year estimates; 2012 American Community Survey 5-year estimates; 2011 American Community Survey 5-year estimates.*. Retrieved February 14, 2015, from American Fact Finder: http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

Derived Indicator Name	Source Indicator Names	Source
Percent with Income Less Then Federal Poverty Level	Total: Under .50; Total: .50 to .99	2013 American Community Survey 5-year Estimate Table C17002
Percent Foreign Born	Total population: Foreign born	2013 American Community Survey 5-year Estimate Table DP02
Percent Non-Citizen	Foreign-born population: Not a U.S. citizen	2013 American Community Survey 5-year Estimate Table DP02
Percent Over 18 Who are Civilian Veterans	VETERAN STATUS - Civilian population 18 years and over - Civilian veterans	2013 American Community Survey 5-year Estimate Table DP02
Percent Civilian Noninstitutionalized Population with a Disability	DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION - Total Civilian Noninstitutionalized Population	2013 American Community Survey 5-year Estimate Table DP02
Percent on Public Assistance	INCOME AND BENEFITS (IN 2013 INFLATION-ADJUSTED DOLLARS): With cash public assistance income; INCOME AND BENEFITS (IN 2013 INFLATION-ADJUSTED DOLLARS): With cash public assistance income	2013 American Community Survey 5-year Estimate Table DP03
Percent on Public Insurance	HEALTH INSURANCE COVERAGE - Civilian noninstitutionalized population - With health insurance coverage - With public coverage	2013 American Community Survey 5-year Estimate Table DP03
Percent Renter-Occupied Households	Occupied housing units: Renter-occupied	2013 American Community Survey 5-year Estimate Table DP04
Percent Vacant Housing Units	Total housing units: Vacant housing units	2013 American Community Survey 5-year Estimate Table DP04
Percent Households with No Vehicle	Occupied housing units: No vehicles available	2013 American Community Survey 5-year Estimate Table DP04
Total Population	Total Population	2013 American Community Survey 5-year Estimate Table DP05
Percent Asian (Not Hispanic)	Total Population: Not Hispanic or Latino (Asian lone)	2013 American Community Survey 5-year Estimate Table DP05
Percent Black (Not Hispanic)	Total Population: Not Hispanic or Latino (Black or African American lone)	2013 American Community Survey 5-year Estimate Table DP05
Percent Hispanic (Any Race)	Total Population: Hispanic or Latino (of any race)	2013 American Community Survey 5-year Estimate Table DP05

Derived Indicator Name	Source Indicator Names	Source
Percent American Indian (Not Hispanic)	Total population: Not Hispanic or Latino - American Indian and Alaska Native alone	2013 American Community Survey 5-year Estimate Table DP05
Percent Pacific Islander (Not Hispanic)	Total population: Not Hispanic or Latino (Native Hawaiian and Other Pacific Islander alone)	2013 American Community Survey 5-year Estimate Table DP05
Percent White (Not Hispanic)	Total population: Not Hispanic or Latino (White alone)	2013 American Community Survey 5-year Estimate Table DP05
Percent Other or Two or More Races (Not Hispanic)	Total population: Not Hispanic or Latino (some other race alone) Total population: Not Hispanic or Latino (Two or More Races)	2013 American Community Survey 5-year Estimate Table DP05
Percent Female	Total population: Female	2013 American Community Survey 5-year Estimate Table DP05
Percent Male	Total population: Male	2013 American Community Survey 5-year Estimate Table DP05
Median Age	Median age (Years)	2013 American Community Survey 5-year Estimate Table DP05
Population by Age Group	Under 5 years; 5 to 9 years; 10 to 14 years; 10 to 14 years; 20 to 24 years; 25 to 34 years; 35 to 44 years; 45 to 54 years; 55 to 59 years; 60 to 64 years; 65 to 74 years; 75 to 84 years; 85 years and over	2013 American Community Survey 5-year Estimate Table DP05
Percent Single Female-Headed Households	Female householder, No Husband Present, Family Household	2013 American Community Survey 5-year Estimate Table S1101
Percent 25 or Older Without a High School Diploma	100 - Percent High School Graduate or Higher	2013 American Community Survey 5-year Estimate Table S1501
Percent Families with Children in Poverty	All families: Percent Below Poverty Level; Estimate; With Related Children Under 18 Years	2013 American Community Survey 5-year Estimate Table S1702
Percent Single Female-Headed Households in Poverty	Female householder, No Husband Present: Percent Below Poverty Level; Estimate; With Related Children Under 18 Years	2013 American Community Survey 5-year Estimate Table S1702
Percent Unemployed	Unemployment Rate; Estimate; Population 16 Years and Over	2013 American Community Survey 5-year Estimate Table S2301
Percent Uninsured	Percent Uninsured; Estimate; Total Civilian Noninstitutionalized Population	2013 American Community Survey 5-year Estimate Table S2701

Table 9. Census Variables used for Mortality and Morbidity Rate Calculations[5,6]

Derived Variable Name	Source Variable Names	Source
Total Population	Total Population	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014) 2010 Decennial Census Summary File 1
Female	Female	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Male	Male	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age Under 1	DP05: Under 5 years PCT12: Male and Female, ages under 1, 1, 2, 3, and 4	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014); 2010 Decennial Census Summary File 1 Table PCT12
Age 1 to 4	DP05: Under 5 years PCT12: Male and Female, ages under 1, 1, 2, 3, and 4	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014); 2010 Decennial Census Summary File 1 Table PCT12
Age 5 to 14	5 to 9 years; 10 to 14 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 15 to 24	15 to 19 years; 20 to 24 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 25 to 34	25 to 34 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 35 to 44	35 to 44 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 45 to 54	45 to 54 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 55 to 64	55 to 59 years; 60 to 64 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 65 to 74	65 to 74 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 75 to 84	75 to 84 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 85 and over	85 years and over	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
White	HISPANIC OR LATINO AND RACE - Total population - Not Hispanic or Latino - White alone	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Black	HISPANIC OR LATINO AND RACE - Total population - Not Hispanic or Latino - Black or African American alone	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Hispanic	HISPANIC OR LATINO AND RACE - Total population - Hispanic or Latino (of any race)	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)

[6] U.S. Census Bureau. (2013). *2010 Census Summary File 1.* Retrieved February 14, 2013, from American Fact Finder: http://factfinder2.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t

Derived Variable Name	Source Variable Names	Source
Native American	HISPANIC OR LATINO AND RACE - Total population - Not Hispanic or Latino - American Indian and Alaska Native alone	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Asian/Pacific Islander	HISPANIC OR LATINO AND RACE - Total population - Not Hispanic or Latino - Asian alone; HISPANIC OR LATINO AND RACE - Total population - Not Hispanic or Latino - Native Hawaiian and Other Pacific Islander alone	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)

Collected morbidity and mortality data included the number of emergency department (ED) discharges, hospital (H) discharges, and mortalities associated with a number of conditions, as well as various cancer and STI incidence rates. Aggregated 2011 – 2013 ED and H discharge data were obtained from the Office of Statewide Health Planning and Development (OSHPD). Table 10 lists the specific variables collected by ZIP code and county. These values report the total number of ED or H discharges that listed the corresponding ICD9 code as either a primary or any secondary diagnosis, or a principle or other E-code, as the case may be. In addition to reporting the total number of discharges associated with the specified codes per ZIP code/county, this data was also broken down by sex (male and female), age (under 1 year, 1 to 4 years, 5 to 14 years, 15 to 24 years, 25 to 34 years, 35 to 44 years, 45 to 54 years, 55 to 64 years, 65 to 74, 75 to 84 years, and 85 years or older), and normalized race and ethnicity (Hispanic of any race, non-Hispanic White, non-Hispanic Black, non-Hispanic Asian or Pacific Islander, non-Hispanic Native American.

Table 10. 2011 – 2013 OSHPD Hospitalization and Emergency Department Discharge Data

Category	Variable Name	ICD9/E-Codes
Cancer	Breast Cancer	174, 175
	Colorectal Cancer	153, 154
	Lung Cancer	162, 163
	Prostate Cancer	185
Chronic Disease	Diabetes	250
	Hypertension	401-405
	Heart Disease	410-417, 428, 440, 443, 444, 445, 452
	Chronic Kidney Disease	580-589
	Stroke	430-436, 438
Infectious Disease	HIV/AIDS	042-044
	STIs	042-044, 090-099, 054.1, 079.4
	Tuberculosis	010-018, 137
Injuries[7]	Assault	E960-E969, E999.1
	Self-Inflicted Injury	E950-E959
	Unintentional Injury	E800-E869, E880-E929
Mental Health	Mental Health	290, 293-298, 301,311
	Mental Health: Substance Abuse	291-292, 303-305
Respiratory	Asthma	493-494
	Chronic Obstructive Pulmonary Disease (COPD)	490-496
Other	Hip Fractures	820
	Oral cavity/Dental	520-529
	Osteoporosis	733

Mortality data, along with some birth data, for each ZIP code in 2010, 2011, and 2012 were collected from the California Department of Public Health (CDPH). The specific variables collected are defined in Table 11. The majority of these variables were used to calculate specific rates of mortality for 2012. A smaller number of them were used to calculate more complex derived indicators. To increase the stability of these derived indicators, rates were calculated using data from 2010 to 2012. These variables include the total number of live births, total number of infant deaths (ages under 1 year), all-cause mortality by age, births with low infant birthweight, and births with mother's age at delivery under 20. Table 11 consequently also lists the years for which each variable was collected.

[7] E-code definitions for injury variables derived from CDC. (2011). *Matrix of E-code Groupings.* Retrieved March 4, 2013, from Injury Prevention & Control: Data & Statistics(WISQARS): http://www.cdc.gov/injury/wisqars/ecode_matrix.html

Table 11. CDPH Birth and Mortality Data by ZIP Code

Variable Name	ICD10 Code	Years Collected
Total Deaths		2012
Male Deaths		2012
Female Deaths		2012
Deaths by Age Group: Under 1, 1-4, 5-14, 15-24, 25-34,45-54, 55-64, 65-74, 75-84, and 85 and over		2010 - 2012
Diseases of the Heart	I00-I09, I11, I13, I20-I51	2012
Malignant Neoplasms (Cancer)	C00-C97	2012
Cerebrovascular Disease (Stroke)	I60-I69	2012
Chronic Lower Respiratory Disease	J40-J47	2012
Alzheimer's Disease	G30	2012
Unintentional Injuries (Accidents)	V01-X59, Y85-Y86	2012
Diabetes Mellitus	E10-E14	2012
Influenza and Pneumonia	J09-J18	2012
Chronic Liver Disease and Cirrhosis	K70, K73-K74	2012
Intentional Self Harm (Suicide)	U03, X60-X84, Y87.0	2012
Essential Hypertension & Hypertensive Renal Disease	I10, I12, I15	2012
Nephritis, Nephrotic Syndrome and Nephrosis	N00-N07, N17-N19, N25-N27	2012
All Other Causes	Residual Codes	2012
Total Births		2010 - 2012
Births with Infant Birthweight Under 1500 Grams, 1500-2499 Grams		2010 - 2012
Births with Mother's Age at Delivery Under 20		2010 - 2012

The remaining secondary variables were collected from a variety of sources, and at various geographic levels. Table 12 lists the sources of these variables, and lists the geographic level at which they were reported.

Table 12. Remaining Secondary Variables

Variable	Year	Definition	Reporting Unit	Data Source
Current Smokers	2014	Current Smoking Status - Adults and Teens	County	2014 California Health Interview Survey http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/geography (last accessed 9 Oct 2015)
Modified Retail Food Environment Index (mRFEI)	2013	Table 00CZ2 for the following NAICS codes: 445120, 722513, 445230, 452910, 445110	ZCTA	US Census Bureau 2013 County Business Patterns
Health Professional Shortage Areas (Primary Care, Dental, Mental Health)	2015	Current Primary Care, Dental Health, and Mental Health Health Provider Shortage Areas	Shortage Areas (non-point locations)	US Department of Health & Human Services Health Resources and Services Administration; http://datawarehouse.hrsa.gov/data/datadownload/hpsadownload.aspx (last accessed 29 Aug 2015)
Major Crime Rate	2013	Major Crimes (combination of violent crimes, property crimes, and arson)	Law enforcement jurisdiction	California Attorney General - Criminal Justice Statistics Center: Crimes and Clearances http://oag.ca.gov/crime/cjsc/stats/crimes-clearances (last accessed 3 Sep 2015)
Domestic Violence Rate	2013	Domestic Violence-Related Calls for Assistance	Law enforcement jurisdiction	California Attorney General – Criminal Justice Statistics Center: Domestic Violence-Related Calls for Assistance http://oag.ca.gov/crime/cjsc/stats/domestic-violence (last access 30 Oct 2015)

Variable	Year	Definition	Reporting Unit	Data Source
Pollution Burden	2014	Cal EnviroScreen Pollution Burden Scores indicator (based on ozone and PM2.5 concentrations, diesel PM emissions, drinking water contaminants, pesticide use, toxic releases from facilities, traffic density, cleanup sites, impaired water bodies, groundwater threats, hazardous waste facilities and generators, and solid waste sites and facilities)	Tract	California Office of Environmental Health Hazard Assessment CalEnviroScreen Version 2.0 http://oehha.ca.gov/ej/ces2.html

ZIP Code Definitions

All morbidity and mortality variables collected in this analysis are reported by patient mailing ZIP codes. ZIP codes are defined by the US 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 approach of the US Census Bureau, which is the main source of population and demographic information in the US. Instead of measuring the population along a collection of roads, the Census reports population figures for distinct, contiguous areas. In an attempt to support the analysis of ZIP code data, the 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, in combination the morbidity and mortality data reported at the ZIP code level, allow us to calculate rates for each ZCTA. But the difference in the definition between mailing ZIP codes and ZCTAs has two important implications for analyses of ZIP level data.

First, it should be understood that 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. Secondly, 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 ZCTA. But residents whose mailing addresses correspond to these ZIP codes will still show up in reported morbidity and mortality data. This means that rates cannot be calculated for these ZIP codes individually because there are no matching ZCTA population figures.

In order to incorporate these patients into the analysis, the point location (latitude and longitude) of all ZIP codes in California[8] were compared to ZCTA boundaries[9]. Because various morbidity and mortality data sources were available in different years, this comparison was made between the ZCTA boundaries and the point locations of ZIP codes in April of the year (or the final year

[8] Datasheer, L.L.C. (2015, April 15). *ZIP Code Database DELUXE BUSINESS.* Retrieved from Zip-Codes.com: http://www.Zip-Codes.com

[9] U.S. Census Bureau. (2015). *TIGER/Line® Shapefiles and TIGER/Line® Files.* Retrieved August 31, 2011, from http://www.census.gov/geo/maps-data/data/tiger-line.html

in the case of variables aggregated over multiple years) for which the morbidity and mortality variables were reported. All ZIP codes (whether PO Box or unique ZIP code) that were not included in the ZCTA dataset were identified. These ZIP codes were then assigned to either ZCTA that they fell inside of, or in the case of rural areas that are not completely covered by ZCTAs, the ZCTA to which they were closest. Morbidity and mortality information associated with these PO Box or unique ZIP codes were then assigned added to the ZCTAs to which they were assigned.

For example, 94609 is a PO Box located in Carmichael. 94609 is not represented by a ZCTA, but it could have patient data reported as morbidity and mortality variables. Through the process identified above, it was found that 94609 is located within 94608, which does have an associated ZCTA. Morbidity and mortality data for ZIP codes 94609 and 94608 were therefore assigned to ZCTA 94608, and used to calculate rates. All ZIP code level morbidity and mortality variables given in this report are therefore actually reporting approximate rates for ZCTAs. But for the sake of familiarity of terms they are presented in the body of the report as ZIP code rates.

General Processing Steps

Rate Smoothing

All OSHPD, as well as all single-year CDPH, variables were collected for all ZIP codes in California. The CDPH datasets included separate categories that included either patients who did not report any ZIP code, or patients from ZIP codes whose number of cases fell below a minimum level. These patients were removed from the analysis. As described above, patient records in ZIP codes not represented by ZCTAs were added to those ZIP codes corresponding to the ZCTAs that they fell inside or were closest to. When consolidating ZIP codes into ZCTAs, any ZIP code with no value reported were treated as having a value of 0. If a two or more ZIP codes were combined into a single ZCTA, and at least one of those ZIP codes had a value reported, all other ZIP codes with a masked value were treated as having values of 0. Thus ZCTA values were recorded as NA only if all ZIP codes contributing values to them had masked values reported for all associated ZIP codes.

The next step in the analysis process was to calculate rates for each of these variables. However, rather than calculating raw rates, empirical bayes smoothed rates (EBR) were created for all variables possible[10]. Smoothed rates are considered preferable to raw rates for two main reasons. First, the small population of many ZCTAs, particularly those in rural areas, meant that the rates calculated for these areas would be unstable. This problem is sometimes referred to as the small number problem. Empirical bayes smoothing seeks to address this issue by adjusting the calculated rate for areas with small populations so that they more closely resemble the mean rate for the entire study area. The amount of this adjustment is greater in areas with smaller populations, and less in areas with larger populations.

[10] Anselin, L. (2003). *Rate Maps and Smoothing.* Retrieved February 16, 2013, from http://www.dpi.inpe.br/gi

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 variable rate for ZCTAs in the entire state. This adjustment can be substantial for ZCTAs with very small populations. The difference between raw rates and EBR 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, it also has a secondary benefit of better preserving the privacy of patients within the ZCTAs.

EBR were calculated for each variable using the appropriate base population figure reported for ZCTAs in the American Community Survey 5-year estimate tables: overall EBR for ZCTAs were calculated using total population; and sex, age, and normalized race/ethnicity EBR were calculated using the appropriate corresponding population stratification. In cases where multiple years of data were aggregated, populations for the central year were used and multiplied by the number of years of data to calculate rates. For OSHPD data, 2012 population data was used. For multi-year CDPH variables (2010 – 2012), 2011 data was used. Population data from 2012 was used to calculate single-year CDPH variables.

ZCTAs with NA values recorded were treated as having a value of 0 when calculating the overall expected rates for a state as a whole, but were kept as NA when smoothing the value for the individual ZCTA. This meant that smoothed rates could be calculated for each variable in each area, but if a given ZCTA had a value of NA for a given variable, it retained that NA value after smoothing.

EBR were attempted for every overall variable, but could not be calculated for certain variables. In these cases, raw rates were used instead. The final rates in either case for H, ED, and the basic mortality variables were then multiplied by 10,000, so that the final rates represent H or ED discharges, or deaths, per 10,000 people.

Age Adjustment

The additional step of age adjustment[11] was performed on the all-cause mortality variable. Because the occurrence of these conditions varies as a function of the age of the population, differences in the age structure between ZCTAs could obscure the true nature of the variation in their patterns. For example, it would not be unusual for a ZCTA with an older population to have a higher rate of ED visits for stroke than a ZCTA with a younger population. In order to accurately compare the experience of ED visits for stroke between these two populations, the age profile of the ZCTA needs to be accounted for. Age adjusting the rates allows this to occur.

To age adjust these variables, we first calculated age stratified rates by dividing the number of occurrences for each age category by the population for that category in each ZCTA. Because estimates of age under 1 and from 1 to 4 were not available in the American Community Survey datasets used in this analysis, the proportion of the population under age 5 that was also under age 1 was calculated using 2010 decennial Census data for each geographic area. These proportions were then compared to the age under 5 variables from

[11] Klein, R. J., & Schoenborn, C. A. (2001). *Age adjustment using the 2000 projected U.S. population. Healthy People Statistical Notes, no. 20.* Hyattsville, Maryland: National Center for Health Statistics.

the American Community Survey datasets for each geographic area to estimate the values for the population under 1 and from 1 to 4. These estimated values were then used to calculate age stratified rates. Age stratified EBR were used whenever possible. Each age stratified rate was then multiplied by a coefficient that gives the proportion of California's total population that was made up by that age group as reported in the 2010 Census. The resulting values are then summed and multiplied by 10,000 to create age adjusted rates per 10,000 people.

Benchmark Rates

A final step was to obtain or generate benchmark rates to compare the ZCTA level rates to. Benchmarks for all OSHPD variables were calculated at the HSA, county, and state levels. HSA rates were calculated by first summing the total number of cases and relevant populations for each variable across all ZCTAs in the HSA. ZCTAs with NA values were treated at this stage as having a value of 0. Smoothed EBR rates were then calculated for each HSA using a broader set of HSAs.

County benchmark rates were calculated as raw rates for each county, or in the case of small counties, group of counties, using the relevant populations variables. State rates were calculated as raw rates by first summing all county level values (treating and NA value as a 0), and then dividing these values by the relevant population value.

HSA, county, and state benchmark rates were also provided for CDPH data. HSA benchmarks were calculated in a process similar to that described above for OSHPD HSA benchmarks: the total number of cases and relevant populations were summed for each variable across all ZCTAs in the HSA, and used to calculate smoothed EBR rates using a broader set of HSAs.

County and state benchmark rates were either calculated using CDPH data reported at the county and state level12,13, or else obtained from the County Health Status Profiles 201414. The resulting benchmark values for CDPH and OSHPD variable were all reported as rates per 10,000 unless the original variable was reported using some other standard as described below.

Processing for Specific Variables

Additional processing was needed to create the Community Health Vulnerability Index (CHVI), the CDPH related variables, and as well as some of the other variables. The process used to calculate these variables are described in this section below.

[12] California Department of Public Health. (2010,2011,2012). *Ten Leading Causes of Death, California Counties and Selected City Health Departments*. Retrieved July 7, 2015, from http://www.cdph.ca.gov/data/statistics/Documents/VSC-2012-0520.pdf; http://www.cdph.ca.gov/data/statistics/Documents/VSC-2011-0520.pdf; http://www.cdph.ca.gov/data/statistics/Documents/VSC-2010-0520.pdf

[13] California Department of Public Health. (2015a, July 17). Retrieved from Center for Health Statistics and Informatics: Vital Statistics Query System.: http://www.apps.cdph.ca.gov/vsq/

[14] California Department of Public Health. (2015b, July 2). Retrieved from County Health Status Profiles 2014: http://www.cdph.ca.gov/programs/ohir/Documents/OHIRProfiles2014.pd

Community Health Vulnerability Index (CHVI)

The CHVI is a health care disparity index based in largely based on the Community Need Index (CNI) developed by Barsi and Roth15. The CHVI uses the same basic set of demographic variables to address health care disparity as outlined in the CNI, but these variables are aggregated in a different manner to create the CHVI. For this report, the following nine variables were obtained from the 2013 American Community Survey 5-year Estimate dataset at the census tract level:

- Percent Minority
- Population 5 Years or Older who speak Limited English
- Percent 25 or Older Without a High School Diploma
- Percent Unemployed
- Percent Families with Children in Poverty
- Percent Households 65 years or Older in Poverty
- Percent Single Female Headed Households in Poverty
- Percent Renter Occupied Households
- Percent Uninsured

All census tracts that crossed ZCTAs within the HSA were included in the analysis. Each variable was scaled using a min-max stretch, so that the tract with the maximum value for a given variable within the study area received a value of 1, and the tract with the minimum value for that same variable within the study area received a 0. All scaled variables were then summed to form the final CHVI. Areas with higher CHV values therefore represent locations with higher concentrations of the target index populations, and are likely experiencing poorer health care disparities.

Major Crime and Domestic Violence Rates

Major crimes and domestic violence related calls for assistance reported in the State of California Department of Justices' Crime Data reports are listed by reporting police agency. In order to estimate major crime and domestic violence rates, these values need to be associated with particular geographic areas, and then divided by those area populations. This was done for this report by comparing the names of police agencies to populations reported for "places" (including both incorporated and unincorporated areas) by the US Census. Both crime and population data were obtained for 2013.

Many reporting agencies, such as those associated with hospitals, transit and freight rail lines, university campuses, and state and federal agencies, did not correspond to a specific census place. Internet searches were used to identify the Census places they were associated with, and their cases were added to those places. For example, the crimes or calls for assistance reported by a University police department were added to the city or county that the university campus was located in. For areas where this was unclear based on the name alone, internet searches were conducted to determine the place an agency fell inside of. Because reported crimes or calls for agencies were organized by county, if the crimes for an agency could not be associated with any specific place, its reported crimes were grouped together with those for the county sheriff's department.

To calculate rates, the total number of crimes or calls for assistance for each Census place resulting from the process described above were was divided by the population of that place

[15] Barsi, E. L., & Roth, R. (2005). The "Community Need Index". *Health Progress, 86*(4), 32-38. Retrieved from https://www.chausa.org/docs/default-source/health-progress/the-community-need-index-pdf.pdf?sfvrsn=2

and multiplied by 10,000 to report the number of crimes per 10,000 in that place. For crimes reported for (or grouped with) the county sheriff's department, the county population was modified by subtracting the total population of all Census places with reported crimes. This meant that the major crime rate reported for the county was reporting not the total county's crime rate, but the rate of crimes occurring in those portions of the county that were not otherwise covered by another reporting agency.

Overall county major crime rates and domestic violence related calls for assistance were, however, calculated for benchmarking purposes by summing the total number of major crimes reported by any agency within the county, dividing that by the total population of the county, and multiplying the result by 10,000. For further detail as to which specific crimes are covered within the "major crime" category, interested readers are referred to the State of California Department of Justices' Crime Data reports, available online at: http://oag.ca.gov/crime.

Modified Retail Food Environment Index (mRFEI)

The Modified Retail Food Environment Index (mRFEI) variable reports the percentage of the total food outlets in a ZCTA that are considered healthy food outlets. Values below 0 are given for ZCTAs with no food outlets. The mRFEI variable was calculated using a modification of the methods described by the National Center for Chronic Disease Prevention and Health Promotion16 using ZIP code level data obtained from the US Census Bureau's 2013 County Business Pattern datasets. Healthy food retailers were defined based on North American Industrial Classification Codes (NAICS), and included:

- Large grocery stores: NAICS code 445110, with 50 or more employees
- Fruit and vegetable markets: NAICS 445230
- Warehouse clubs: NAICS 452910
- Food retailers that were considered less healthy included:
- Small grocery stores: NAICS code 445110, with 1 – 4 employees
- Limited-service restaurants: 722513
- Convenience stores: 445120

To calculate the mRFEI, ZIP code values were converted to ZCTAs using previously described processes. The total number of health food retailers was then divided by the total number of healthy and less healthy food retailers for each ZCTA, and the result was multiplied by 100 to calculate the final mRFEI value for the ZCTA. HSA mRFEI benchmark values were calculated by first summing the total number of each type of foo

[16] National Center for Chronic Disease Prevention and Health Promotion. (2011). *Census Tract Level State Maps of the Modified Retail Food Environment Index (mRFEI).* Centers for Disease Control. Retrieved Jan 11, 2016, from http://ftp.cdc.gov/pub/Publications/dnpao/census-tract-level-state-maps-mrfei_TAG508.pdf

APPENDIX B: Community Input Tracking Form

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
1	Key Informant Interview	Public Health Officer	Sacramento County Public Health Dept.	1	Public Health Department Representative	Leader	05/19/15
2	Group Key Informant Interview	Continuity of Care Service Director, Discharge Planning and Social Services Departments	Kaiser Permanente Sacramento Medical Center	1	Hospital representative	Representative	06/02/15
3	Group Key Informant Interview	Social Work Manager	Kaiser Permanente Sacramento Medical Center	1	Hospital representative	Representative	06/02/15
4	Group Key Informant Interview	Continuum Administrator	Kaiser Permanente Sacramento Medical Center	1	Hospital representative	Representative	06/02/15
5	Group Key Informant Interview	Care Coordinator	Mercy San Juan Medical Center -	1	Hospital representative	Representative	06/02/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
			Dignity				
6	Group Key Informant Interview	Social Work Manager	Mercy General Hospital- Dignity	1	Hospital representative	Representative	06/03/15
7	Group Key Informant Interview	Physician, ER	Mercy General Hospital- Dignity	1	Hospital representative	Representative	06/03/15
8	Group Key Informant Interview	Case Management Director	Sutter General Hospital /Sutter Center for Psychiatry	1	Hospital representative	Representative	06/03/15
9	Group Key Informant Interview	Social Work Manager	Sutter General Hospital /Sutter Center for Psychiatry	1	Hospital representative	Representative	06/03/15
10	Group Key Informant Interview	Program Manager	UC Davis Med Center	1	Hospital representative	Representative	06/03/15
11	Group Key Informant Interview	Managed Care	UC Davis Med Center	1	Hospital representative	Representative	06/03/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
12	Group Key Informant Interview	Physician, Senior Leadership	UC Davis Med Center	1	Hospital representative	Representative	06/03/15
13	Group Key Informant Interview	Nurse Clinical Manager	UC Davis Med Center	1	Hospital representative	Representative	06/03/15
14	Group Key Informant Interview	Case Management Supervisor	Sutter Davis Hospital	1	Hospital representative	Representative	06/11/15
15	Group Key Informant Interview	Patient Advocate	Woodland Healthcare	1	Hospital representative	Representative	06/11/15
16	Group Key Informant Interview	Health Educator/ Navigator	Woodland Healthcare	1	Hospital representative	Representative	06/11/15
17	Key Informant Interview	Director of Public Health	Yolo County Public Health	1	Public Health Department Representative	Leader	06/15/15
18	Key Informant Interview	Mental Health Director	Yolo County Public Health	1	Public Health Department Representative	Leader	06/15/15
19	Key Informant	Executive Director	Center for Community	1	Minority, Medically Underserved, Low-	Representative	06/22/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
	Interview		Health and Well-Being		Income		
20	Key Informant Interview	Chief Executive Officer	Peach Tree Health	1	Minority, Medically Underserved, Low-Income	Representative	06/22/15
21	Key Informant Interview	Chief Executive Officer	Sacramento Native American Health Center	1	Minority, Medically Underserved, Low-Income	Representative	06/23/15
22	Key Informant Interview	Director	Sacramento City Unified School District- Student Support and Health Services	1	Minority, Medically Underserved, Low-Income	Representative	06/25/15
23	Key Informant Interview	Director of Residential & Crisis Response Services	WEAVE	1	Minority, Medically Underserved, Low-Income	Representative	06/26/15
24	Key Informant Interview	Director	Department of Human Assistance	1	Minority, Medically Underserved, Low-Income	Representative	07/02/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
25	Key Informant Interview	Executive Director	Health Education Council	1	Minority, Medically Underserved, Low-Income	Representative	07/07/15
26	Key Informant Interview	Chief Executive Officer	Saint John's Program for Real Change	1	Minority, Medically Underserved, Low-Income	Representative	07/08/15
27	Key Informant Interview	Associate Director	Empower Yolo	1	Minority, Medically Underserved, Low-Income	Representative	07/14/15
28	Key Informant Interview	Director of Nursing	Communicare	1	Minority, Medically Underserved, Low-Income	Representative	07/14/15
29	Key Informant Interview	Chief Executive Officer	Communicare	1	Minority, Medically Underserved, Low-Income	Representative	07/14/15
30	Key Informant Interview	Executive Director	Yolo Healthy Aging Alliance (YHAA)	1	Minority, Medically Underserved, Low-Income	Representative	07/15/15
31	Key Informant	Development Director	TLCS Inc.	1	Minority, Medically Underserved, Low-	Representative	07/16/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
	Interview				Income		
32	Key Informant Interview	Executive Director	Sacramento Steps Forward	1	Minority, Medically Underserved, Low-Income	Representative	07/16/15
33	Key Informant Interview	Executive Director	Folsom Cordova Community Partnership	1	Minority, Medically Underserved, Low-Income	Representative	07/16/15
34	Key Informant Interview	Director	Slavic Assistance Center-Sacramento	1	Minority, Medically Underserved, Low-Income	Representative	07/20/15
35	Key Informant Interview	Chief Executive Officer	WellSpace Health	1	Minority, Medically Underserved, Low-Income	Representative	07/22/15
36	Key Informant Interview	Executive Director	Sheriff's Community Impact Program	1	Minority, Medically Underserved, Low-Income	Representative	07/22/15
37	Key Informant Interview	Managing Attorney	Legal Services for Northern California- Health	1	Minority, Medically Underserved, Low-Income	Representative	07/22/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
38	Key Informant Interview	Executive Director	Sacramento Covered	1	Minority, Medically Underserved, Low-Income	Representative	07/23/15
39	Key Informant Interview	Program Manager	Sacramento Covered	1	Minority, Medically Underserved, Low-Income	Representative	07/23/15
40	Key Informant Interview	Executive Director	Sacramento LGBT Center	1	Minority, Medically Underserved, Low-Income	Representative	07/23/15
41	Key Informant Interview	Project Manager	Yolo Adult Day Health Care	1	Minority, Medically Underserved, Low-Income	Representative	07/24/15
42	Key Informant Interview	Executive Director	Mutual Assistance Network	1	Minority, Medically Underserved, Low-Income	Representative	07/29/15
43	Key Informant Interview	Executive Director	Yolo County Children's Alliance	1	Minority, Medically Underserved, Low-Income	Representative	07/29/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
44	Key Informant Interview	Executive Director	Mercy Housing	1	Minority, Medically Underserved, Low-Income	Representative	07/29/15
45	Key Informant Interview	Executive Director	Life Matters	1	Minority, Medically Underserved, Low-Income	Representative	08/03/15
46	Key Informant Interview	Executive Director	Suicide Prevention and Crisis Services of Yolo County	1	Minority, Medically Underserved, Low-Income	Representative	08/04/15
47	Key Informant Interview	Executive Director	Wind Youth Services	1	Minority, Medically Underserved, Low-Income	Representative	08/04/15
48	Key Informant Interview	Executive Director	El Hogar	1	Minority, Medically Underserved, Low-Income	Representative	08/06/15
49	Focus Group	Latina Mothers Focus Group	Knights Landing Family Resource Center	9	Minority, Medically Underserved, Low-Income	Member	08/06/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
50	Key Informant Interview	Executive Director	Eskaton	1	Minority, Medically Underserved, Low-Income	Representative	08/07/15
51	Key Informant Interview	Associate Director	Child Abuse Prevention Center	1	Minority, Medically Underserved, Low-Income	Representative	08/10/15
52	Key Informant Interview	Co-founder and Agency Administrator	Roberts Family Development Center	1	Minority, Medically Underserved, Low-Income	Representative	08/11/15
53	Key Informant Interview	Director	Yolo County Health & Human Services Agency	1	Minority, Medically Underserved, Low-Income	Representative	08/13/15
54	Key Informant Interview	Co-executive Director & Clinical Director	Strategies for Change	1	Minority, Medically Underserved, Low-Income	Representative	08/14/15
55	Key Informant Interview	Executive Director	Turning Point	1	Minority, Medically Underserved, Low-Income	Representative	08/19/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
56	Key Informant Interview	Executive Director	Southeast Asian Assistance Center	1	Minority, Medically Underserved, Low-Income	Representative	08/19/15
57	Focus Group	Latina Mothers Focus Group	Center for Families-West Sacramento	11	Minority, Medically Underserved, Low-Income	Member	08/19/15
58	Key Informant Interview	Executive Director	North Franklin District Business Association	1	Minority, Medically Underserved, Low-Income	Representative	08/20/15
59	Focus Group	LGBTQ Focus Group	Gender Health Center	8	Minority, Medically Underserved, Low-Income	Member	08/21/15
60	Focus Group	Service Provider Focus Group	Sacramento Covered	6	Minority, Medically Underserved, Low-Income	Representatives	09/04/15
61	Focus Group	Slavic/Ukrainian/Russian Community Member Focus Group	Slavic Assistance Center	10	Minority, Medically Underserved, Low-Income	Member	09/28/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
62	Focus Group	Community Member Mothers Focus Group	Folsom Cordova Community Partnership	10	Minority, Medically Underserved, Low-Income	Member	09/30/15
63	Focus Group	Food Bank Clients Focus Groups	Yolo Food Bank	6	Minority, Medically Underserved, Low-Income	Member	10/09/15
64	Focus Group	Service Provider Focus Group	Sierra Health Foundation- Respite Care Partnership	5	Minority, Medically Underserved, Low-Income	Representatives; members	10/12/15
65	Focus Group	Community in Recovery Focus Group	Strategies for Change- North Sacramento	9	Minority, Medically Underserved, Low-Income	Member	10/15/15
66	Focus Group	Low-Income/ Disabled Residents Focus Group	Yolo Office of Housing	11	Minority, Medically Underserved, Low-Income	Member	10/16/15
67	Focus Group	Community Member Focus Group	Greater Sacramento Urban League	21	Minority, Medically Underserved, Low-Income	Member	10/20/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
68	Focus Group	Community Member Families Focus Group	Roberts Family Development Center	23	Minority, Medically Underserved, Low-Income	Member	11/04/15

Appendix C: Health Need Profiles

KFH-Sacramento Service Area Health Needs (in order of priority)	Health Need Criteria
1. Access to Behavioral Health Services (Mental Health and Substance Abuse) 2. Healthy Eating and Active Living 3. Safe, Crime and Violence Free Communities 4. Basic Needs (Food, Housing, Employment, Education) 5. Access to High Quality Health Care and Services 6. Disease Prevention, Management and Treatment 7. Pollution Free Living and Work Environments	1. At least 50% of secondary data (quantitative) indicators within a health need category compared unfavorably to benchmarks or demonstrated racial/ethnic group disparities, or 2. At least 75% of primary data (qualitative) sources mentioned a health outcome or related condition associated with the health need category. ***Note**: California state benchmarks are included for reference. Differences between counties and California benchmarks are not necessarily statistically significant. Red color coding is used to highlight indicators that have a higher rate or percentage that is an undesirable difference from the KHF-Sacramento and green color coding is used to signifying desirable differences.* * 1-2% undesirable difference from benchmark for service area overall ** > 2% undesirable difference from benchmark for service area overall

ACCESS TO BEHAVIORAL HEALTH SERVICES (MENTAL HEALTH AND SUBSTANCE ABUSE)		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS**	**Contributing Factors RELATED INDICATORS**
Behavioral Health o **Mental Health -** Mental health and well-being is essential to living a meaningful and productive life. The burden of mental illness in the United States is among the highest of all diseases, and people with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including substance abuse and suicide. People with severe mental disorders on average tend to die earlier	**Mortality – Suicide (per 100,000)** • HSA 12.54** // CA 9.8 • Non-Hispanic White 14.96** // HSA 12.54 • Native Hawaiian/Pacific Islander Alone 23.84** // HSA 12.54	• Life expectancy at birth** • Tobacco usage (adults and teens)** • COPD (ED)** • COPH (H)**

(10-25 years) as compared to the general population. Mental health disorders are also associated with chronic diseases including diabetes, heart disease, and cancer. Mental health and well-being provides people with the necessary skills to cope with and move on from daily stressors and life's difficulties allowing for improved personal wellness, meaningful social relationships, and contributions to communities or society. Social engagement opportunities are particularly important for youth and seniors that may be experiencing isolation or depression. o **Substance Abuse/Tobacco -** Reducing tobacco use and treating/reducing substance abuse improves the quality of life for individuals and their communities. Tobacco use is the most preventable cause of death, with second hand smoke exposure putting people around smokers at risk for the same respiratory diseases as smokers. Substance abuse is linked with community violence, sexually transmitted infections, and teen pregnancies. For some individuals, substance abuse will develop into a chronic illness that will require lifelong monitoring and care. Access to treatment for substance abuse and co-occurring disorders will improve the health, safety and quality of life of individuals with substance use disorders as well as their children and families. *Sources:* http://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health http://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse http://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use	**Mental Health – Needing Mental Health Care** • Hispanic/Latino 25.03%** // HSA 15.10% **Mental Health (Emergency Department) (per 10,000)** • HSA 270.28** // CA 149.93 **Mental Health (Hospitalization) (per 10,000)** • HSA 223.48** // CA 186.92 **Self-Inflicted Injury (Emergency Department) (per 10,000)** • HSA 12.14** // CA 8.18 **Self-Inflicted Injury (Hospitalization) (per 10,000)** • HSA 5.17 // CA 4.40 **Health Professional Shortage Area - Mental Health** (See map) **Alcohol - Excessive Consumption** • HSA 18.40%* // CA 17.20% **Alcohol – Expenditures** • HSA 14.76%* // CA 12.93% **Substance Abuse (Emergency Department) (per 10,000)** • HSA 479.23** // CA 253.80 (see map) **Substance Abuse (Hospitalization) (per 10,000)**	• Chronic lower respiratory disease – Mortality

http://www.who.int/mental_health/management/info_sheet.pdf	• HSA 199.71** // CA 145.00	

Primary Data:
46 of 47 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to accessing behavioral health services as a health need. Themes related to this health need are as follows:

Mental Health:

- Social engagement and support were mentioned as important factors in assisting communities in being healthier. The lack of engagement amongst residents and local elected officials was discussed. Also, the neglect of children/youth and elderly individuals was highlighted as an important consideration.
- Depression and anxiety were highlighted as significant mental health issues in this service area.
- Daily stress was mentioned as being an important health issue by residents in this service area. Residents were concerned about meeting their basic needs, such as food, housing and transportation. Stress was mentioned as being prevalent, especially for those with substance use and mental health issues.
- Co-morbid physical health and mental health/substance use issues were discussed. Residents connected the two issues as being prevalent in this hospital service area.
- Alzheimer's and dementia were mentioned as being of concern in the senior population of this service area. Senior neglect and isolation were mentioned generally and also for seniors experiencing Alzheimer's and/or dementia. The true need for Alzheimer's care was mentioned as being unclear as it was reported that data are not collected for Alzheimer's regularly. The cost of care for seniors was highlighted as being extreme and unattainable for many families.
- Culturally sensitive care is desired in this hospital service are for both mental health and substance use disorders.
- There is limited capacity for both inpatient and outpatient mental health services. Residents are concerned about session limits, especially related to the treatment of severe mental health issues.
- People with severe mental health issues such as schizophrenia and bipolar disorder face specific challenges particularly if they are women, people of color or experiencing homelessness. Preventative mental health care is lacking and people with more moderate mental health such as depression and anxiety may not be able to receive help until they are in crisis.

Substance Use:

- Alcohol and other drugs were discussed generally as being connected and as contributing factors to overall health issues in this service area. Alcohol, meth, cocaine, pain medications, marijuana and tobacco products were discussed. Youth use of the aforementioned substances was discussed as being a significant concern. Additionally, easy access to these drugs was mentioned as a serious issue.
- Participants discussed specific geographic safety concerns mainly related to substance use issues. Locations mentioned include neighborhoods, schools and parks and populations of concern were mainly youth and individuals experiencing homelessness.

- Physical and mental health/substance use were discussed often as being as significant health needs. Physical health issues included diabetes, liver issues, heart disease and other serious health issues. Mental health and/or substance use disorders were discussed as having contributed to the overall poor health of residents.
- Often participants discussed these substance abuse and mental health together and there seemed to be a belief that the two were connected.

Geographic Impact:

Figure 7. Health Provider Shortage Area – Mental Health

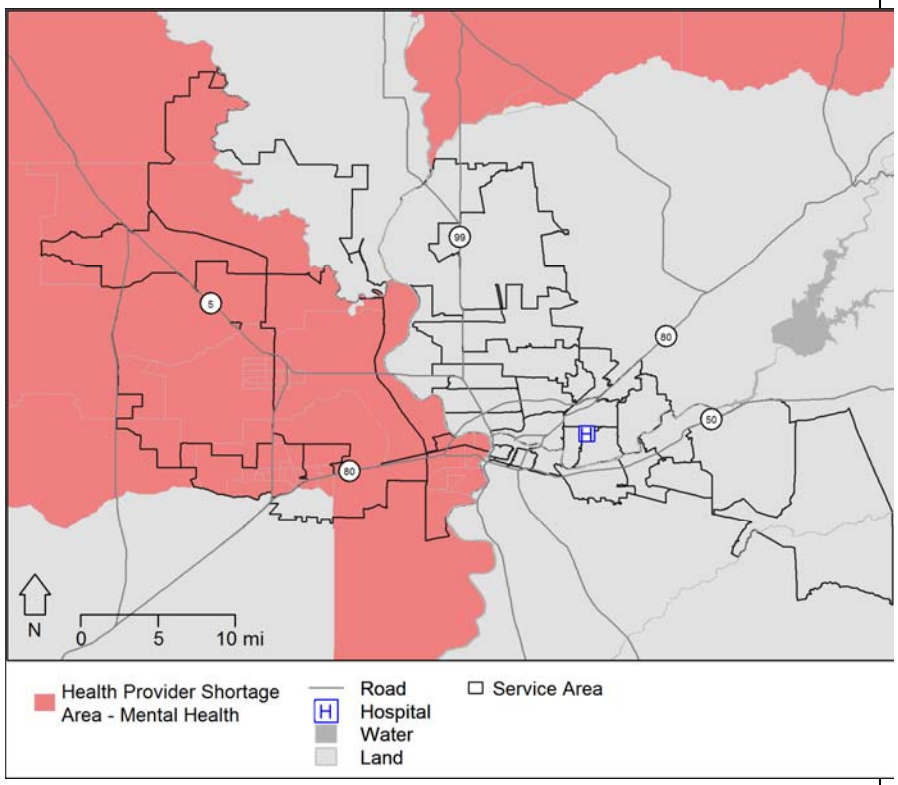


Table 13. ZIP codes with the worst rates for ED visit and Hospitalization rates for mental health compared to hospital service area, county and state benchmarks (rates per 10,000 population)

	ZIP Code	ED	Hospitalization
MENTAL HEALTH	95608	392.75	331.15
	95660*	364.34	296.22
	95695*	341.27	170.36
	95811*	399.70	334.87
	95814*	1323.63	827.70
	95815*	329.73	304.00
	95816	296.59	331.69
	95821*	433.18	327.46
	95825*	402.93	299.05
	95841*	415.25	364.79
	KFH-Sacramento	270.28	223.48
	SACRAMENTO	271.38	227.04
	SUTTER	173.69	215.22
	YOLO	195.58	143.92
	CALIFORNIA	149.93	186.92

Sources: ED visits and hospitalizations: OSHPD, 2011 -2013
* Indicates Focus Community

Figure 8. ED Mental Health Rate

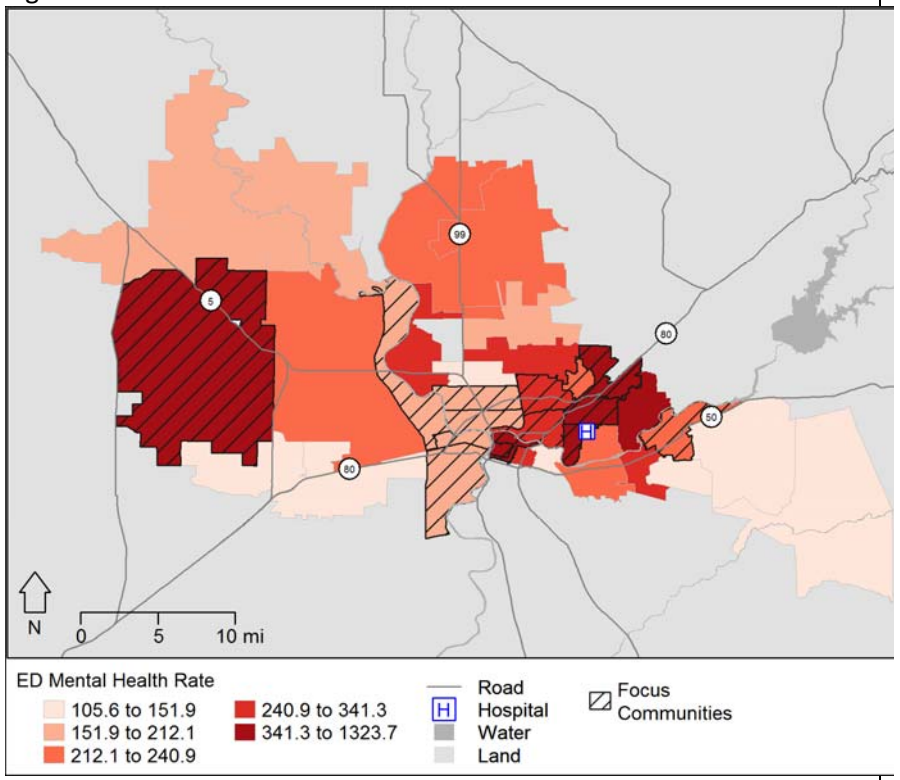
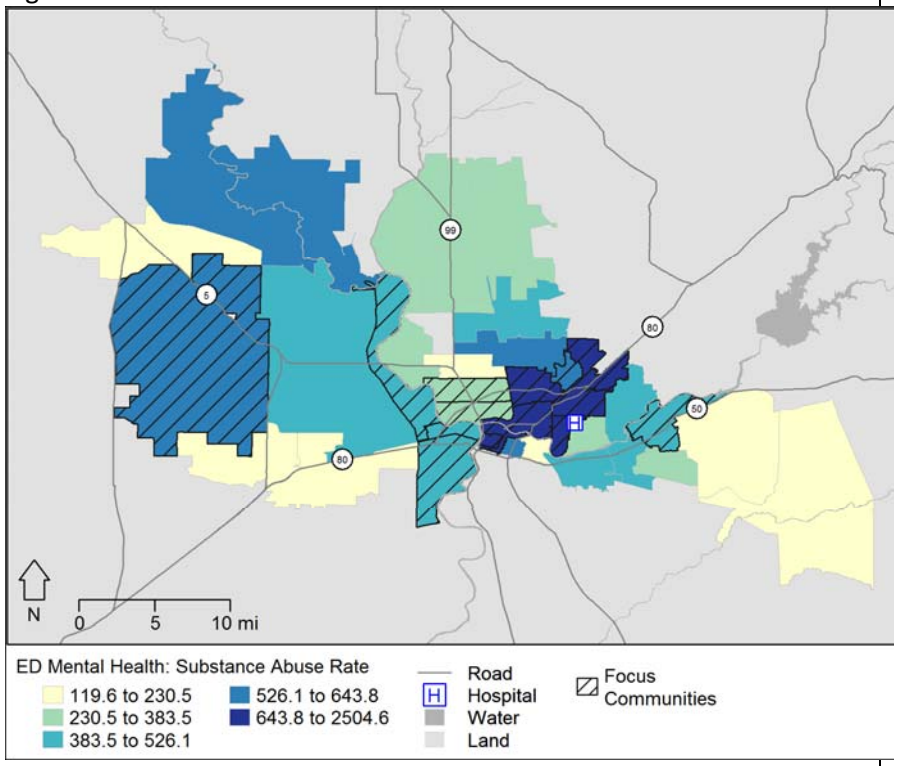


Table 14. ZIP codes with the worst rates for ED visit and Hospitalization rates fo substance abuse compared to hospital service area, county and state benchmarl (rates per 10,000 population)

	ZIP Code	ED	Hospitalizatio
SUBSTANCE ABUSE	95660*	697.69	348.50
	95673	548.65	277.44
	95811*	1001.07	376.18
	95814*	2504.54	922.96
	95815*	958.20	389.88
	95821*	764.68	303.58
	95825*	661.69	210.21
	95838*	643.76	272.23
	95841*	649.87	357.05
	KFH-Sacramento	479.23	199.71
	SACRAMENTO	438.58	196.37
	SUTTER	399.87	193.03
	YOLO	360.54	121.75
	CALIFORNIA	253.80	145.00

Sources: ED visits and hospitalizations: OSHPD, 2011 -2013
* Indicates Focus Community

Figure 9. ED Mental Health: Substance Abuse Rate



HEALTHY EATING AND ACTIVE LIVING		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS**	**Contributing Factors RELATED INDICATORS**
Active Living and Healthy Eating A lifestyle that includes eating healthy and physical activity improves overall health, mental health and cardiovascular health. A healthful diet and regular physical activity help individuals to maintain a healthy weight and reduce the risk for many health conditions including obesity, type 2 diabetes, heart disease, osteoporosis and some cancers. Access to and availability of healthier foods can help people follow healthful diets and may also have an impact on weight. Access to recreational opportunities and a physical environment conducive to exercise can encourage physical activity that improves health and quality of life. *Sources:* http://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status http://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity	**Obesity (Adult)** • HSA 24.90%** // CA 22.30% **Obesity (Youth)** • Non-Hispanic Black 20.68%** // HSA 17.63% • Hispanic/Latino (Any Race) 23.75%** // HSA 17.63% **Overweight (Youth)** • Black Alone 23.39%** // HSA 20.08% • Hispanic/Latino (Any Race) 22.41%** // HSA 20.08% **Diabetes Mellitus – Mortality (per 10,000)** • HSA 2.33 // CA 2.11 (see map)	• Food Environment - Fast Food Restaurants** • Food Environment - Grocery Stores* • Food Environment - WIC-Authorized Food Stores** • Physical Inactivity (Youth)** (health disparities) • Diabetes Management (Hemoglobin A1c Test)* • Low Fruit/Vegetable Consumption (Youth) (health disparities) • Breastfeeding (Any) (health disparities) • Breastfeeding (Exclusive) (health disparities) • Walking/Biking/Skating to School (health disparities) • Osteoporosis (Emergency Department)** • Osteoporosis (Hospitalization)* • Modified Retail Food Environment Index (MRFEI)*
Primary Data: 45 of 47 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to healthy eating and active living as a health need. Themes related to this health need are as follows: **Healthy Eating:**		

- Food access issues were discussed at length. Portions of this service area were considered to be food deserts by those interviewed (see map in basic needs section), and transportation issues in getting to grocery stores that sell healthy food was highlighted. Community members suggested an increase in healthy food outlets and/or farmers markets that are affordable and culturally relevant to the area.
- The inherent challenges of poverty and being able to purchase healthy foods was mentioned regularly. Healthy choices are expensive, particularly for people on fixed incomes (seniors, mothers on WIC, CalFresh-eligible individuals etc.). It's difficult to eat healthy when you can't afford it.
- Culturally relevant health education and literacy is needed for people to know how to prepare healthy foods and shop healthy on a budget. Some community members suggested using the Promotora or Community Health Leader model for this type of education.
- Barriers to preparing and eating healthy foods include lack of time, lack of incentive (e.g. seniors living alone), ethnic and cultural traditions (e.g. eating unhealthy food for celebrations)
- Interviewees discussed the huge proliferation of unhealthy food options in their communities and schools. Unhealthy options such as fast food are more accessible, easier and cheaper than healthy options. Processed foods (especially those with high sugar and salt and/or carbohydrates) last longer for individuals with EBT benefits that may be used up by the end of the month.

Active Living:

- Community members discussed the desire for additional resources to make physical activity more accessible and easier. Suggestions included more recreation opportunities and classes via recreation centers, accessible and attractive public parks, and affordable gym options.
- Interviewees commented regularly on urban design and the lack of properly designed roadways for safe walking or biking. There is a desire for improved sidewalks and bike lanes in order to facilitate more physical activity, especially in areas that are lacking complete streets.
- Some commented on the lack of safety being a barrier to physical activity. Real and perceived threats of violence are a deterrent to people being physically active in their neighborhoods, as well as a lack of proper lighting.
- Two other barriers that were mentioned by residents were specific cultural barriers to exercising and the huge amount of screen time and addiction to technology by both youth and adults.

Geographic Impact:

Figure 10. Modified Retail Food Environment Index

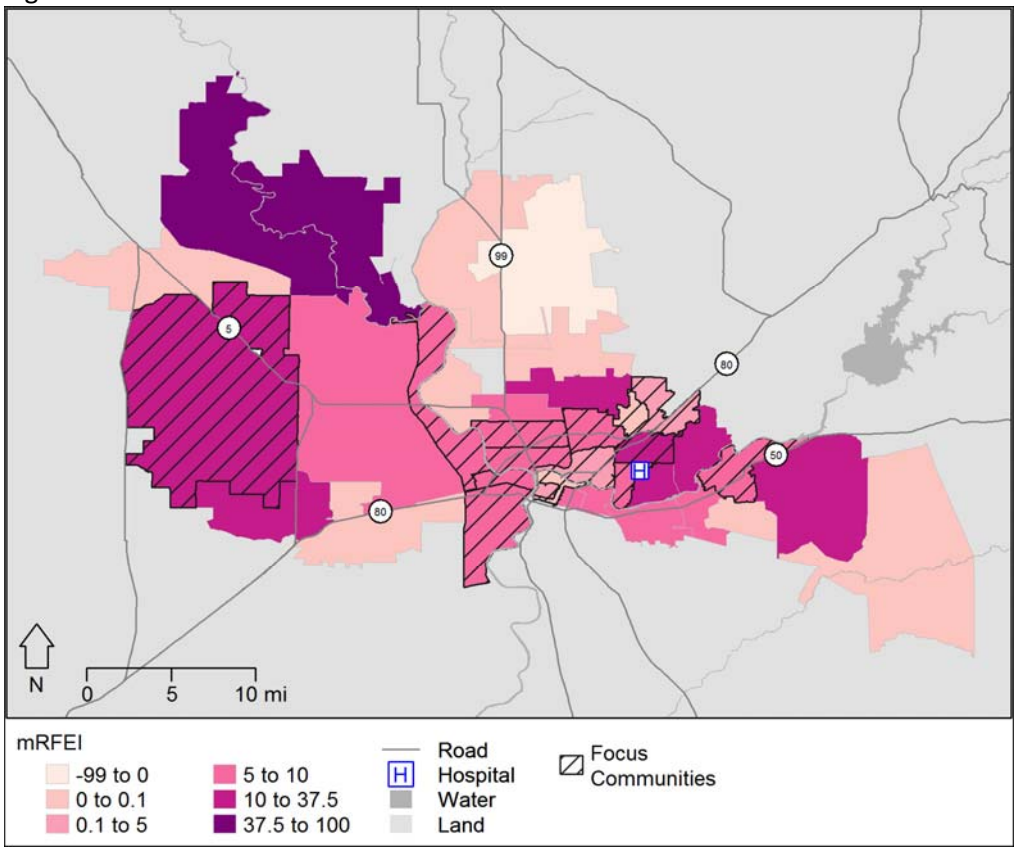


Figure 11. Diabetes Mellitus Mortality Rate

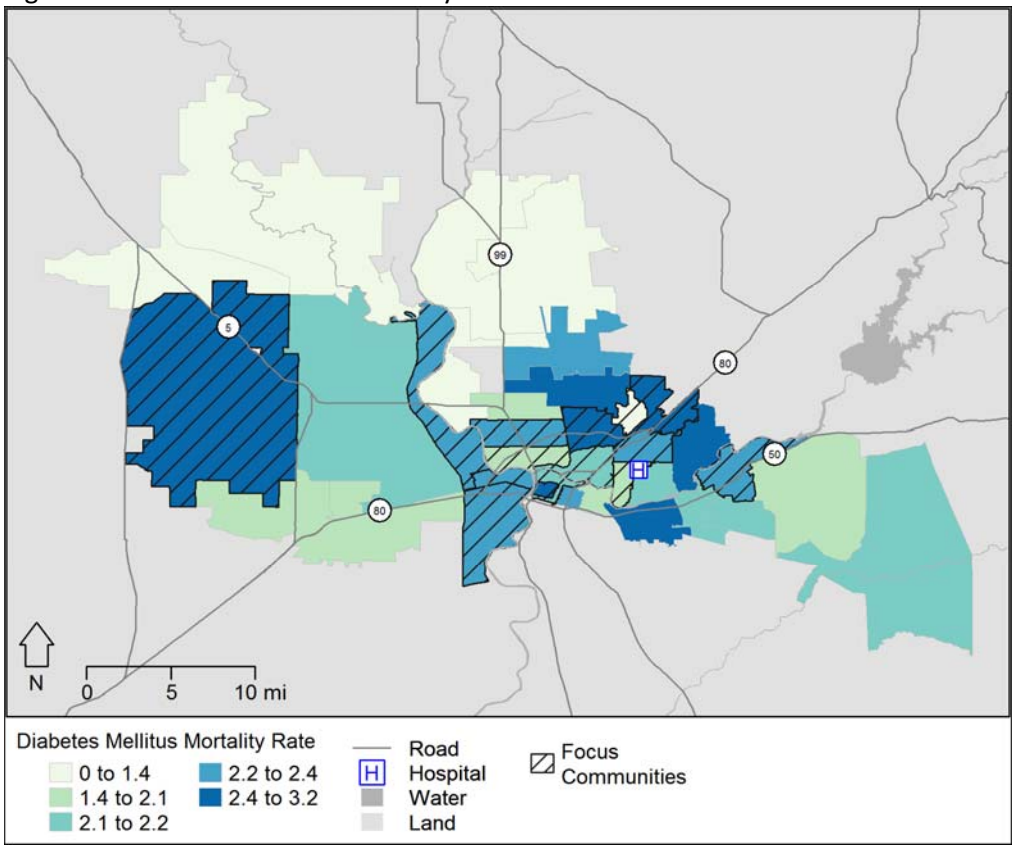


Table 15. ZIP codes with the worst rates for diabetes mortality compared to hospital service area, county and state benchmarks (rates per 10,000 population)

DIABETES	95608	2.67
	95660*	2.63
	95673	2.55
	95695*	3.13
	95814*	2.77
	95826	2.35
	95838*	2.96
	95841*	2.41
	KFH-Sacramento	2.33
	SACRAMENTO	2.26
	SUTTER	2.64
	YOLO	1.94
	CALIFORNIA	2.11

Source: Mortality CDPH, 2010-2012
* Indicates Focus Community

SAFE, CRIME AND VIOLENCE-FREE COMMUNITIES		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS**	**Contributing Factors RELATED INDICATORS**
<u>Safe, Crime and Violence-Free Communities</u> Safe communities contribute to overall health and well-being. Injuries and violence contribute to premature death, disability, poor mental health, high medical costs and loss of productivity. Individual behaviors such as substance use and aspects of the social environment such as peer group associations can affect the risk of injury and violence. The physical environment may also affect the rate of injuries related to falls, motor vehicle accidents and violent crime. Safe communities promote community cohesion and economic development, provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. *Sources:* http://www.healthypeople.gov/2020/topics-objectives/topic/injury-and-violence-prevention	**Mortality – Homicide** • Black Alone 16.62%** // HSA 5.85 **Violence – Youth Intentional Injury (per 100,000)** • HSA 868.1** // CA 738.7 **Violence – Domestic Violence (per 100,000)** • HSA 10.5* // CA 9.5 **Violence – Assault (Injury) (per 100,000)** • HSA 341.1** // CA 290.3 **Violence – Assault (Crime) (per 100,000)** • HSA 290.4** // CA 249.4 **Violence – Robbery (Crime) (per 100,000)** • HSA 161.1** // CA 149.5 **Violence – All Violent Crimes (per 100,000)** • HSA 485.70** // CA 425	• Alcohol – Excessive Consumption* • Alcohol – Expenditures* • Violence – School Suspensions** • Substance Abuse (Emergency Department)** • Substance Abuse (Hospitalization)** • Physical Inactivity (Youth)** (health disparities)

	Violence – Rape (Crime) (per 100,000) • HSA 29.60** // CA 21 **Mortality – Pedestrian Accident (per 100,000)** • HSA 3.04* // CA 1.97 **Unintentional Injury (Emergency Department) (per 10,000)** • HSA 768.33** // CA 666.38 **Unintentional Injury (Hospitalization) (per 10,000)** • HSA 172.62** // CA 154.85 **Major Crimes (Assault, Rape, Robbery) (per 10,000)** • HSA 460.40** // CA 312.65 **Domestic violence/intimate partner violence (per 10,000)** • HSA 83.57** // CA 40.18 **Assault (Emergency Department) (per 10,000)** • HSA 40.43** // CA 30.36 **Assault (Hospitalization) (per 10,000)** • HSA 6.12** // CA 3.88	

Primary Data:
45 of 47 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to safe, crime and violence-free communities as a health need. Themes related to this health need are as follows:

- Substance abuse (including alcohol abuse) was discussed as being a health and safety issues for communities in this service area. Residents were uncomfortable with substance use (alcohol, heroin, meth, cocaine, opioids/pain meds, marijuana and tobacco) by other community members, especially youth and those experiencing homelessness. Residents were also uncomfortable with the sale and trafficking of drugs in their neighborhoods and expressed a desire for more substance abuse treatment options.
- Domestic violence and sexual assault were highlighted as significant issues in this service area, due to the stress of living in poverty and the cycle of emotional, physical, and financial abuse.
- Child abuse/trauma and bullying were highlighted as significant issues in this service area. Suggestions included more child abuse and bullying prevention campaigns and programs.
- Gang violence was discussed as creating health issues within the communities of this service area. Residents are fearful of gang retaliation, robberies, and third party gun and knife violence. More youth development programs were highlighted as a significant need to prevent youth from being involved in gangs.

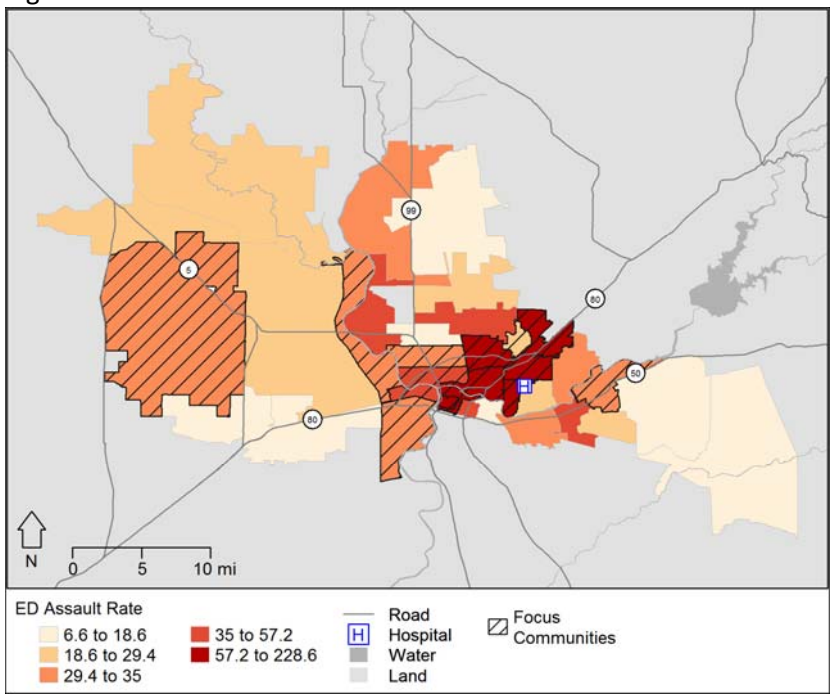
Geographic Impact:	Figure 12. ED Assault Rate 

Figure 13. Hospitalization Assault Rate

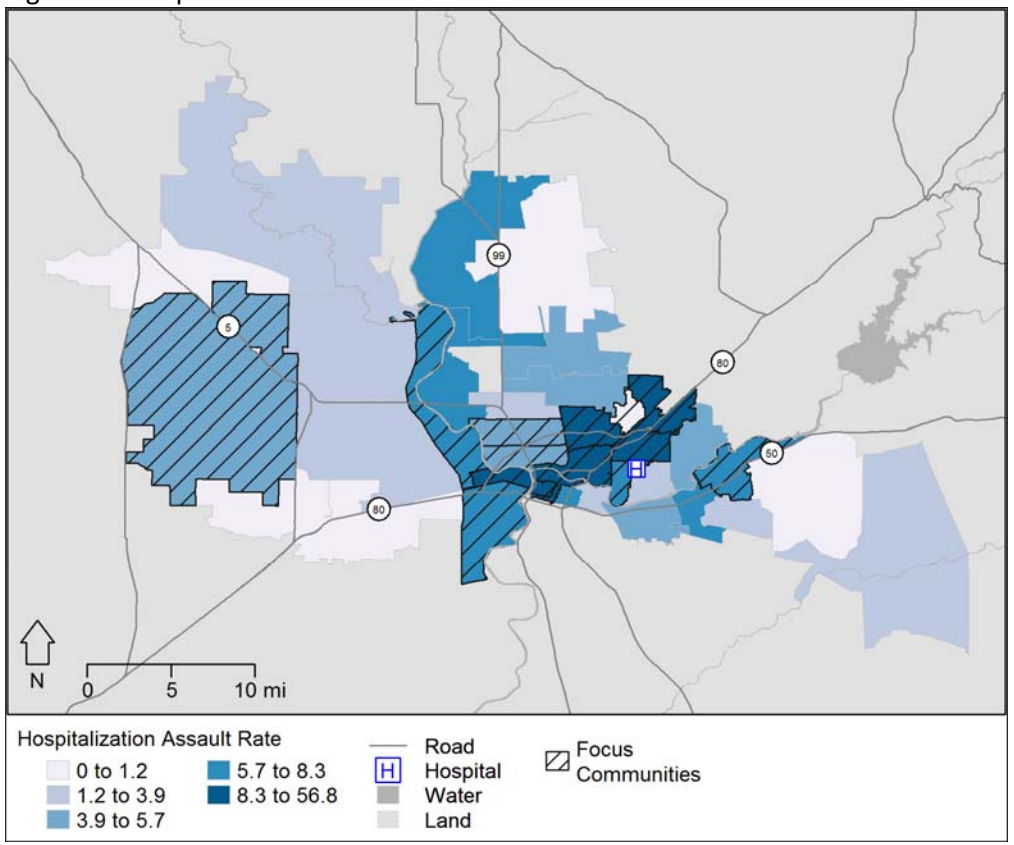


Table 16. Zip codes with the worst rates for ED visit and Hospitalization rates for assault compared to hospital service area, county and state benchmarks (rates per 10,000 population)

	ZIP Code	ED	Hospitalization
ASSAULT	95605*	49.88	8.26
	95660*	57.11	10.74
	95811*	87.71	18.47
	95814*	228.56	56.75
	95815*	87.95	13.47
	95821*	64.44	8.49
	95825*	58.12	6.22
	95838*	66.60	11.36
	95841*	66.12	9.63
	KFH-Sacramento	40.43	6.12
	SACRAMENTO	39.09	5.78
	SUTTER	26.67	3.17
	YOLO	24.21	3.02
	CALIFORNIA	30.36	3.88

Sources: ED visits and hospitalizations: OSHPD, 2011 -2013
* Indicates Focus Community

Figure 14. ED Unintentional Injury Rate

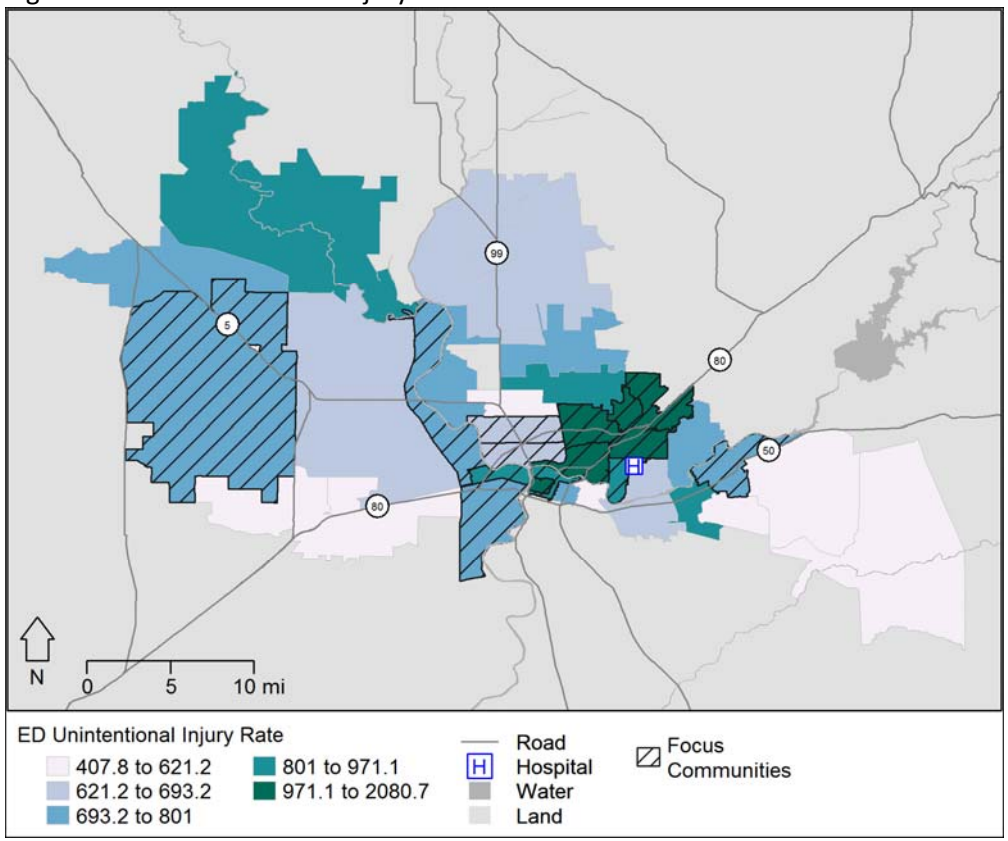


Figure 15. Hospitalization Unintentional Injury Rate

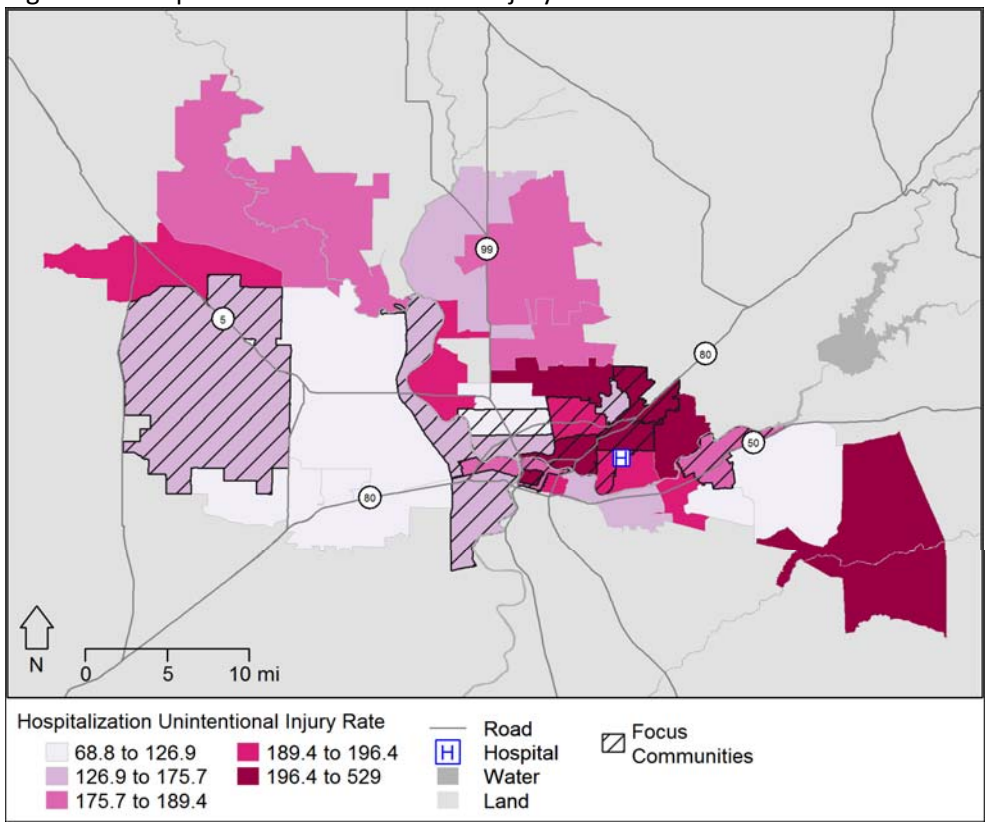


Table 17. Zip codes with the worst rates for ED visit and Hospitalization rates for unintentional injury compared to hospital service area, county and state benchmarks (rates per 10,000 population)

	ZIP Code	ED	Hospitalization
UNINTENTIONAL INJURY	95608	799.30	240.75
	95652*	1013.72	126.84
	95660*	1045.87	238.89
	95673	954.55	241.39
	95683	480.20	196.33
	95697	1017.91	185.51
	95814*	2080.61	528.95
	95815*	1135.11	220.47
	95821*	1019.71	215.68
	95838*	971.06	189.32
	95841*	1038.23	248.30
	KFH-Sacramento	768.33	172.62
	SACRAMENTO	761.56	176.40
	SUTTER	623.40	189.33
	YOLO	645.28	121.09
	CALIFORNIA	666.38	154.85

Sources: ED visits and hospitalizations: OSHPD, 2011 -2013
* Indicates Focus Community

BASIC NEEDS (FOOD, HOUSING, EMPLOYMENT, EDUCATION)		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS**	**Contributing Factors RELATED INDICATORS**
<u>Basic Needs</u> Lack of basic needs such as food, housing and educational and job opportunities may lead to serious health problems and poor quality of life. People with a quality education, secure employment and stable housing tend to be healthier throughout their lives. Education is associated with longer life expectancy and health-promoting behaviors such as going for routine checkups and recommended screenings. Without a good education, prospects for a stable job with good earnings also decrease. Secure employment that provides sufficient income allows people to obtain health coverage, medical care, food security and quality housing. Food security may improve access to and consumption of healthy foods and decrease the risk of being overweight or obese. Quality housing is associated with positive physical and mental well-being and helps to prevent disease and other health problems that may arise from unsafe living conditions. Homelessness also has a notable impact on health: people who are homeless have a mortality rate four to nine times higher compared to the general population and are at greater risk of infectious and chronic illness, poor mental health and substance abuse than those who are not homeless. *Sources:* http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health http://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf http://www.cdc.gov/features/homelessness/	**Poverty - Population Below 100% FPL** • HSA 19.15%** // CA 15.94% • Black Alone 32.61%** • Native American/Alaskan Native Alone 22.69%** • Some Other Race Alone 28.45%** • Multiple Race 23.42%** • Hispanic/Latino (Any Race) 26.07%** **Poverty - Population Below 200% FPL** • HSA 39.60%** // CA 35.91% **Poverty - Children Below 100% FPL** • HSA 24.52%** // CA 22.15%	• Food Security - Food Desert Population** (see map) • Education - High School Graduation Rate* (health disparities) • Education - Reading Below Proficiency** (health disparities) • Children Eligible for Free/Reduced Price Lunch** • Food Security - Population Receiving SNAP** • Insurance - Population Receiving Medicaid* • Food Security - Food Insecurity Rate* • Economic Security - Households with No Vehicle*

	• Black Alone 45.94%** • Native American/Alaskan Native Alone 27.42%** • Native Hawaiian/Pacific Islander Alone 32.70%** • Some Other Race Alone 36.33%** • Hispanic/Latino (Any Race) 36.06%**	• Education - Less than High School Diploma (or Equivalent) (health disparities) • Insurance - Uninsured Population (health disparities) • Life Expectancy at Birth* • Population with public insurance*

Primary Data:
46 of 47 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to basic needs as a health need. Themes related to this health need are as follows:

- Economic security is an issue within the HSA. Many community members expressed that they struggle to find employment and the cost of living is high which means they live on restricted incomes. Many are unwilling to work minimum wage jobs and rely on safety net resources such as SNAP, WIC, and TANF. There is a need for more job training and employment assistance programs within the service area.
- Residents expressed that affordable and low-income housing options are greatly needed within the service area. Specifically, housing for low-income seniors and homeless individuals is desperately needed. In addition, community members in some areas expressed concerns about the city of Sacramento's "revitalization" efforts that have resulted in higher housing costs and displacement of long-time residents.
- Community members expressed a concern about low education levels, and the need for equal education opportunities in order to obtain better jobs. There was a general sentiment that getting a good education leads to better health.
- There were also significant concerns related to food insecurity. Despite our region being surrounded by productive agriculture and our namesake as the "Farm to Fork Capital", there is still significant reliance by some on safety net resources (i.e. EBT, WIC, food banks and pantries).

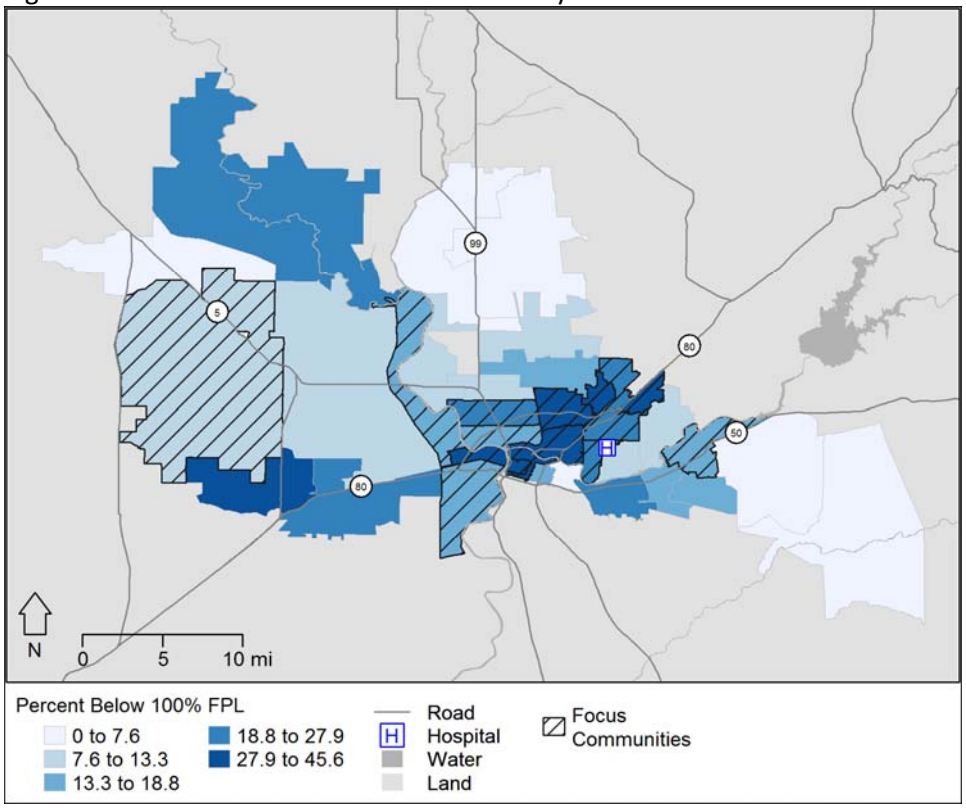
Geographic Impact:	Figure 16. Percent Below 100% Federal Poverty Level 

Figure 17. Life Expectancy at Birth

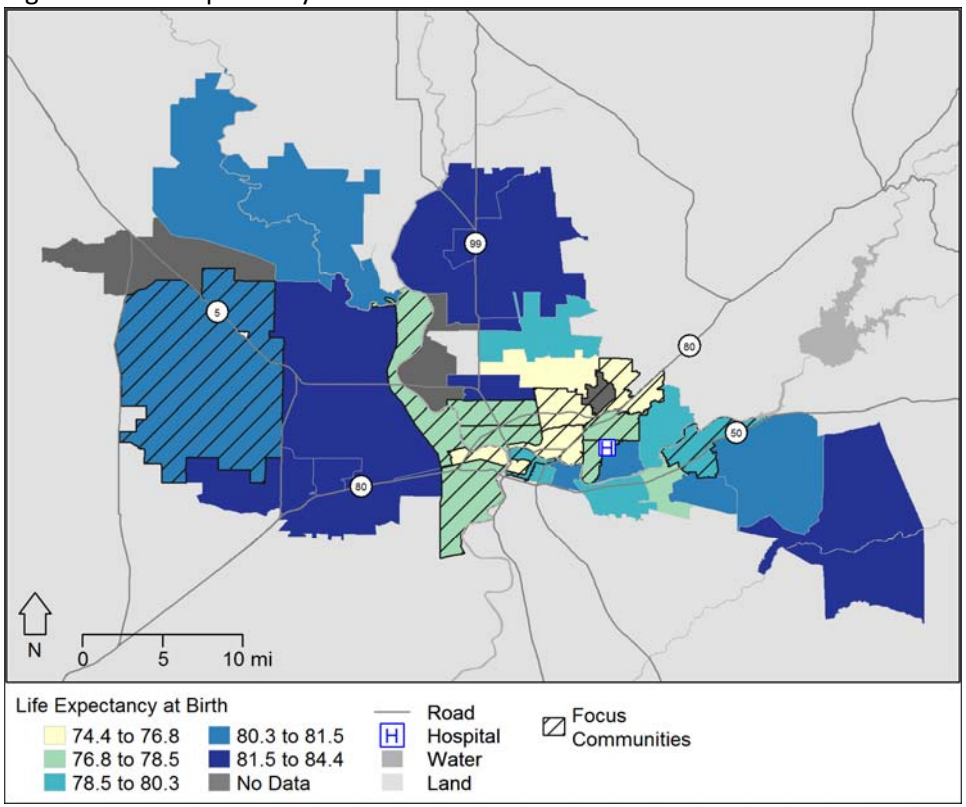


Table 18. ZIP codes with the worst rates for life expectancy at birth (years) and for percent living below 100% Federal Poverty Level (FPL) compared to hospital service area, county and state benchmarks

ZIP Code	Life Expectancy	FPL 100%
95605*	76.07	29.2
95652*	n/a	45.53
95660*	76.7	22.92
95673	75.34	14.69
95811*	79.89	31.09
95814*	74.35	28.51
95815*	74.37	34.06
95838*	74.57	30.1
95841*	75.65	27.88
KFH-Sacramento	78.79	19.15
SACRAMENTO	78.74	17.59
YOLO	80.38	19.13
SUTTER	78.02	16.66
CALIFORNIA	80.53	15.94

Sources: Mortality CDPH, 2010-2012; 2013 American Community Survey 5-year Estimate

* Indicates Focus Community

ACCESS TO HIGH QUALITY HEALTH CARE AND SERVICES		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS**	**Contributing Factors RELATED INDICATORS**
<u>Access to Care</u> Access to high quality, affordable health care and health services that provide a coordinated system of community care is essential to the prevention and treatment of morbidity and increases the quality of life, especially for the most vulnerable. Essential components of access to care include health insurance coverage, access to a primary care physician and clinical preventive services, timely access to and administration of health services, and a robust health care workforce. Culturally and linguistically appropriate health services are necessary to decrease disparities for diverse populations, including racial and ethnic minorities, LBGTQ populations and older adults. Health education/literacy and patient navigation services are also increasingly important following the passage of the Affordable Care Act of 2010, as the newly insured gain entry to the health care system. **Maternal and Infant Health -** Maternal and infant health is important for the health of future generations. Increasing access to quality preconception, prenatal, perinatal and inter-conception care improves health outcomes for both the mom and the baby and is essential to addressing persistent	**Lack of a Consistent Source of Primary Care** • Non-Hispanic Other 15.08%** // HSA 12.40% • Hispanic/Latino (Any Race) 20.92%**// HSA 12.40% **Prenatal Care (% of live births with mothers who received prenatal care within the first trimester) (per 10,000)** • HSA 78.80** // CA 83.60 **Access to Dentists (per 100,000)** • HSA 67** // CA 77.5 **Dental Care - No Recent Exam (Youth)** • HSA 21.00%** // CA 18.50% • Non-Hispanic White 33.07%** • Hispanic/Latino (Any Race) 30.86%** **Dental/Oral Diseases (Emergency Department) (per 10,000)** • HSA 75.64** // CA 41.34 (see map) **Dental/Oral Diseases (Hospitalizations) (per 10,000)** • HSA 9.75 // CA 7.81	• Insurance - Population Receiving Medicaid* • Cancer Screening - Pap Test* • Insurance - Uninsured Population (health disparities) • Population with public insurance* • Food Security - Food Insecurity Rate* • Breastfeeding (Any) (health disparities) • Breastfeeding (Exclusive) (health disparities)

disparities in maternal, infant and child health. **Oral Health -** Oral health contributes to a person's overall health and well-being. Oral diseases contribute to the high costs of care and cause pain and disability for those who do not have access to preventative oral health services and dental treatment. Dental care for low-income children is particularly important since tooth decay is the most common chronic childhood disease and may lead to problems in eating, speaking and learning if left untreated. *Sources:* http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health http://www.healthypeople.gov/2020/topics-objectives/topic/oral-health http://www.gao.gov/new.items/d081121.pdf		

Primary Data:

45 of 47 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to accessing healthcare services as a health need. Themes related to this health need are as follows:

- There is a lack of health education and literacy within the service area. Community members expressed the desire for more education regarding how to navigate the healthcare system, how to access their benefits, and how to access specific resources. The newly insured often don't know how to navigate health care systems and may use the ER as a one-stop-shop to get their health needs met. The need for health education was also expressed in terms of treating and preventing chronic diseases and illnesses (ex. diabetes management programs, dialysis education, Hepatitis C education, nutrition education, etc.), as these services are often not available or accessible.
- Residents often discussed their desire for culturally sensitive care. The demographics of the HSA are diverse with a variety of minority groups that have distinct language and/or cultural differences. Many of these groups have historically been marginalized and are in the process of building trust in the healthcare system. Community members spoke about the need for culturally relevant outreach and services, using innovative strategies to reach adults and youth from underserved populations (i.e. ethnic groups, people of color, refugees and recent immigrants, undocumented, LGBT, homeless, gang members, etc.) Providers need more cultural sensitivity training for working with diverse populations. The health care workforce often lacks diversity and needs more staff who are bilingual and bicultural.
- Seniors are in high need of services and have many barriers to accessing care (transportation, income, insurance, etc.). Living on restricted incomes can have a negative impact on health behaviors (e.g. having to choose between food and medication). Seniors with dementia and Alzheimer's often can't get the supportive services they need, elder abuse and bullying is a concern in group living situations and preventative care (e.g. fall prevention and medication management) are also lacking.
- Access to dental care is limited, particularly for Medi-Cal populations and there are few dental providers that accept Medi-Cal and some of these patients end up in the Emergency Department (see map). Oral health for children is particularly important but many low-income children do not receive regular check-ups.
- Access to primary care services is a challenge, particularly for Medi-Cal populations. Getting an appointment with an assigned PCP can take months, people are often assigned to PCPs that aren't accepting new patients, and some people end up using the ER since they can't get in to see their PCP.
- The lack of linguistically appropriate services is a barrier to care for ESL and LEP populations. Interpretation and translation services are often lacking or inadequate. Navigating Medi-Cal is particularly difficult if English is a second language.

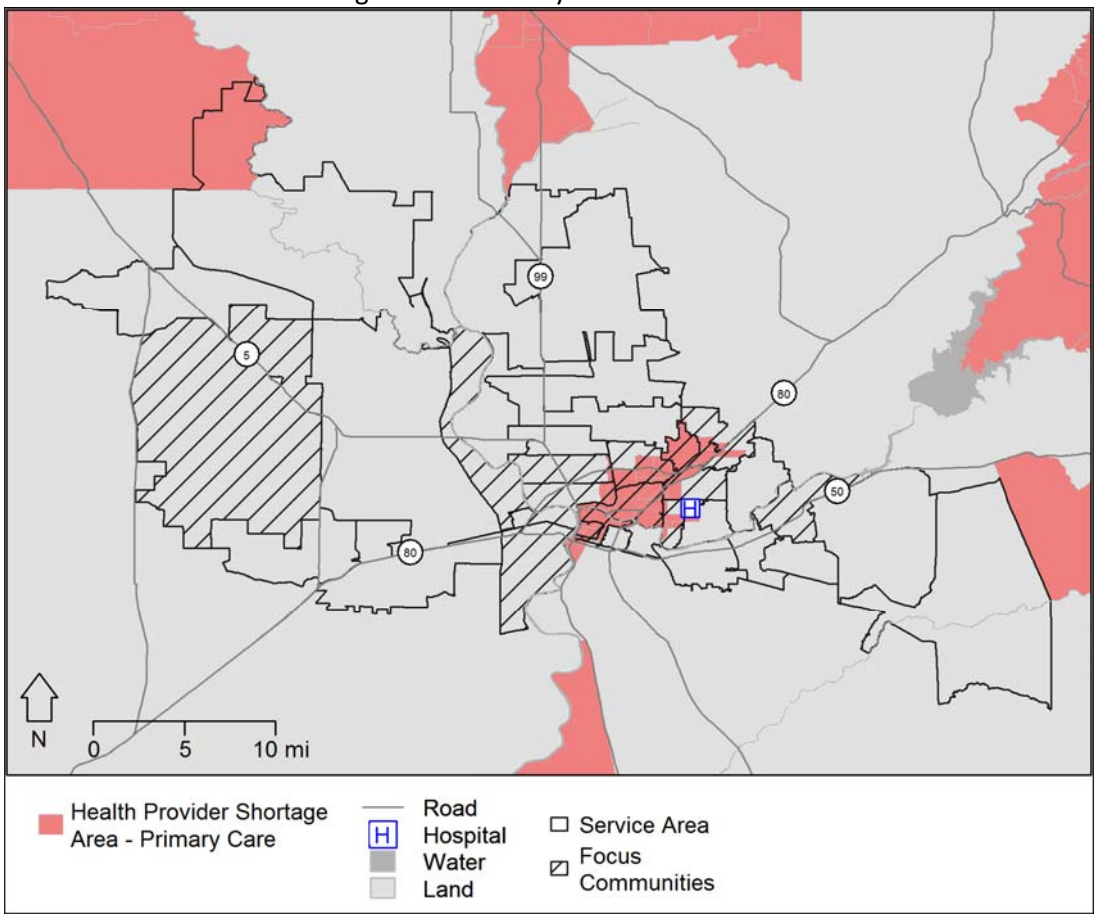
Geographic Impact:	Figure 18. Health Provider Shortage Area – Primary Care 

Figure 19. Health Provider Shortage Area – Dental

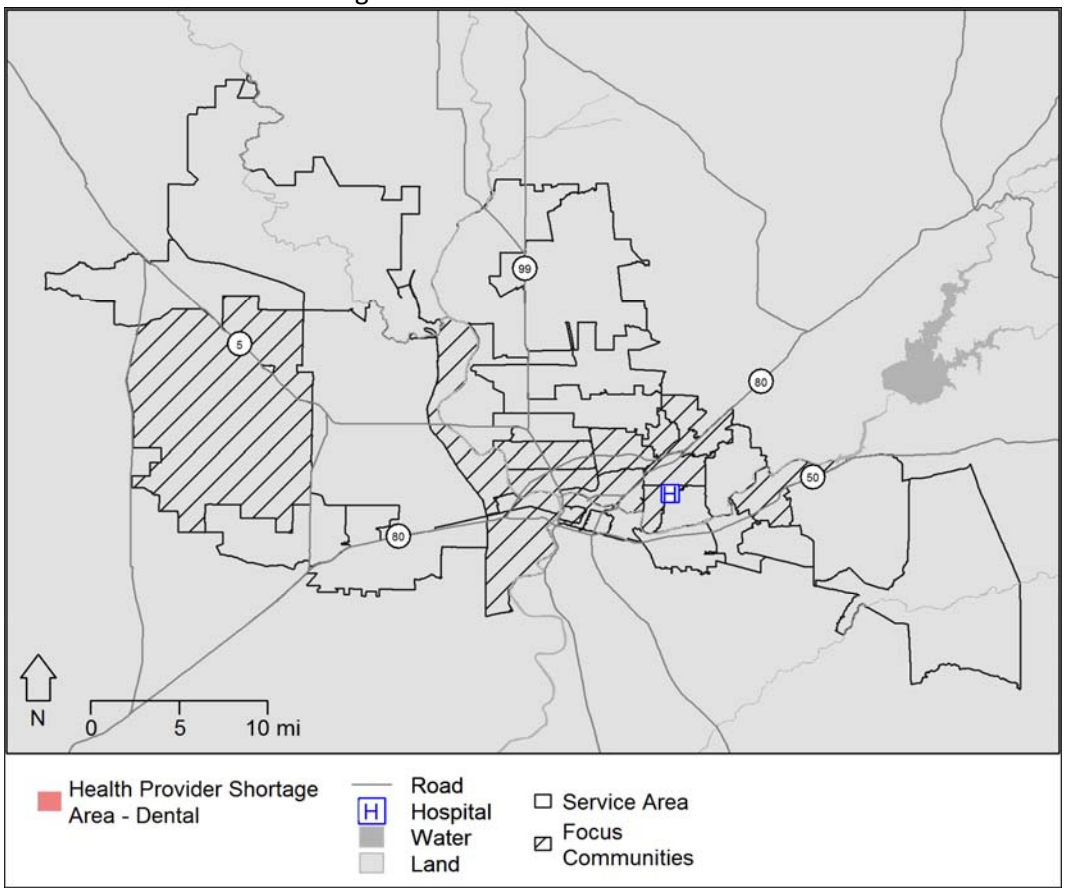


Table 19. ZIP codes with the worst rates for ED visit and Hospitalization rates for oral/dental diseases compared to hospital service area, county and state benchmarks (rates per 10,000 population)

	ZIP Code	ED	Hospitalization
ORAL AND DENTAL DISEASES	95605*	91.72	11.38
	95652*	283.33	10.63
	95660*	141.24	12.39
	95811*	115.04	13.28
	95814*	216.57	29.18
	95815*	164.45	15.38
	95821*	137.23	12.85
	95825*	122.58	10.71
	95838*	119.21	11.42
	95841*	137.86	12.58
	KFH-Sacramento	75.64	9.75
	SACRAMENTO	72.66	9.77
	SUTTER	47.18	6.89
	YOLO	47.42	8.60
	CALIFORNIA	41.34	7.81

Sources: ED visits and hospitalizations: OSHPD, 2011 -2013
* Indicates Focus Community

Table 20. ZIP codes with the worst rates for prenatal care compared to hospital service area, county and state benchmarks (rates per 10,000 population)

PRENTAL CARE	95660*	70.26
	95673	73.21
	95815*	72.64
	95821*	74.71
	95827	76.07
	95838*	70.08
	95841*	74.78
	K_Sacramento	78.80
	SACRAMENTO	81.40
	SUTTER	69.20
	YOLO	82.70
	CALIFORNIA	83.60

Source: Mortality CDPH, 2010-2012
* Indicates Focus Community

DISEASE PREVENTION, MANAGEMENT AND TREATMENT		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS**	**Contributing Factors RELATED INDICATORS**
Disease Prevention and Management Increasing the focus on disease prevention and management will improve health, quality of life and prosperity in communities. Chronic diseases such as heart disease, cancer and chronic lower respiratory diseases are the leading causes of death in the United States and approximately one out of every two adults is affected by chronic illness, many of which are preventable. There are also significant disparities among racial and ethnic minority groups as well as among children and seniors. Focusing on preventing disease and illness before they occur and better management of existing chronic diseases will create healthier places and decrease health care costs. *Source:* http://www.cdc.gov/Features/PreventionStrategy **Asthma** Prevention, early-detection, treatment and management of asthma improves quality of life and productivity. Reducing exposures to triggers and risk factors such as tobacco smoke and poor air quality can decrease the burden of asthma and promote better health. *Source:*	**Cancer** **Cancer Incidence – Breast (per 100,000)** • HSA 131.2** // CA 122.1 • White Alone 139.3** **Mortality – Cancer (per 100,000)** • HSA 173.27** // CA 157.1 • Non-Hispanic White 183.27** • Black alone 213.54** • Native Hawaiian/Pacific Islander 189.55** **Cancer Incidence – Colon and Rectum (per 100,000)** • HSA 42.1** // CA 40 • Black alone 52.5** **Cancer Incidence – Prostate (per 100,000)** • HSA 129.5** // CA 126.9 • Black alone 202.8** **Cancer Incidence – Lung (per 100,000)** • HSA 54.9** // CA 48 • White alone 57.5** • Black alone 65.4** **Lung Cancer (Emergency Department) (per 10,000)**	• Alcohol – Excessive Consumption* • Alcohol – Expenditures* • Obesity (Adult)** • Food Security – Food Desert Population** • Cancer Screening – Pap Test* • Air Quality – Particulate Matter 2.5** • Tobacco Usage (adults and teens)** • Pollution Burden Score • Physical Inactivity (Youth)** (health disparities) • Diabetes Management (Hemoglobin A1c Test)* • High Blood Pressure – Unmanaged** • Overweight (Youth) (health disparities) • Obesity (Youth) (health disparities) • Hypertension (Emergency Department)** • Diabetes (Emergency Department)** • Essential Hypertension & Hypertensive Renal Disease (Mortality) • STD – No HIV Screening (health disparities)

http://www.healthypeople.gov/2020/topics-objectives/topic/respiratory-diseases **Cancer** Screening and early detection can help to reduce the illness, disability and death caused by cancer. Many cancers are preventable by reducing risk factors such as tobacco use, physical inactivity, poor nutrition and obesity and promoting preventative behaviors such as vaccination against human papillomavirus and hepatitis B. *Source:* http://www.healthypeople.gov/2020/topics-objectives/topic/cancer **CVD/Stroke** Cardiovascular disease is the leading cause of death and strokes are the third leading cause of death in the United States. Heart disease and stroke can result in serious illness and disability, a decreased quality of life and a significant financial burden on society. These diseases can be prevented and managed through behaviors such as engaging in regular physical activity, eating healthy foods and not smoking. *Source:* http://www.healthypeople.gov/2020/topics-objectives/topic/heart-disease-and-stroke **HIV/AIDS/STDs** Preventing or reducing the transmission of HIV/AIDS and STDs leads to healthier, longer lives. There are approximately 19 million STD infections each year, almost half among the millennial	• HSA 3.78* // CA 2.68 **Prostate Cancer (Emergency Department) (per 10,000)** • HSA 8.14** // CA 5.79 **Colorectal Cancer (Emergency Department) (per 10,000)** • HSA 2.30 // CA 1.85 **Breast Cancer (Emergency Department) (per 10,000)** • HSA 8.75** // CA 6.59 **CVD/Stroke** **Mortality - Ischaemic Heart Disease (per 100,000)** • HSA 167.28** // CA 163.18 • Non-Hispanic White 168.56** • Black 218.55** • Native Hawaiian/Pacific Islander 327.27** **Mortality – Stroke (per 100,000)** • HSA 43.03** // CA 37.38 • Black alone 62.58** • Native Hawaiian/Pacific Islander 65.47** **Heart Diseases (Emergency Department) (per 10,000)** • HSA 183.75** // CA 112.64 **Heart Diseases (Hospitalization) (per 10,000)** • HSA 232.50** // CA 222.00	

population. HIV/AIDS/STDs are costly to treat and have long term health consequences, especially on reproductive health. *Sources:* http://www.healthypeople.gov/2020/topics-objectives/topic/hiv; http://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases	**Stroke (Emergency Department) (per 10,000)** • HSA 28.61** // CA 18.55 **Stroke (Hospitalization) (per 10,000)** • HSA 57.01** // CA 52.23 **Asthma** **Asthma – Prevalence** • HSA 17.90%** // CA 14.20% **Asthma (Emergency Department) (per 10,000)** • HSA 232.25** // CA 148.86 **HIV/AIDS/STDs** **STD – Chlamydia (per 100,000)** • HSA 505** // CA 444.9 **STD – HIV Prevalence (per 100,000)** • HSA 230** // CA 363 • Non-Hispanic White 254.36** • Non-Hispanic Black 650.75** **Gonorrhea Rate (per 10,000)** • HSA 15.22**// CA 11.68 **Sexually Transmitted Infections (Emergency Department) (per 10,000)** • HSA 4.93* // CA 3.2	

Primary Data:

35 of 47 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to disease prevention, management and treatment as a health need. Themes related to this health need are as follows:

- Participants from 27 (out of 47 total) focus groups and key informant interviews within the service area spoke about cardiovascular diseases as being problematic within their communities. They spoke frequently about hypertension, especially the need for diagnosis and management of hypertension with education and affordable medication. They also spoke about congestive heart failure, and had specific concerns about heart disease incidence among youth.
- Cancer is also a known issue within the health service area, mentioned in 14 focus groups and key informant interviews. Participants spoke about various types of cancer diagnoses within the community, including lung, breast, colon, prostate, cervical, and stomach cancers. They also spoke of the possible connection between pesticide exposure and cancer, as well as the importance of cancer screening programs.
- Asthma was also noted as a problematic health condition within the service area, brought up in 11 focus groups and key informant interviews. It was noted by community members that many people (both youth and adults) are suffering from asthma due to the inhalation of contaminated air and smoke, and that asthma medications can be cost prohibitive. Observations were also made in relation to the number of smoke shops in low-income areas and the need for more laws to regulate second hand smoke and tobacco use.
- Sexually transmitted diseases (STDs) are also of concern to people in this service area, mentioned in 7 focus groups and key informant interviews. Interviewees spoke of stigma related to STDs, acknowledging that it is not always discussed openly, especially between parents and their children. In addition, participants spoke about the fact that the gay, transgender, and substance using populations suffer with a disproportional burden of HIV, syphilis, and Hepatitis C. There was a recommendation for more testing and education on how to manage and treat STDs.

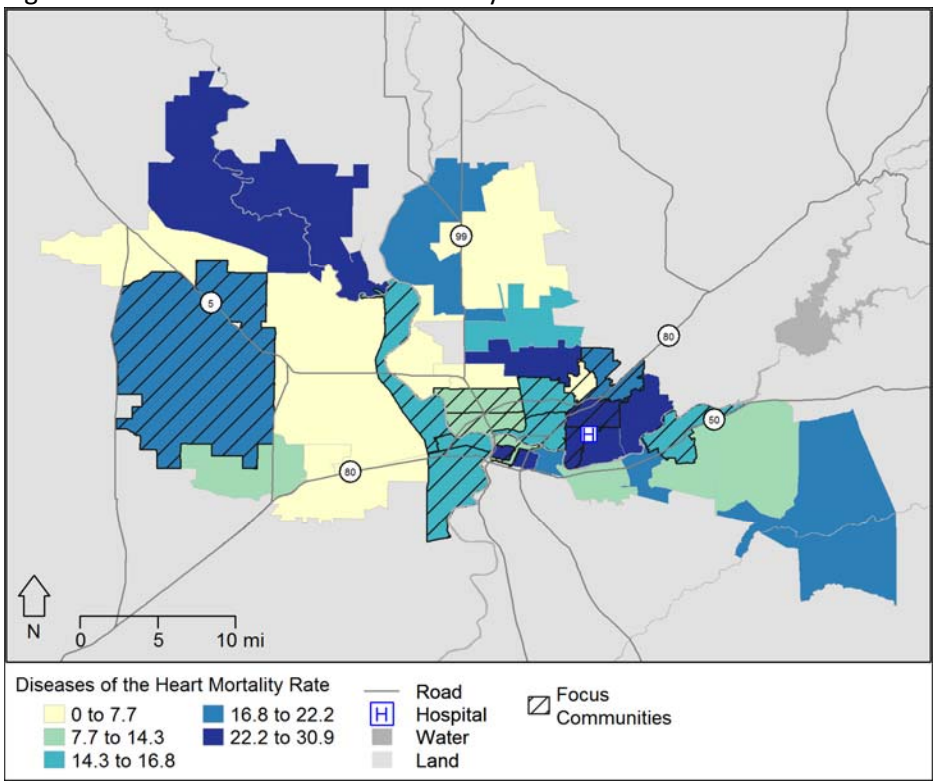
Geographic Impact:	Figure 20. Diseases of the Heart Mortality Rate 

Table 21. ZIP codes with the worst rates for heart disease mortality compared to hospital service area, county and state benchmarks (rates per 10,000 population)		
HEART DISEASE	95608	30.82
	95645	22.11
	95673	22.90
	95814*	29.50
	95816	23.20
	95821*	24.84
	95825*	30.14
	95864	24.18
	KFH-Sacramento	16.89
	SACRAMENTO	16.75
	YOLO	11.90
	SUTTER	18.60
	CALIFORNIA	15.82
Source: Mortality CDPH, 2010-2012 * Indicates Focus Community		

Figure 21. Cancer Mortality Rate

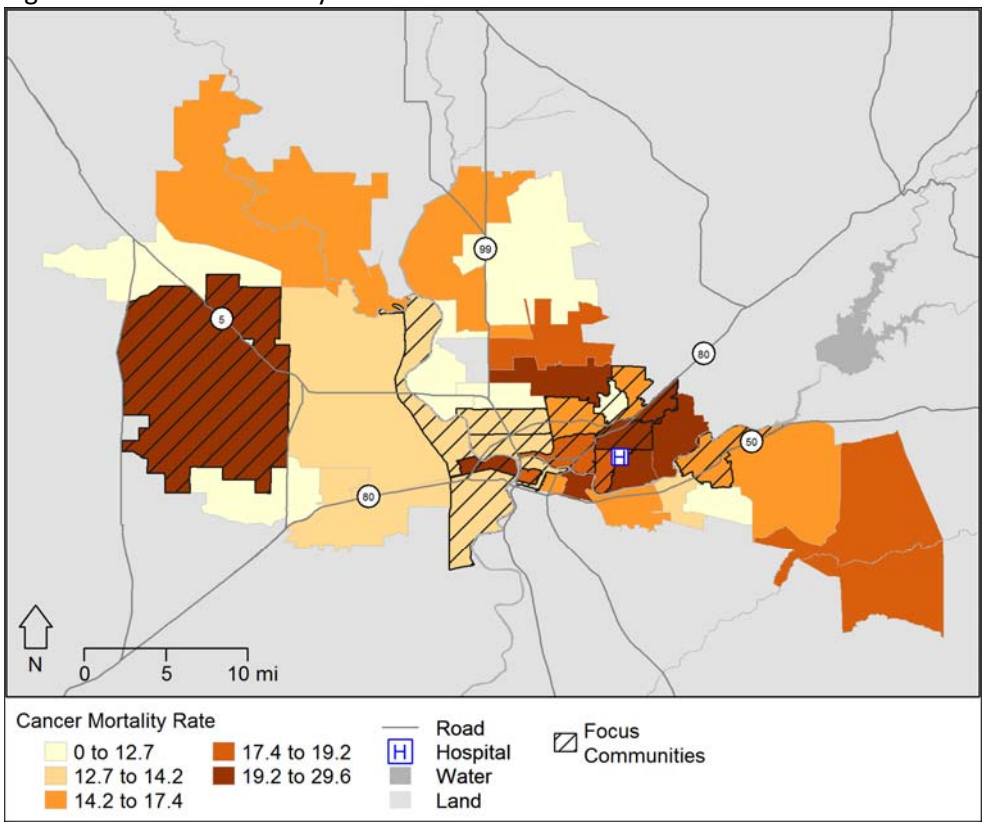


Table 22. ZIP codes with the worst rates for cancer mortality compared to hospital service area, county and state benchmarks (rates per 10,000 population)

CANCER	95605*	21.15
	95608	25.04
	95673	19.14
	95695*	20.11
	95819	23.63
	95821*	20.92
	95841*	21.77
	95864	29.56
	KFH-Sacramento	17.07
	SACRAMENTO	17.24
	SUTTER	17.44
	YOLO	15.08
	CALIFORNIA	15.41

Source: Mortality CDPH, 2010- 2012
* Indicates Focus Community

Figure 22. ED Asthma Rate

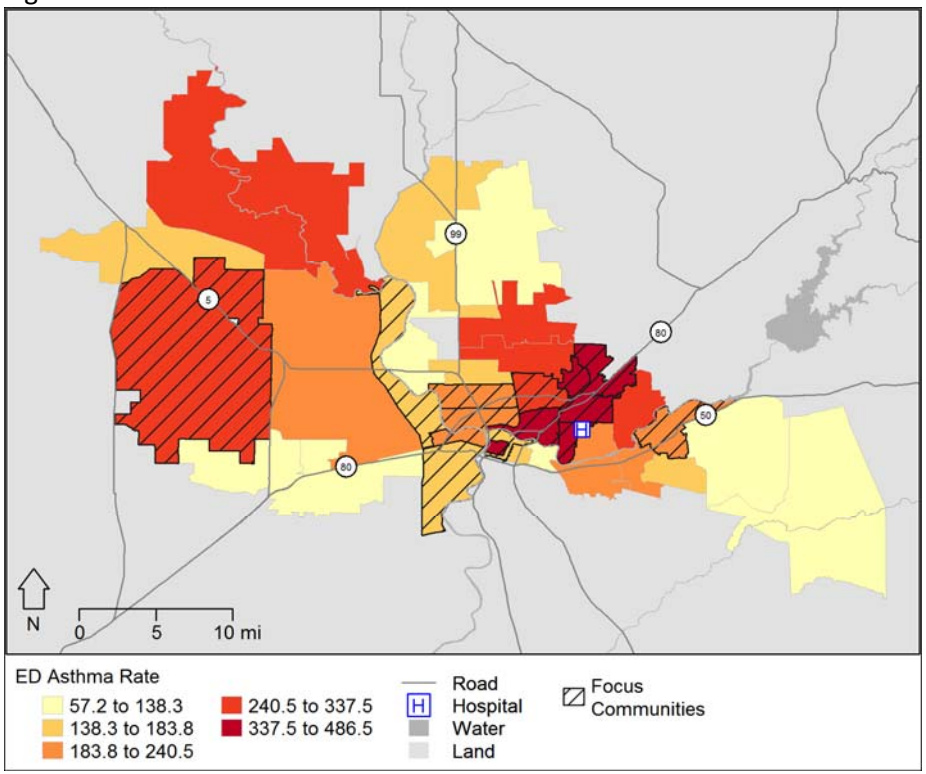


Figure 23. Hospitalization Asthma Rate

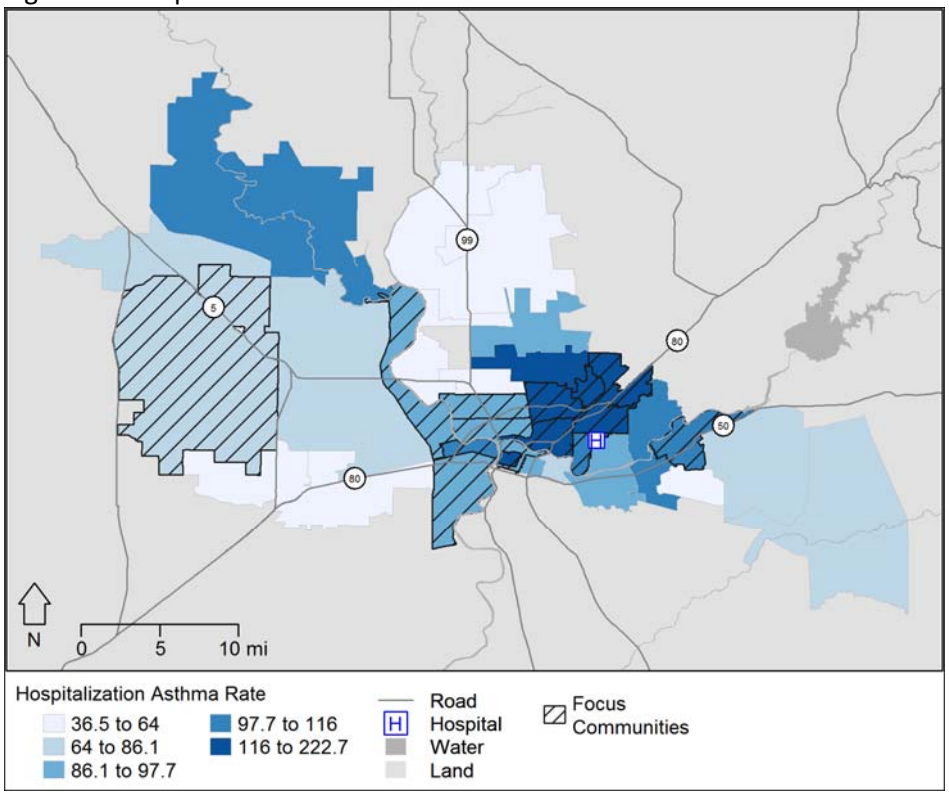


Table 23. ZIP codes with the worst rates for ED visit and Hospitalization rates for asthma compared to hospital service area, county and state benchmarks (rates per 10,000 population)

	ZIP Code	ED	Hospitalization
ASTHMA	95652*	412.33	132.53
	95660*	381.80	142.17
	95673	272.78	115.94
	95697	364.26	76.78
	95814*	486.50	222.67
	95815*	362.61	135.35
	95821*	378.96	128.00
	95825*	337.43	109.69
	95838*	317.39	119.57
	95841*	378.33	136.24
	KFH-Sacramento	232.25	94.99
	SACRAMENTO	235.95	101.20
	SUTTER	144.80	91.39
	YOLO	153.89	65.31
	CALIFORNIA	148.86	70.55

Sources: ED visits and hospitalizations: OSHPD, 2011 -2013

* Indicates Focus Community

Figure 24. ED Sexually Transmitted Infection Rate

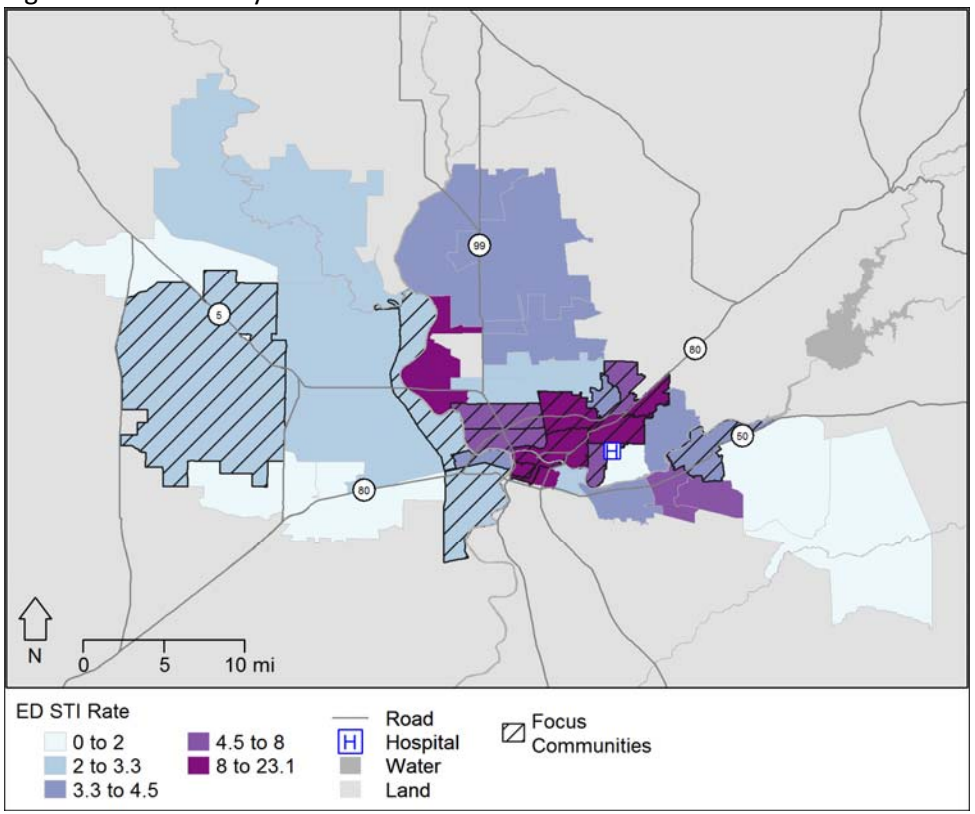


Figure 25. Hospitalization Sexually Transmitted Infection Rate

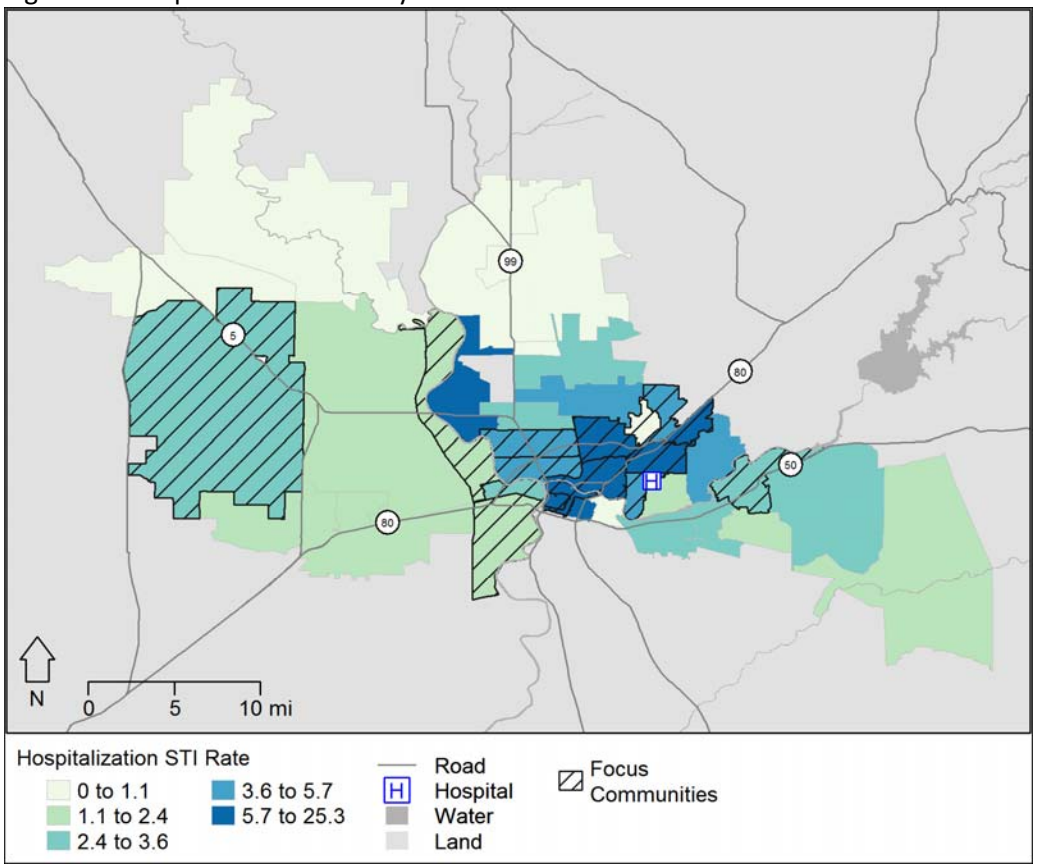


Table 24. ZIP codes with the worst rates for ED visit and Hospitalization rates for sexually transmitted infections compared to hospital service area, county and state benchmarks (rates per 10,000 population)

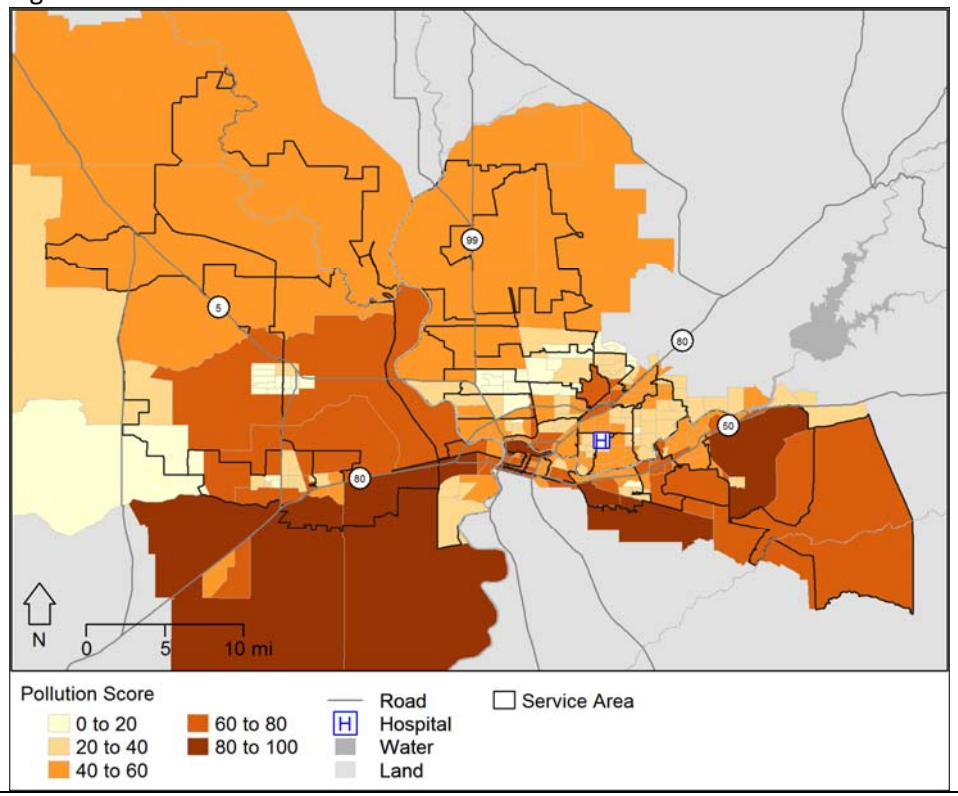
	ZIP Code	ED	Hospitalization
SEXUALLY TRANSMITTED INFECTIONS	95811*	13.62	14.60
	95814*	23.03	25.24
	95815*	11.56	5.76
	95816	10.58	15.89
	95821*	8.74	8.56
	95837	17.14	7.84
	95838*	8.22	6.86
	95841*	7.96	5.65
	KFH-Sacramento	4.93	4.14
	SACRAMENTO	5.53	3.95
	SUTTER	1.02	1.48
	YOLO	1.51	1.68
	CALIFORNIA	3.20	4.58

Sources: ED visits and hospitalizations: OSHPD, 2011 -2013
* Indicates Focus Community

POLLUTION FREE LIVING AND WORK ENVIRONMENTS		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS**	**Contributing Factors RELATED INDICATORS**
<u>Pollution Free Communities</u>	**Air Quality – Particulate Matter 2.5** • HSA 13.07%** // CA 4.17% **Asthma Prevalence** • HSA 17.90%** // CA 14.20% **Pollution Burden Score** • HSA 0.47 (see map)	• Transit – Road Network Density* • Climate & Health – Canopy Cover* • Physical Inactivity (Youth)** (health disparities) • Mortality – Ischemic Heart Disease** (health disparities) • COPD (ED)** • COPD (H)** • Asthma (ED)** • Current Smokers (Tobacco) • Heart Diseases (ED)** • Heart Diseases (H) ** • Chronic Lower Respiratory Disease – Mortality*

Primary Data:
23 of 47 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to pollution free living and work environments as a health need. Themes related to this health need are as follows:

- Poor air quality is an issue within the HSA. Community members spoke about air pollution and the connection to high rates of asthma. Interviewees also spoke about poor air quality in relation to second hand smoke from cigarettes and marijuana and the need for more enforcement of anti-smoking laws and smoking cessation programs.
- Pesticide exposure is a concern in some communities, especially in rural parts of the HSA and for the migrant worker population. Community members spoke about living close to agricultural areas where pesticides are being sprayed on crops, which contributes to allergies and eye, nose and throat problems. It was suggested that there may be a connection between pesticide exposure over time and high cancer rates.
- Another smaller theme was in relation to dumping of trash within neighborhoods and the river. Community members spoke about the need for neighborhood beautification and clean-up programs.

Geographic Impact:	Pollution Burden Scores are particularly high in the following ZIP codes: 95691* (West Sacramento), 95618 (Davis East), 95811* (Midtown Sacramento), 95826 (Rosemont/Rancho Cordova), and 95742 (Nimbus) (see map). * Indicates focus community Figure 26. Pollution Burden Score 

APPENDIX D: Detailed Methodology Process for Identifying Significant Health Needs

BARHII Framework

Quantitative indicators used in this assessment was guided by a conceptual framework developed by the Bay Area Regional Health Inequities Initiative (BARHII) (refer to Figure 6 in Appendix A). The BARHII Framework demonstrates the connection between social inequalities and health and focuses attention on measures that had not characteristically been within the scope of public health departments. Valley Vision used the BARHII framework to organize the quantitative indicators collected from the CHNA-DP, as well as the additional indicators collected by Valley Vision. The BARHII Framework was also used to frame the primary data collection too, to capture both "upstream" and "downstream" factors influencing health in the HSA.

Potential Health Needs

Significant health needs were identified through an integration of both qualitative and quantitative data. The process began with generating a list of eight broad potential health needs (PHN categories) that could exist within the HSA as well as subcategories of these broad needs as applicable. The PHN categories and subcategories were identified through consideration of the following inputs: 1) the health needs identified in the 2013 CHNA process; 2) the categories in the Kaiser Permanente CHNA data platform (CHNA-DP) - preliminary health needs identification tool; 3) and a preliminary review of primary data. For a detailed list of the PHN categories please see Table 25.

Table 25. Full Description of Potential Health Need (PHN) Categories and Subcategories

Potential Health Need Category	Subcategory	Components/Description
Access to High Quality Health Care and Services	Access to Care; Maternal and Infant Health; Oral Health	This category encompasses the following needs related to access to care: • Access to Primary and Specialty Care • Access to Dental Care • Access to Maternal and Infant Care • Health Education & Literacy • Continuity of Care, Care Coordination & Patient Navigation • Linguistically & Culturally Competent Services This category includes health behaviors that are associated with access to care (e.g. cancer screening), health outcomes that are associated with access to care/lack of access to care (e.g. low birth weight) and aspects of the service environment (e.g. health professional shortage area).

Access to Behavioral Health Services	Mental Health; Substance Abuse	This category encompasses the following needs related to behavioral health: • Access to mental health and substance abuse prevention and treatment services • Tobacco education, prevention and cessation services • Social engagement opportunities (especially for youth and seniors) • Suicide prevention This category includes health behaviors (e.g. substance abuse), associated health outcomes (e.g. COPD) and aspects of the social and physical environment (e.g. social support and access to liquor stores). In addition, this category includes life expectancy since persons with severe mental health issues may have a lower life expectancy.
Affordable and Accessible Transportation	N/A	Includes the need for public or person transportation options, transportation to health services and options for persons with disabilities.
Basic Needs	Food Security, Housing; Economic Security; Education	This category encompasses the following basic needs: • Economic security (income, employment, benefits) • Food security/insecurity • Housing (affordable housing, substandard housing) • Education (reading proficiency, high school graduation rates) • Homelessness
Disease Prevention, Management and Treatment	Cancer; CVD/Stroke; Asthma; HIV/STIs	This category encompasses the following health outcomes that require disease prevention and/or management measures as a requisite to improve health status: • Cancer: Breast, Cervical, Colorectal, Lung, Prostate • CVD/Stroke: Heart Disease, Hypertension, Renal Disease, Stroke • HIV/AIDS/STDS: Chlamydia, Gonorrhea; HIV/AIDS • Asthma This category includes health behaviors that are associated with chronic and communicable disease (e.g., fruit/vegetable consumption, screening), health outcomes that are associated with these diseases or conditions (e.g. overweight/obesity), and associated aspects of the physical environment (e.g. food deserts).
Healthy Eating and Active Living (HEAL)	N/A	This category includes all components of healthy eating and active living including health behaviors (e.g. fruit and vegetable consumption), associated health outcomes (e.g. diabetes) and aspects of the physical environment/living conditions (e.g. food deserts).

Pollution-Free Living and Work Environments	Climate and Health	This category includes measures of pollution such as air and water pollution levels. This category includes health behaviors associated with pollution in communities (e.g. physical inactivity), associated health outcomes (e.g. COPD) and aspects of the physical environment (e.g. road network density). In addition, this category includes tobacco usage as a pollutant.
Safe, Crime and Violent Free Communities	Violence/ Injury Prevention	This category includes safety from violence and crime including violent crime, property crimes and domestic violence. This category includes health behaviors (e.g. assault), associated health outcomes (e.g. mortality - homicide) and aspects of the physical environment (e.g. access to liquor stores). In addition, this category includes factors associated with unsafe communities such as substance abuse and lack of physical activity opportunities, and unintentional injury such as motor vehicle accidents.

Once the PHN categories were created, quantitative and qualitative indicators associated with each category and subcategory were identified in a crosswalk table. The potential health need categories, subcategories and associated indicators were then vetted and finalized by members of the CHNA Collaborative prior to identification of the significant health needs. A full list of the indicators associated with each PHN category is displayed below in Table 26. Indicators were sourced from the CHNA-DP and as outlined in Appendix A.

Table 26. Primary and Secondary Indicators Associated With Potential Health Needs

Access to High Quality Health Care and Services	
Quantitative Indicators	Qualitative Indicators
Access to Care – General • Access to Dentists • Access to Primary Care • Cancer Screening - Mammogram • Cancer Screening - Pap Test • Cancer Screening - Sigmoid/Colonoscopy • Federally Qualified Health Centers • Health Professional Shortage Area - Dental • Health Professional Shortage Area - Primary Care • Insurance - Population Receiving Medicaid • Insurance - Uninsured Population • Lack of a Consistent Source of Primary Care • Preventable Hospital Events	• Continuity of care/coordinated care • Cost of care/prescription cost/copays • Culturally sensitive care • Delayed care • Dental/oral health • Distance/transport to care • ER overwhelm/ overutilization • Health care for the undocumented • Health education/ health literacy • Insurance restrictions/ coverage gaps • Language barriers • Long wait times/limited providers/impacted system • Maternal infant health • Medi-Cal access
VV sourced indicators: • Population with Public Insurance	

Maternal Infant Health • Breastfeeding (Any) • Breastfeeding (Exclusive) • Education - Head Start Program Facilities • Education - School Enrollment Age 3-4 • Food Security - Food Insecurity Rate • Infant Mortality • Lack of Prenatal Care • Low Birth Weight • Teen Births (Under Age 20)	• Pain management • Patient navigation/referral • Prevention services/preventative care • Primary care • Senior care services • Specialty care
VV sourced indicators • Prenatal Care in First Trimester	
Oral Health • Absence of Dental Insurance Coverage • Dental Care - Lack of Affordability (Youth) • Dental Care - No Recent Exam (Adult/Youth) • Drinking Water Safety • Health Professional Shortage Area - Dental • Poor Dental Health • Soft Drink Expenditures	
VV sourced indicators • Dental/Oral Diseases (ED/H)	
Access to Behavioral Health Services	
Quantitative Indicators	Qualitative Indicators
Mental Health • Access to Mental Health Providers • Lack of Social or Emotional Support • Mental Health - Depression Among Medicare Beneficiaries • Mental Health - Needing Mental Health Care • Mental Health - Poor Mental Health Days • Mortality – Suicide	• Comorbidity • Depression-anxiety • Desire for alternative treatment • Elderly-Alzheimer's-dementia • ER/ Hospital • Homelessness • Limited services-lack of capacity • Mental health/substance abuse • Need for culturally sensitive care • Serious mental Illness • Stigma/discrimination • Stress • Suicide • Trauma and/or ACEs
VV sourced indicators • Alzheimer's Disease • Health Professional Shortage Area - Mental Health • Life expectancy at birth • Mental Health (ED/H) • Self-Inflicted Injuries (ED/H)	

<table>
<tr><td>Substance Abuse
• Alcohol - Excessive Consumption
• Alcohol - Expenditures
• Liquor Store Access
• Tobacco Expenditures
• Tobacco Usage (Adults)</td><td rowspan="2">• Alcohol and other drugs
• Barriers to accessing services
• Co-morbidity
• Criminalization of drugs
• Geographic-safety concerns
• Homelessness
• Limited resources/capacity
• Methamphetamines-cocaine
• Mental health/substance abuse
• Opiates
• Outreach and education
• Parental and pre-Natal Use
• Transition aged youth
• Tobacco-E cigs</td></tr>
<tr><td>VV sourced indicators
• Chronic liver disease and cirrhosis – MORT
• Chronic Lower Respiratory Disease - MORT
• COPD (ED/H)
• Substance Abuse (ED/H)
• Tobacco Usage (Adults and Teens)</td></tr>
<tr><td colspan="2">Affordable and Accessible Transportation</td></tr>
<tr><td>• Commute to Work - Alone in Car
• Commute to Work - Walking/Biking
• Economic Security - Commute Over 60 Minutes
• Economic Security - Households with No Vehicle
• Transit - Public Transit within 0.5 Miles
• Transit – Walkability
• Walking/Biking/Skating to School</td><td rowspan="2">• Lack of transport as a barrier to access health care services
• Lack of transport as a barrier to access healthy foods
• Long distance and difficulty accessing health care services
• No active transport infrastructure
• Personal transportation barriers
• Public transportation barriers</td></tr>
<tr><td>VV sourced indicators
• Population with Any Disability</td></tr>
<tr><td colspan="2">Basic Needs</td></tr>
<tr><td>Quantitative Indicators</td><td>Qualitative Indicators</td></tr>
</table>

- Children Eligible for Free/Reduced Price Lunch
- Economic Security - Commute Over 60 Minutes
- Economic Security - Households with No Vehicle
- Economic Security - Unemployment Rate
- Education - Head Start Program Facilities
- Education - High School Graduation Rate
- Education - Less than High School Diploma (or Equivalent)
- Education - Reading Below Proficiency
- Education - School Enrollment Age 3-4
- Food Security - Food Insecurity Rate
- Food Security - Population Receiving SNAP
- Food Security - School Breakfast Program
- Housing - Assisted Housing
- Housing - Cost Burdened Households
- Housing - Substandard Housing
- Housing - Vacant Housing
- Insurance - Population Receiving Medicaid
- Insurance - Uninsured Population
- Median Income
- Percent Households 65 years or Older In Poverty
- Percent with social support (SNAP, public cash assistance, etc.)
- Poverty - Children Below 100% FPL
- Poverty - Population Below 100% FPL
- Poverty - Population Below 200% FPL

VV sourced indicators

- Life Expectancy at Birth
- Percent Single Female Headed Households in Poverty
- Population 5 Years or Older who speak Limited English
- Population with Public Insurance

<u>Housing</u>

- Gentrification/displacement
- Housing discrimination
- Homelessness/shelter crisis
- Lack of affordable housing
- Role of public housing agencies
- Seniors/aging in place
- Substandard housing

<u>Food Security</u>

- Cost of living/poverty
- Food banks, pantries, closets
- Lack of quantity and quality of school food
- Safety net programs (CalFresh, WIC, Meals on Wheels)
- Transportation barriers

<u>Economic Security</u>

- Loss of safety net benefits
- Need for job training resources
- Safety net benefits (TANF, CalFresh, WIC)
- Stigma/shame of poverty
- Unemployment/lack of jobs

<u>Education</u>

- Differences in K-12 opportunity
- Educational attainment (dropouts, GED, higher Ed)
- Financial education and literacy
- Health education and literacy
- High cost of education
- Need for cultural sensitivity
- School discipline issues

Disease Prevention, Management and Treatment	
Quantitative Indicators	Qualitative Indicators
Asthma • Air Quality - Ozone (O3) • Air Quality - Particulate Matter 2.5 • Asthma - Prevalence • Asthma (H) • Obesity (Adult/Youth) • Overweight (Adult/Youth) • Tobacco Expenditures • Tobacco Usage (Adults)	• Air pollution/contamination • Anti-smoking laws and regulations • Cost of asthma medications Environmental triggers (dust, mites, cockroaches, mold) • Secondhand smoke (cigarettes/marijuana) • Smoke shops
VV sourced indicators • Asthma (ED) • Pollution Burden Score • Tobacco Usage (Adults & Teens)	
Cancer • Air Quality - Particulate Matter 2.5 • Alcohol - Excessive Consumption • Alcohol - Expenditures • Cancer Incidence - Breast • Cancer Incidence - Cervical • Cancer Incidence - Colon and Rectum • Cancer Incidence - Lung • Cancer Incidence - Prostate • Cancer Screening - Mammogram • Cancer Screening - Pap Test • Cancer Screening - Sigmoid/Colonoscopy • Food Security - Food Desert Population • Fruit/Vegetable Expenditures • Liquor Store Access • Low Fruit/Vegetable Consumption (Adult) • Mortality - Cancer • Obesity (Adult) • Overweight (Adult) • Physical Inactivity (Adult) • Tobacco Expenditures • Tobacco Usage (Adults)	• Air pollution exposure • Breast cancer • Cancer screening programs • Cervical cancer • Colorectal cancer • Early detection • Lack of healthy eating and active living opportunities • Lung cancer • Oncology/oncologists • Pesticide exposure • Prevention and education • Prostate cancer • Stomach cancer
VV sourced indicators • Breast Cancer (ED/H) • Colorectal Cancer (ED/H) • Lung Cancer (ED/H) • Pollution Burden Score • Prostate Cancer (ED/H) • Tobacco Usage (Adults & Teens)	

Disease Prevention, Management and Treatment (continued)	
Quantitative Indicators	Qualitative Indicators
CVD/Stroke • Alcohol - Excessive Consumption • Alcohol - Expenditures • Diabetes (H) • Diabetes Management (Hemoglobin A1c Test) • Diabetes Prevalence • Heart Disease Prevalence • High Blood Pressure - Unmanaged • Liquor Store Access • Mortality - Ischaemic Heart Disease • Mortality - Stroke • Obesity (Adult/Youth) • Overweight (Adult/Youth) • Park Access • Physical Inactivity (Adult/Youth) • Recreation and Fitness Facility Access • Tobacco Expenditures • Tobacco Usage (Adults) • Transit – Walkability	• Congestive heart failure (CHF) • Cost of medication • CVD/Stroke • Diagnosis, management, and treatment • Lack of healthy eating and active living opportunities • Hypertension • Stroke
VV sourced indicators • Diabetes (ED) • Essential Hypertension & Hypertensive Renal Disease – MORT • Heart Disease (ED/H) • Hypertension (ED/H) • Stroke (ED/H) • Tobacco Usage (Adults & Teens)	
HIV/AIDS/STDs • HIV/AIDS (ED) • STD - Chlamydia • STD - HIV Hospitalizations • STD - HIV Prevalence • STD - No HIV Screening	• Diagnosis, management, and treatment of STIs • Incidence/prevalence • Lack of continuity between health systems and public health • Need for reproductive health education • Stigma/discrimination • Vulnerable populations
VV sourced indicators • STIs (ED/H)	

Healthy Eating and Active Living (HEAL)	
Quantitative Indicators	Qualitative Indicators
• Breastfeeding (Any) • Breastfeeding (Exclusive) • Commute to Work - Alone in Car • Commute to Work - Walking/Biking • Diabetes Hospitalizations • Diabetes Management (Hemoglobin A1c Test) • Diabetes Prevalence • Economic Security - Commute Over 60 Minutes • Food Environment - Fast Food Restaurants • Food Environment - Grocery Stores • Food Environment - WIC-Authorized Food Stores • Food Security - Food Desert Population • Fruit/Vegetable Expenditures • Low Fruit/Vegetable Consumption (Adult/Youth) • Obesity (Adult/Youth) • Overweight (Adult/Youth) • Park Access • Physical Inactivity (Adult/Youth) • Recreation and Fitness Facility Access • Soft Drink Expenditures • Transit - Walkability • Walking/Biking/Skating to School	• Biking • CalFresh (EBT) and WIC • Community gardens • Cost barriers • Cost of healthy food • Cultural barriers • Need for education and classes • Farmers markets • Food access issues • Food deserts • Food distribution • Gyms • Lack of motivation • Lack of sidewalks or bike lanes • Lack of time • Lack of transportation • Natural environment (trails and rivers) • Perishability of fresh foods • Public parks/pools • Recreation opportunities • Safety • School physical activity • Technology and screen time • Unhealthy food options • Walking and walkability
VV sourced indicators • Diabetes Mellitus – MORT • Modified Retail Food Environment Index (MRFEI) • Osteoporosis (ED/H)	
Pollution-Free Living and Work Environments	
• Air Quality - Ozone (O3) • Air Quality - Particulate Matter 2.5 • Asthma - Prevalence • Climate & Health - Canopy Cover • Commute to Work - Alone in Car • Drinking Water Safety • Low Birth Weight • Mental Health - Poor Mental Health Days • Mortality - Ischemic Heart Disease • Obesity (Adult/Youth) • Physical Inactivity (Adult/Youth) • Tobacco Expenditures • Tobacco Usage (Adults) • Transit - Public Transit within 0.5 Miles • Transit - Road Network Density	• Air quality • Environmental hazards/toxins (cockroaches, mold, mildew, asbestos) • Respiratory conditions (asthma, COPD, infections, allergies) • Second hand smoke (tobacco and marijuana) • Transportation

<table>
<tr><th colspan="2">Pollution-Free Living and Work Environments (continued)</th></tr>
<tr><td>Quantitative Indicators</td><td>Qualitative Indicators</td></tr>
<tr><td>VV sourced indicators
• Asthma (ED)
• Chronic Lower Respiratory Disease – MORT
• COPD (ED/H)
• Heart Disease (ED/H)
• Pollution Burden Score
• Tobacco Usage (Adults and Teens)</td><td></td></tr>
<tr><th colspan="2">Safe, Crime and Violence-Free Communities</th></tr>
<tr><td>• Alcohol - Excessive Consumption
• Alcohol - Expenditures
• Liquor Store Access
• Major Crimes (Violent Crimes, Property Crimes, Larceny/Theft, Arson)
• Mortality - Homicide
• Mortality - Motor Vehicle Accident
• Mortality - Pedestrian Accident
• Physical Inactivity (Adult/Youth)
• Transit - Walkability
• Violence - All Violent Crimes
• Violence - Assault (Crime)
• Violence - Assault (Injury)
• Violence - Domestic Violence
• Violence - Rape (Crime)
• Violence - Robbery (Crime)
• Violence - School Expulsions
• Violence - School Suspensions
• Violence - Youth Intentional Injury</td><td rowspan="2">• Alcohol abuse
• Bullying
• Child abuse and trauma
• Child Protective Services
• Domestic Violence
• Drug dealing
• Gang violence
• Gun and knife violence
• Hate crimes
• Homicide
• Human Trafficking
• Motor vehicle accidents
• Pedestrian accidents
• Prostitution
• Rape and sexual assault
• Substance Use
• Tension with police
• Theft</td></tr>
<tr><td>VV sourced indicators
• Assault (ED/H)
• Major Crimes (Violent Crimes, Property Crimes, Larceny/Theft, Arson)
• Rate of Law Enforcement Calls for Domestic Violence/Intimate Partner Violence
• Substance Abuse (ED/H)
• Unintentional Injury (ED/H)</td></tr>
</table>

Significant Health Needs

While all of these potential health needs exist within the HSA to a greater or lesser extent, the purpose was to identify those that were most significant. A health need was determined to be significant through extensive analysis of the secondary and primary data for the HSA.

For the secondary (quantitative) data, indicators were flagged that compared unfavorably to state benchmarks or had evident racial/ethnic group disparities. Indicators from the CHNA-DP were flagged if: (a) the HSA value performed poorly (>2% or 2 percentage point difference) or moderately (between 1-2% or 1-2 percentage point difference) compared to the state benchmark; or (b) a given indicator had one or more racial/ethnic group disparities where a given racial/ethnic group performed poorly (>2% or 2 percentage point difference) compared to the value for the HSA. Indicators sourced by Valley Vision were flagged if they compared unfavorably to benchmark by any amount, as presented in Table 27 below.

Table 27. Measures for PHN Identification and Benchmark Comparisons

Indicator	HSA Value	Indicator Flag Criteria
Alzheimer's Disease	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Assault (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Assault (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Asthma (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Breast Cancer (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Breast Cancer (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Chronic liver disease and cirrhosis – MORT	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Chronic Lower Respiratory Disease - MORT	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Colorectal Cancer (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Colorectal Cancer (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
COPD (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
COPD (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Dental/Oral Diseases (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Dental/Oral Diseases (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Diabetes (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Diabetes Mellitus – MORT	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Domestic Violence/Intimate Partner Violence	Maximum Rate for Associated Agencies	Exceeds State Benchmark
Essential Hypertension & Hypertensive Renal Disease – MORT	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Gonorrhea – Incidence	Maximum Rate for Associated County	Exceeds State Benchmark
Health Professional Shortage Area - Mental Health	HSA Intersects Mental Health Shortage Area	HSA intersects HPSA
Heart Disease (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Heart Disease (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
HIV/AIDS (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Hypertension (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Hypertension (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Life Expectancy at Birth	Calculated HSA Rate from ZCTA rates	Below State Benchmark
Lung Cancer (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Lung Cancer (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Major Crimes	Maximum Rate for Associated Agencies	Exceeds State Benchmark

Mental Health (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Mental Health (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Modified Retail Food Environment Index (MRFEI)	Calculated HSA Rate from ZCTA rates	Below State Benchmark
Osteoporosis (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Osteoporosis (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Percent Single Female Headed Households in Poverty	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Pollution Burden Score	Percent of HSA ZCTAs that intersect census tract within the top 20% of pollution burden scores in the state	Exceeds 25% of ZCTAs in the HSA
Population 5 Years or Older who speak Limited English	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Population with Any Disability	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Population with Public Insurance	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Prenatal Care	Calculated HSA Rate from ZCTA rates	Below State Benchmark
Prostate Cancer (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Prostate Cancer (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Self-Inflicted Injuries (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Self-Inflicted Injuries (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
STIs (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
STIs (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Stroke (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Stroke (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Substance Abuse (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Substance Abuse (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Tobacco Usage (adults and teens)	Maximum Rate for Associated County	Exceeds State Benchmark
Unintentional Injury (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Unintentional Injury (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark

For the primary (qualitative) data, the number of sources referring to each potential health need was totaled to generate a percentage for each PHN category. A source (e.g. key informant or community member focus group interview) was considered to refer to a heath need if either a health outcome or related condition pertaining to the health need was mentioned by the source. In some cases, a reference could be applied to more than one PHN category.

A potential health need was identified as significant if it met or exceeded the thresholds determined by:

1. 50% of secondary data indicators compared unfavorably to benchmarks and/or;
2. 75% of primary data sources referred to the health need and/or;
3. 25% of primary data sources identified the health need as having a high level of priority/importance.

Health needs that met or exceeded the thresholds for both the primary and secondary data categories were given a score of two (2 points); health needs that met or exceeded the thresholds for only one of the categories were given a score of one (1 point). The health needs were then ranked so that those with two points were put into a higher tier for prioritization than

those with one point. Finally, the percentage of importance was used as a way to prioritize the significant health needs. The prioritized significant health needs are displayed in Table 28.

Table 28. Prioritization of significant health needs within tiers by percentage of importance from community input

PHN Category	QUANT	QUAL	SCORE	IMPORTANCE
	50%	75%		25%
1. Behavioral Health	64%	98%	**2**	**55%**
2. HEAL	53%	96%	**2**	**47%**
3. Safe Communities	81%	96%	**2**	**30%**
4. Basic Needs	60%	98%	**2**	**28%**
5. Access to Care	41%	96%	**1**	**45%**
6. Disease Prevention and Management	75%	74%	**1**	**28%**
7. Pollution Free Communities	58%	49%	**1**	**3%**

Resource Identification Process

The following process was used to identify the resources available to address the significant health needs and catalog them for inclusion in the final CHNA report.

1. A search was conducted to develop a comprehensive list of the resources available in the HSA to address the significant health needs. First, all resources identified in the 2013 CHNA report were included for consideration. Secondly, qualitative data from key informant interviews and focus groups were analyzed to include the resources identified by community input. The organizations and agencies that participated in key informant interviews and focus groups were also included as resources in the comprehensive list of all resources available to address the significant health needs.
2. After compiling the initial list, a verification process was conducted to assure that each resource was current and actively available. This included a thorough Internet search as well as phone verification as needed.
3. Once all resources on the list had been confirmed, each resource was considered in relation to the significant health needs for the HSA. As best as possible, each resource was assessed to determine which of the health needs it most closely addressed.

The final list of health resources is available in Appendix J.

APPENDIX E: Focus Communities Methodology

The identification of Focus Communities was an integral part of the CHNA process. These identified Focus Communities were defined as geographic areas (ZIP codes) within the HSA that had the greatest concentration of social inequities that may result in poor health outcomes.

Focus Communities were defined following an analysis of social inequities data as the census tract and ZIP code levels (Table 30), as well as mapped by GIS systems, initial input from key informant interviews and consideration of ZIP codes that were identified as Focus Communities in the 2013 CHNA (previously called Communities of Concern). The Focus Communities determined for KFH-Sacramento are listed in Table 29 along with socio-demographic data for these communities that can be compared to the county and state benchmarks.

Table 29. Demographics of Focus Communities

	ZIP	TPOP	MINO	LENG	NDIP	UEMP	PVFC	PVEL	PVSF	RENT	UINS
	95605	14160	56.2	15.5	24.8	16.2	32.6	6	33.1	59	18.3
	95652	836	37.9	2.4	6	15.9	40.6	0	73.6	100	10.2
North Highlands	95660	32835	46	9.69	16.9	12	26.5	2.99	43.3	44.4	19.6
Rancho Cordova	95670	53259	44.4	8.44	10.3	13.2	21.7	1.43	39.2	42.3	15.3
West Sacramento/ Broderick	95691	35485	52	8.36	17.1	10.8	18.4	1.11	40.3	36.7	15.9
West Woodland	95695	37686	49.7	10	20.8	11	14.1	3.59	27.6	46	15.9
Downtown/Midtown Sacramento	95811	7370	46.7	4.24	13.2	14.6	50.3	1.91	70.2	88.9	20.8
Downtown/Midtown Sacramento	95814	9802	49.6	8.79	18.4	9.4	58.6	5.73	77.8	91.3	14.4
North Sacramento	95815	25627	66.1	12	30.5	24.1	46.4	2.51	72.5	64.5	20.4
Watt/Marconi	95821	33190	38.1	4.54	13.8	18.9	33.7	2.25	54	54.2	16
Arden-Arcade	95825	31505	50.2	6.93	12.7	15.3	37.3	2.1	54.3	75.2	22.6
South Natomas	95833	38264	68.6	6.63	15.9	16.8	22.1	1.03	30	52.6	15.8
West and North Natomas	95834	24201	72.2	8.36	10.6	12.9	22.4	1.23	40.7	58.5	15
Del Paso Heights	95838	35584	73	10.4	30.1	16.7	34.5	3.13	54.5	49.3	20.2
Old Foothill Farms	95841	18612	35.5	9.5	16.3	15	34.5	2.68	51.3	62.2	21.3
SACRAMENTO		1435207	52.1	7.12	14.1	13.7	20.1	1.92	37.6	43.3	14.6
SUTTER		94787	50.2	10.9	21.7	15	20.1	2.1	42.3	40.4	18.9
YOLO		202288	50.6	7.89	15.7	10.4	14.7	2.09	28.8	47.1	13.2
CALIFORNIA		37659181	60.3	10.8	18.8	11.5	17.8	2.26	36.8	44.7	17.8

TPOP	Total Population
MINO	Percent Minority
LENG	Population 5 Years or Older who speak Limited English
NDIP	Percent 25 or Older Without a High School Diploma
UNEMP	Percent Unemployed
PVFC	Percent Families with Children in Poverty
PVEL	Percent Households 65 years or Older in Poverty

PVSF	Percent Single Female Headed Households in Poverty
RENT	Percent Renter Occupied Households
UINS	Percent Uninsured
Source: 2013 American Community Survey 5-year Estimate	

Table 30. Social Inequities and Community Health Vulnerability Index (CHVI) Indicators used to determine Focus Communities

- Median income
- GINNI coefficient (measure of income inequality)
- Population in poverty (under 100 Federal Poverty Level)
- Percent with public assistance
- Percent households 65 years or older in poverty
- Percent families with children in poverty
- Percent single female headed households in poverty
- Percent unemployed
- Percent Non-White or Hispanic population
- Foreign born population
- Citizenship status
- Population 5 Years or Older who speak Limited English
- Single female headed households
- Percent homeowners with housing expenses greater than 30% of income (homes with mortgages)
- Percent homeowners with housing expenses greater than 30% of income (homes without mortgages)
- Percent renters with housing expenses greater than 30% of income
- Uninsured population
- Population with public insurance
- Population with any disability
- Population over 18 that are civilian veterans
- Percent renter occupied housing units
- Percent population 25 or older without a high school diploma

Note: variables were analyzed at the census tract and ZIP code levels, as well as mapped by Geographical Information Systems (GIS).

APPENDIX F: Informed Consent

Informed Consent

Gathering Information for a Community Health Assessment

Purpose:
You have been invited to participate in a community health assessment. This assessment will help to inform area leaders on the specific needs of the communities which they serve. We will focus our questions on two main topics: 1) the health status of the community at large, and 2) the factors that help or prevent community members from living a healthy life. The information we gather from you will be combined with that of other interviews and focus groups. We will summarize these findings and report these to local leaders in your area.

Procedures:
The interview will capture your own experiences and opinions about community health issues. Completion of the questionnaire and the interview will take about 1 hour. We will also record and later transcribe the session. All identifying information will be removed from the transcripts and at the end of the project the recording will be destroyed.

Potential Risks or Benefits:
Some of the interview questions may be emotionally charged; otherwise there are no risks that we are aware of to answering the questions presented. There are no direct benefits to participating in this interview.

Participant's Rights:
Both completion of a short questionnaire and participation in this interview are completely voluntary; you may choose to not participate and terminate your involvement at any time.

Confidentiality and Anonymity:
Should you choose to participate, you will receive a copy of this consent form. The information you provide and anything you share with us will be kept in the strictest confidence. We will list your organization and or job title in the final report and may use quotes from the transcript of your interview; however, these ***will not*** be associated with your name directly. These forms and any information you provide will be kept in a secure location and there will be no link between the information we collect and this document.

How to obtain Additional Information:
If you have any questions or comments regarding this document, interview or final report please contact: **Anna Rosenbaum,** Health Equity Manager at **Valley Vision (**www.valleyvision.org) 916-325-1630.

I hereby agree to participate in this interview, understand that I will be provided a copy of this consent form for my own records, and acknowledge that my responses will be recorded.

Participant Name (Print)	Interviewer Name (Print)
Participant Signature Date	Interviewer Signature Date

Informed Consent

Gathering Information for a Community Health Assessment

Purpose:
You have been invited to participate in a focus group for a community health needs assessment. This assessment will help to inform area leaders on the specific needs of the communities which they serve. We will focus our questions on two main topics: 1) the general health of the community, and 2) the factors that help or prevent community members from living a healthy life. The information we gather from you will be combined with that of other interviews and focus groups. We will summarize these findings and report these to local leaders in your area.

Procedures:
The focus group will capture your own experiences and opinions about community health issues. Completion of the questionnaire and the focus group will take about 90 minutes. We will also record and later transcribe the session. All identifying information will be removed from the transcripts and at the end of the project the recording will be destroyed.

Potential Risks or Benefits:
Some of the focus group questions may be emotionally charged otherwise there are no risks that we are aware of to answering the questions presented. Benefits include contributing to an important health assessment, along with compensation outlined below.

Participant's Rights:
Both completion of a short questionnaire and participation in this focus group are completely voluntary; you may choose to not participate and terminate your involvement at any time.

Compensation:
For your participation in the focus group you will be given a $10 gift card to a local retail outlet. Gifts cards will be distributed after completion of the focus group. If you are not able to complete the focus group you will not receive a gift card.

Confidentiality and Anonymity:
Should you choose to participate, you will receive a copy of this consent form. The information you provide and anything you share with us will be kept in the strictest confidence. We may use quotes from the focus group transcript; however they will not be associated with your name directly. These forms and any information you provide will be in a secure location and there will be no link between the information we collect and this document.

How to obtain Additional Information:
If you have any questions or comments regarding this document, the questionnaire, focus group, or final report please contact: **Anna Rosenbaum,** Data Manager at **Valley Vision** (www.valleyvision.org) 916-325-1630 (office).

I hereby agree to participate in this focus group, understand that I will be provided a copy of this consent form for my own records, and acknowledge that my responses will be recorded.

Participant Name Print	Interviewer Name Print
Participant Signature Date	Interviewer Signature Date

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Consentimiento Informado

Acumulando Información para conducir una Evaluación de las Necesidades de Salud de la Comunidad

Objetivo:
Usted ha sido invitado a participar en un grupo de enfoque para la evaluación de las necesidades de la salud de la comunidad. Esta evaluación le ayudará a informar a los líderes de la zona en las necesidades específicas de las comunidades a las que sirven. Nuestras preguntas se concentraran en dos temas principales: 1) la salud general de la comunidad, y 2) los factores que ayudan o que impiden a los miembros de la comunidad vivir una vida saludable. La información que juntamos de usted será combinada con los resultados de otras entrevistas y grupos de enfoque. Vamos a resumir estas conclusiones y reportar éstos resultados a los líderes de su área.

Procedimientos:
El grupo de enfoque captura tus propias experiencias y opiniones sobre temas de la salud de la comunidad Realización de un cuestionario y el grupo de enfoque tomara aproximada mente un hora y media (1 ½). Nos gustaría grabar la sesión y luego transcribir la. Toda la información de identificación será borrada de las transcripciones y al final del proyecto, la grabación será destruida.

Riesgos Potenciales o Beneficios:
Algunas preguntas pueden ser emocionalmente cargadas, a lo contrario, no hay ningún riesgo que estemos consciente al contestar las preguntas presentadas. Los beneficios por su participación en este grupo de enfoque incluye la oportunidad de participar en una evaluación importante y una tarjeta de regalo de 10 dólares (más detalles abajo).

Los Derechos del Participante:
La participación en este grupo de enfoque y en el cuestionario es completamente voluntaria, usted puede decidir a no participar y puede terminar su participación en cualquier momento que usted desea.

Compensación
Recibirá una tarjeta de regalo de $10 para una tienda local por participar en el grupo de enfoque. Después de completar el grupo de enfoque, le daremos la tarjeta de regalo. Si no eres capaz de completar el grupo de enfoque no recibirá tarjeta de regalo.

Confidencialidad y Anonimato
Si usted decide participar, usted recibirá una copia de esta forma de consentimiento. La información que usted nos dará será mantenida con la confidencialidad más estricta. Usted no será identificado en ninguna manera, su nombre no aparecerá en ningún documento y sólo el investigador tendrá el acceso a estos documentos. Estas formas y cualquier información coleccionada serán guardadas en una ubicación segura y no habrá ningún enlace entre la información que coleccionamos y este documento.

Como obtener más Información:
Si tienes preguntas en par de esta forma, el cuestionario, el grupo de enfoque o el reporte final, póngase en contacto con **Giovanna Forno,** de **Valley Vision** (www.valleyvision.org) 916-325-1630 (oficina).

Por este medio consiento en participar en el grupo de enfoque y reconozco que mis repuestas serán grabadas. También entiendo que me van a dar una copia de esta forma de consentimiento para mis propios archivos.

Nombre del Participante	Nombre del Entrevistador
Firma del Participante Fecha	Firma del Entrevistador Fecha

APPENDIX G: Demographic Forms

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Key Informant Questionnaire

Please complete this short questionnaire, which will give us more information about your professional experience, role and expertise working with special populations. Your answers to these questions will be combined with that of other key informants and cannot be used to identify you individually.

1. What sector do you work in? (Choose only one)

- ☐ Academic/Research
- ☐ Community Based Organization
- ☐ Health Care - Department/Division: _____
- ☐ Public Health - Department/Division: _____
- ☐ Social Services - Department/Division: _____
- ☐ Other (define): _____

2. What is your primary job classification? (Choose all that apply)

- ☐ Administrative or clerical personnel
- ☐ Community Health Worker/Promotora
- ☐ Community Organizer/Advocate
- ☐ Epidemiologist
- ☐ Environmental health worker
- ☐ Health Educator
- ☐ Medical Assistant
- ☐ Nurse
- ☐ Nutritionist
- ☐ Patient Navigator
- ☐ Physician
- ☐ Program Manager/Coordinator
- ☐ Senior Leadership/Upper Management
- ☐ Social Worker/Case Manager
- ☐ Other (define): _____

3. How would you define the geographic area served by your organization?

_____

_____

4. Do you work with any of the following vulnerable populations? (Choose all that apply)

- ☐ Low-Income
- ☐ Medically underserved
- ☐ Racial or ethnic minority (specify): _____
- ☐ Other (specify): _____
- ☐ Other (specify): _____

Thank you for your participation!

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Self-Report Demographic Data Card

Gathering Information for a Community Health Assessment

Please share…
Tell us a little about you….

This questionnaire helps us to gain more information about our community participants. Your answers to the following questions will be confidential and anonymous and cannot be used to identify you personally. Please note completion of this questionnaire is completely voluntary.

For each of the following, please choose ONE that describes you best:

1. **What is your gender identity (example: male, female, transman, transwoman, please specify)?**

   _____

2. **What is your ethnicity?**

   ☐Hispanic/Latino ☐Not Hispanic/Latino

3. **Please check ONE or MORE racial group(s) that describe you:**

   ☐African American/Black
   ☐Asian
   ☐Hawaiian Native/Pacific Islander
   ☐Hispanic/Latino only
   ☐Native American/Alaska Native
   ☐White/Caucasian
   ☐Other (Specify):_____

4. **What year were you born?** _____

5. **Please check the highest level of school you have completed.**

   ☐ High school graduate (diploma or the equivalent, for example, GED)
   ☐ NOT a high school graduate (diploma or the equivalent, for example, GED)

6. **What is your ZIP code of residence (where you live)?** _____

7. **Do you currently participate in any of the following programs? Choose ALL that apply.**

   ☐ CalFresh (Food Stamps, SNAP, EBT)
   ☐ CalWORKS (TANF)
   ☐ Head Start
   ☐ Medi-Cal
   ☐ Reduced Price School Meal
   ☐ Section 8 Public Housing
   ☐ Supplemental Security Income (SSI)
   ☐ Women, Infants, & Children (WIC Program)

8. **Are you CURRENTLY covered by any type of health insurance?**

   ☐Yes ☐No

Thank you for your participation!

Tarjeta de Datos Demográficos

Acumulando Información para conducir una Evaluación de las Necesidades de Salud de la Comunidad

Cuéntanos un poco acerca de usted…

Este cuestionario nos ayudará a obtener más información acerca de nuestros participantes de la comunidad. Tus respuestas serán confidenciales y anónimas y no se pueden utilizar para identificarte. Tu participación en este cuestionario es voluntaria.

Por cada pregunta, por favor elije UNO que te describe mejor:

1. **¿Con cuál genero identificas? (ejemplo: femenino, masculino, transexual, otro)**

_____

2. ¿Cuál es tu raza?

☐ Latino/Hispano ☐ No Latino/ Hispano

3. Por favor marca UNO o MÁS grupos raciales que te describe:

☐Afroamericano/Negro
☐Asiático
☐Nativo de Hawái/Isleño del Pacifico
☐Solamente Latino/Hispano
☐Nativo Americano/Nativo de Alaska
☐ Caucásico/Blanco
☐ Otro (especifica):_____

4. ¿En qué año naciste? _____

5. Por favor marca el nivel más alto de la escuela que haya completado:

☐ Graduado de la escuela segundaria, (diploma o el equivalente, por ejemplo, el GED)

☐ No un graduado de la escuela secundaria, (diploma o el equivalente, por ejemplo, el GED)

6. ¿Cuál es tu código postal de residencia (donde usted vive)?_____

7. ¿Participa en alguno de los siguientes programas? Elija TODOS que correspondan:

☐ CalFresh (Cupones De Alimentos, SNAP, EBT)
☐ CalWORKS (TANF)
☐ Head Start
☐ Medi-Cal
☐ Comidas escolares gratis y reducido de precio
☐ Vivienda interés social
☐ Seguridad de ingreso suplementario (SSI)
☐ Programa Mujeres, bebes y niños (WIC)

8. ¿Está usted cubierto por algún tipo de seguranza de salud?

☐Si ☐No

¡Gracias por participar!

APPENDIX H: Interview Guides

Key Informant Interview Guide - Questions

1. **Please, tell me (us) about the community you serve.**
   - *Follow up*: What are the specific geographic areas and/or populations served?

2. **How would you describe the quality of life in the community you serve?**

3. **Please describe the health of the community you serve.**
   - *Follow up:* What are the biggest health issues and/or conditions that your community struggles with?

4. **Of the health issues you've mentioned, which would you say are the most important or urgent to address?**
   - *Follow up:* How would you rank these health issues in terms of importance?

5. **What specific locations struggle with health issues the most?**
   - *Follow up*: What specific groups in the community struggle with these health issues the most?

6. **What are the challenges to being healthy for the community you serve?**

7. **What policies, laws, or regulations prevent the community from living healthy lives?**

8. **What resources exist in the community to help people live healthy lives?**

9. **What would you say has been the impact of the Affordable Care Act** [may also be known as Covered California, Obamacare] **on the community you serve?**

10. **What is** [or *who* is] **needed to improve the health of your community?**

11. **Can you recommend 1 or 2 additional people, groups or organizations you think would be most important to speak to about the health of the community?**

12. **Is there anything else you would like to share with our team about the health of your community** [that hasn't already been addressed]**?**

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Focus Group Guide- Questions

1. **Please, tell us about the community you live in.**
    - Follow Up: What are the specific neighborhoods?
    - Follow Up: What types of people live there (race, age, legal status)?

2. **How would you describe the quality of life in your community?**

3. **How would you describe the health of the community where you live?**

4. **Of the health issues you've mentioned, which would you say are the most important or urgent to address?**
    - Follow up: How would you rank these health issues in terms of importance?

5. **What specific neighborhoods or places in your community struggle with health issues the most?**
    - Follow up: What specific groups in the community struggle with these health issues the most?

6. **What are the challenges to being healthy in your community?**

7. **What rules or laws prevent your community from being healthy?**

8. **What resources exist in your community to help people live healthy lives?**

9. **What would you say has been the impact of universal health care coverage** [may also be known as Covered California, Obamacare, ACA] **on your community?**

10. **What is needed to improve the health of your community?**

11. **Is there anything else you would like to share with our team about the health of your community [that hasn't already been addressed]?**

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Focus Group Guide- Youth

1. **Please, tell us generally about the community you live in.**
    - What are the specific neighborhoods? What types of people live there?
    - How would you describe your neighborhood to someone who has never been there?
    - How would you describe the physical environment?

2. **Is life easy or difficult for most people? Why?**
    - What does everyday life look like for most people?

3. **What are the biggest health issues that people in your community struggle with?**
    - What health issues do you see or hear about from friends and family?

4. **What specific groups of people in your community struggle with health issues the most?**
    - Do you see any differences in health by age, race, gender, sexual orientation, legal status?
    - Where do these groups live?

5. **What are the challenges to being healthy in your community?**
    - Do people engage in healthy or unhealthy behavior where you live?
    - Is it easy or hard to make healthy choices in your neighborhood? (e.g. access to healthy foods, places to exercise, access to health care)
    - Is your neighborhood supportive of health? (e.g. sidewalks, safe streets, safe places to exercise, social supports)

6. **Of the health issues we've talked about, which would you say are the most important or urgent to address?**
    - How would you rank these health issues in terms of importance?

7. **What resources exist in your community to help people live healthy lives?**
    - What are the barriers to accessing these resources?
    - What are gaps in these resources? What resources are missing?

8. **What is needed to improve the health of your community?**

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Guía de Grupo de Enfoque

Acumulando Información para conducir una Evaluación de las Necesidades de Salud de la Comunidad

1. **Por favor, díganme de la comunidad adonde ustedes viven.**
   - **Seguimiento:** ¿Cuáles son los barrios específicamente?
   - **Seguimiento**: ¿Qué tipos de personas viven allí? (edad, raza, genero, estatus legal)

2. **¿Cómo es la vida en la comunidad adonde ustedes viven?**

3. **Por favor, describen la salud de la comunidad adonde ustedes viven**

4. **¿De los problemas de salud que han comentado, cuales son los más importantes de resolver?**
   - **Seguimiento**: ¿Estos son los problemas de salud que han dijeron… cuales son los más importantes/urgentes de resolver?

5. **¿Qué grupos específicos (*tipos de gente por edad, raza, genero, estatus legal*) en tu comunidad luchan lo más con estos problemas de salud?**
   - **Seguimiento**: **¿Qué áreas o barrios específicos luchan con problemas de salud lo más?**

6. **¿Cuáles son las barreras para vivir saludable en la comunidad adonde ustedes viven?**

7. **¿Qué tipos de leyes, reglas, o prácticas impiden tu comunidad de vivir saludable?**

8. **¿Qué recursos existen en tu comunidad para ayudar las personas vivir saludable?**

9. **¿El Affordable Care Act ha impactado la comunidad adonde ustedes viven?** [también se conoce como Covered California, Obamacare]

10. **¿Qué es necesario para mejorar la salud de tu comunidad?**
    - **Seguimiento: ¿Hay algún tipo de persona que podría ayudar mejorar la salud de la comunidad?**

11. **¿Hay algo más que les gustaría compartir con nosotros la salud de la comunidad?**
    - **Seguimiento: ¿Hay preguntas?**

APPENDIX I: Project Summary Sheet

Key Informant Project Summary Sheet

2016 Community Health Needs Assessment – Greater Sacramento Region
Project Summary
January 2015 – June 2016

Project Management:

Valley Vision - www.valleyvision.org, (916) 325-1630
2320 Broadway, Sacramento, CA 95818

- **Anna Rosenbaum**, **MSW, MPH** Senior Project Manager, anna.rosenbaum@valleyvision.org
- **Amelia Lawless, MSW, MPH** Project manager, amelia.lawless@valleyvision.org
- **Giovanna Forno**, **BA** Project Fellow, giovanna.forno@valleyvision.org
- **Sarah Underwood**, **MPH** Project Manager, sarah.underwood@valleyvision.org

Organization Information:

Valley Vision is a social enterprise that tackles economic, environmental and social issues. Our vision is a prosperous and sustainable region for all generations. Founded in 1994, Valley Vision provides research, collaboration, and leadership services to make the greater Sacramento Region prosperous and sustainable. We have conducted CHNAs for the four hospital systems the region since 2007.

Project Overview:

The 2016 Community Health Needs Assessment (CHNA) is a collaborative project that assesses the health status of communities in the Sacramento region. Nonprofit hospitals are required to conduct CHNAs every three years and to adopt implementation plans that address the community health needs identified through the assessment. CHNAs collect input from broad interests across the community, including hospitals, public health, residents and other stakeholders. The findings help hospitals to understand the health status and needs of the communities they serve, and to direct their community benefits programs and activities accordingly. The 2013 CHNA reports are available online at www.healthylivingmap.com, and the 2016 reports will be available in the spring of 2016.

Key Deliverables:

Each CHNA report will:

- Describe the health status of the community served by a hospital facility;
- Identify significant health issues that exist within the community and the factors that contribute to those health issues;
- Determine priority areas and actions for health improvement; and
- Identify potential resources that can be leveraged to improve community health.

Strategic Partners:

Lead project consultation:
Dr. Heather Diaz
Associate Professor, Community Health Education
Dept of Kinesiology & Health Sciences
CSU Sacramento

Data collection, analysis and GIS mapping:
Dr. Mathew C. Schmidtlein
Assistant Professor
Dept of Geography
CSU Sacramento

Transcription and translation services:
Cherie Yure
Southern California Transcription Services

Project Orientation:

Health status indicators will be compiled in a database and analyzed to identify geographic areas in each hospital service area (HSA) where socio-economic and demographic factors result in health disparities. Interviews with health service providers and community key informants will be conducted to better understand the health needs of the communities served by each hospital facility. Focus groups will be conducted with medically underserved, low-income, and minority populations to understand their unique and specific health needs and barriers to care. The health needs identified within each HSA will be categorized and organized to identify the significant health needs within each HSA and to prioritize these significant health needs. All findings will be compiled into a comprehensive report that will inform the healthcare systems in creating implementation plans to direct their community benefit programs and activities.

Project Sponsors:

Community Project Summary Sheet

2016 Community Health Needs Assessment (CHNA)

About the CHNA Project

About the CHNA

The 2016 Community Health Needs Assessment (CHNA) is a collaborative project that looks at the health of the Sacramento region. The four nonprofit hospital systems in the region (Sutter, UC Davis, Kaiser and Dignity) work together to conduct health assessments of the communities they serve. The assessments are then used by the hospital systems to develop plans to improve the health of these communities.

The CHNA Reports

Each CHNA report includes:

- A description of the health of the community served by a hospital facility;
- The health issues within the community and the factors contributing to those health issues;
- The areas and communities that are most affected by these health issues;
- The health needs that are most important to improve overall health for the community;
- Potential resources and services that are available to improve community health.

Previous CHNA reports are available online at http://www.healthylivingmap.com (see 2013 CHNA Reports), and the 2016 reports will be available in the Fall of 2016.

How the Project Works

To get information about the health of the community, we talk to many different groups of people including medical providers, public health workers, community organizations, and residents. We ask people to share information with us about: (1) the health issues they see and experience in their communities; (2) the challenges and opportunities to be healthy in their communities; and (3) the resources that may or may not be available to help people live healthy lives. We then look for patterns or themes in what we hear from the community and identify the priority health needs to be included in the CHNA reports. The reports are then used to help the hospital systems decide which community services and programs to support.

About Us

Valley Vision is an organization that works on economic, environmental and social issues. Our vision is to help create a healthy region for all generations through learning about the community, working with other organizations and helping to lead teams of people. We have worked with the four hospital systems in the Sacramento region on this project since 2007.

The Team

Valley Vision - www.valleyvision.org, (916) 325-1630
2320 Broadway, Sacramento, CA 95818

- **Anna Rosenbaum**, Senior Project Manager, anna.rosenbaum@valleyvision.org
- **Amelia Lawless**, Project Manager: amelia.lawless@valleyvision.org
- **Sarah Underwood**, Project Manager: sarah.underwood@valleyvision.org
- **Giovanna Forno**, Project Fellow: giovanna.forno@valleyvision.org

Project Sponsors

Community Project Summary Sheet – Spanish

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Evaluación de las necesidades de salud de la comunidad- 2016

Acerca de la evaluación

Acerca de la evaluación

La evaluación de las necesidades de salud de la comunidad del año 2016 es un proyecto colaborativo que analiza la salud de la región de Sacramento. Los cuatro sistemas de hospitales sin fin de lucros en la región (Sutter, UC Davis, Kaiser y Dignity) trabajan juntos para conducir evaluaciones de la salud de las comunidades que ellos sirven. Los resultados de las evoluciones son usados por los sistemas de hospitales para desarrollar planes para mejorar la salud de estas comunidades.

Que incluye la evaluación

Cada evaluación incluye:

- Una descripción de la salud de la comunidad atendida por un centro hospitalario
- Los problemas de salud en la comunidad y los factores que contribuyen a esos problemas de salud
- Las zonas y comunidades que son las más afectadas por estos problemas de salud
- Las necesidades de salud que son las más importante de mejorar para la salud general de la comunidad
- Los recursos y servicios potenciales que están disponibles para mejorar la salud de la comunidad

Evaluaciones anteriores están disponibles por la página http://www.healthylivingmap.com (vea 2013 CHNA Reports), y los reportes de 2016 serán disponibles en el otoño de 2016.

Como se conduce la evaluación

Para obtener información de la salud de la comunidad, hablamos con muchos diferentes grupos de gente incluyendo proveedores médicos, trabajadores de salud pública, organizaciones comunitarias y residentes. Pedimos que personas comparten información con nosotros acerca de (1) los problemas de salud que ellos ven y experiencia en sus comunidades, (2) los desafíos y oportunidades para vivir saludable en sus comunidades y (3) los recursos potenciales que son disponibles para ayudar personas vivir saludable. Después, buscamos patrones o temas en lo que escuchamos de la comunidad para identificar las necesidades de salud prioritarios que serán incluidos en el reporte final. Los reportes son usados para ayudar los sistemas de hospitales decidir cuales servicios y programas comunitarias apoyar.

Acerca de Valley Vision

Valley Vision es una organización que trabaja en problemas económicos, ambientes y sociales. Nuestra visión es ayudar creer una región saludable para todas generaciones atreves de aprender de nuestra comunidad, trabajar con otras organizaciones y ayudar a liderar equipos de gente. Hemos trabajado con los cuatro sistemas de hospitales en la región de Sacramento en este proyecto desde el año 2007.

Nuestro Equipo

Valley Vision - www.valleyvision.org, (916) 325-1630
2320 Broadway, Sacramento, CA 95818

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Patrocinadores del proyecto

Dignity Health · KAISER PERMANENTE · Sutter Health We Plus You · UCDAVIS HEALTH SYSTEM

Focus Group Outreach Flyer

You're invited to a group conversation!

Please join us for a 1 ½ hour discussion about the health and wellness of your community. We would like your thoughts

Date:
Time:
Location:

We will provide food and a $10 gift card to those who come.

Thanks for helping us learn about the health needs of your community!

Questions? Contact (PM) at Valley Vision, 916.325.1630

Focus Group Outreach Flyer - Spanish

Por favor acompáñenos a platicar sobre la salud y bienestar de su comunidad. Nos gustaría saber su opinión sobre los problemas de salud donde usted vive.

¿Cuando?
¿A Qué hora?
¿Donde?

¡Vamos a servir almuerzo y regalar una tarjeta de regalo a cada participante!

Agradecemos su participación en la evaluación de las necesidades de salud en la región de Sacramento del año 2016

ix J – Resources Available to Address Significant Health Needs for KFH-Sacramento

me	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
n 4	Arden-Arcade	Yes	X	X	X	X			X
	Arden-Arcade	Yes	X		X		X		X
tion	Midtown Sacramento	Yes					X		
y	Arden-Arcade	Yes	X		X				
n	North Sacramento	Yes			X				
	North Highlands	Yes	X			X	X		
iation-	Midtown Sacramento	Yes				X	X		
	North Sacramento	Yes	X	X					
ity	Tahoe Park	Yes			X				
	South Sacramento, Citrus Heights, Oak Park	Yes		X					

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
Bayanihan Clinic	North Sacramento	Yes	X						
Birth and Beyond Programs	North Highlands, North Sacramento, Rancho Cordova	Yes	X	X	X				
Boys and Girls Clubs of Greater Sacramento	North Sacramento	Yes		X	X		X		X
Breathe California of Sacramento- Emigrant Trails	Downtown Sacramento	Yes	X			X		X	
Bryte and Broderick Community Action Network	West Sacramento	Yes		X					
Building Healthy Communities (BHC)	South Sacramento	Yes					X		X
C.O.R.E Medical Clinic	Midtown Sacramento	Yes	X		X				
Center for AIDS Research, Education and Services- CARES Community Health	Midtown Sacramento	Yes	X		X		X		
Center for Community Health and Well Being Inc. (partnered with Peach Tree Health)	Midtown Sacramento	Yes	X						

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
Central Downtown Food Basket	East Sacramento, Midtown Sacramento	Yes		X			X		
Child Abuse Prevention Center	North Highlands	Yes							X
Children's Receiving Home of Sacramento	Arden-Arcade	Yes	X	X	X		X		
Clara's House	Midtown Sacramento	Yes	X						
Clean and Sober Homeless Recovery Communities	Downtown Sacramento	Yes			X				
Clinica Tepati (located within WellSpace Clinic)	Midtown Sacramento	Yes	X						
CommuniCare	Davis, West Sacramento, Woodland, Esparto (dental only)	Yes	X		X	X	X		
Cordova Lane Center - Folsom Cordova USD	Rancho Cordova	Yes		X	X				
Cordova Recreation & Park District	Rancho Cordova	Yes		X	X		X		

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
Crisis Nursery Program-Sacramento Children's Home	Arden-Arcade	Yes	X		X				X
Del Oro Caregiver Resource Center	Citrus Heights	Yes				X			
Department of Human Assistance	Arden-Arcade, North Sacramento	Yes		X					
Dignity Health	Rancho Cordova	Yes	X						
El Hogar Community Services Inc.	Natomas, Downtown Sacramento	Yes		X	X				X
Elica Health Centers	Midtown Sacramento	Yes	X						
Empower Yolo	Woodland	Yes		X	X				X
Eskaton	Carmichael	Yes	X	X	X				
Firehouse Community Center	North Sacramento	Yes					X		
First 5 Sacramento	North Sacramento	Yes	X	X	X	X	X	X	X

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
First 5 Yolo	Woodland	Yes	X	X	X	X	X	X	X
Folsom Cordova Community Partnership	Rancho Cordova	Yes	X	X	X				
Fourth & Hope	Woodland	Yes		X	X				
Francis House	Downtown Sacramento	Yes		X					
Gender Health Center	Oak Park	Yes	X	X	X				X
Golden Days Adult Day Health	West Sacramento	Yes	X						
Goodwill- Sacramento Valley & Northern Nevada	Rosemont	Yes		X					
Greater Sacramento Urban League	North Sacramento	Yes		X					
Guest House Homeless Clinic	Downtown Sacramento	Yes	X		X				
Head Start- Yolo County Office of Education	Woodland	Yes		X		X	X		
Health Education Council	West Sacramento	Yes					X		X

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
Health For All Community Clinics	Downtown Sacramento, North Sacramento, South Sacramento	Yes	X	X					
Helping Hearts Foundation Inc.	Rancho Cordova	Yes		X					X
Heritage Oaks Hospital	Arden-Arcade	Yes	X		X				
HIV/Communicable Disease Prevention	Rosemont	Yes	X						
Hmong Women's Heritage Association	South Sacramento	Yes			X				
Interim HealthCare/Interim HomeStyle Services	Arden-Arcade	Yes	X		X				
Johnston Community Center	Arden-Arcade	Yes		X			X		
Kaiser Permanente Fair Oaks Boulevard Medical Offices	Arden-Arcade	Yes	X			X	X		
Kaiser Permanente Point West Medical Offices	Point West	Yes	X			X			
Kaiser Permanente Rancho Cordova Medical Offices	Rancho Cordova	Yes	X			X	X		

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
Kaiser Permanente Sacramento Medical Center	Arden-Arcade	Yes	X						
La Familia Counseling Center, Inc.	South Sacramento	Yes	X	X	X		X		X
Legal Services of Northern California- Health Rights	Downtown Sacramento	Yes		X					
Life Matters	Foothill Farms	Yes		X					
Loaves and Fishes	Downtown Sacramento	Yes	X	X	X				
McClellan VA Clinic	McClellan	Yes	X						
Meals on Wheels Sacramento	Rocklin	Yes		X					
Mercy Clinic - Loaves & Fishes	Downtown Sacramento	Yes	X						
Mercy Housing	South Sacramento	Yes		X					
Mercy San Juan Medical Center	Carmichael	Yes	X		X	X	X		
Mexican Consulate General in Sacramento	Natomas	Yes		X					X

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
Molina Healthcare	North Sacramento, Citrus Heights	Yes	X						
Mutual Assistance Network (MAN)	North Sacramento	Yes		X	X		X		
My Sister's House	South Sacramento	Yes	X	X	X				X
Neil Orchard Senior Activities Center	Rancho Cordova	Yes					X		
New Testament Baptist Church	North Highlands	Yes	X	X	X				X
Next Move	Oak Park	Yes	X	X					X
Paratransit, Inc.	South Sacramento	Yes							
Paul Hom Asian Clinic	East Sacrameno	Yes	X						
People Reaching Out	North Highlands	Yes			X				
Pioneer Congregational United Church of Christ	Midtown Sacramento	Yes		X					
Planned Parenthood B Street Health Center	Midtown Sacramento	Yes	X			X			

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
Planned Parenthood Capitol Plaza Center	Downtown Sacramento	Yes	X			X			
Planned Parenthood North Highlands Health Center	North Highlands	Yes	X			X			
Planned Parenthood Woodland Health Center	Woodland	Yes	X			X			
PRIDE Industries	Auburn, Fair Oaks, Grass Valley, North Sacramento, North Highlands, Placerville, South Scramento, Woodland	Yes		X					
RISE Inc.	Esparto	Yes		X					
River City Food Bank	Midtown Sacramento	Yes					X		
River Oak Center for Children	North Highlands	Yes			X				
Roberts Family Development Center	North Sacramento	Yes		X			X		

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
Sacramento Area Congregations Together (Sacramento ACT)	Rosemont	Yes	X	X					
Sacramento Chinese Community Services Center (SCCS)	Downtown Sacramento	Yes			X		X		
Sacramento City Unified School District	South Sacramento	Yes	X	X	X				
Sacramento County Department of Health and Human Services	South Sacramento	Yes	X		X	X	X	X	X
Sacramento County Department of Health and Human Services- Public Health Department	South Sacramento	Yes	X			X	X	X	
Sacramento Covered	Rosemont	Yes	X						
Sacramento Employment and Training Agency (SETA)	North Sacramento	Yes		X					
Sacramento Food Bank and Family Services	Oak Park	Yes		X			X		
Sacramento Housing and Redevelopment Agency (SHRA)	Downtown Sacramento	Yes		X					

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
Sacramento Junior Giants	South Sacramento	Yes					X		
Sacramento LGBT Community Center	Midtown Sacramento	Yes		X					X
Sacramento Life Center (SLC)	Midtown Sacramento	Yes	X						
Sacramento Native American Health Center, Inc.	Midtown Sacramento	Yes	X		X	X	X		X
Sacramento Steps Forward	North Sacramento	Yes		X					
Sacramento Tree Foundation	North Sacramento	Yes						X	
Sacramento Works Job Center	Galt, Rancho Cordova, South Sacramento, North Sacramento	Yes		X					
Saint John's Program for Real Change	South Sacramento	Yes		X	X				
SeniorCare PACE	South Sacramento, Downtown Sacramento	Yes	X			X	X		

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
SETA Head Start	North Sacramento	Yes		X		X	X		
Sherrif Community Impact Program	Arden-Arcade	Yes			X		X		X
Shingle Springs Tribal TANF Program	El Dorado, Sacramento, Shingle Springs	Yes		X					
Sierra Health Foundation	North Sacramento	Yes	X		X	X	X		X
Slavic Assistance Center	Arden-Arcade	Yes		X					
Smile Keepers - Dental Health Program	Rosemont	Yes	X						
St. John's Shelter Program for Women and Children	Rosemont	Yes	X	X	X		X		
St. Vincent de Paul Sacramento Council	Broderick	Yes		X					
Stanford Settlement	North Sacramento	Yes		X			X		
Strategies for Change	North Highlands	Yes		X	X				X

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
Su Familia- The National Hispanic Family Health Helpline	Washington, D.C	Yes	x						
Suicide Prevention and Crisis Services of Yolo County	Davis	Yes			x				
Sutter Center for Psychiatry	Rosemont	Yes			x				
Sutter Davis Hospital	Davis	Yes	x		x	x	x		
Sutter Medical Center	Midtown Sacramento	Yes	x		x	x			
Terra Nova Counseling	Midtown Sacramento, Natomas	Yes			x				
The Birthing Project Clinic	Midtown Sacramento	Yes	x						
The Keaton Raphael Memorial	Sacramento	Yes	x			x			
The Mental Health Association in California	Midtown Sacramento	Yes			x				
The Salvation Army	Rosemont	Yes		x					
The Salvation Army- Adult Rehabilitation Center	Downtown Sacramento	Yes			x				

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
The SOL Project- Saving Our Legacy, African Americans for Smoke-Free Safe Places	Downtown Sacramento	Yes			x				
TLCS (Transitional Living and Community Support)	Arden-Arcade	Yes	x	x	x				
Turning Point Community Programs	Rancho Cordova	Yes		x	x				
U.S Department of Veterans Affairs- Sacramento Vet Center	Arden-Arcade	Yes		x	x				
UC Davis	Davis	Yes		x					
UC Davis Medical Center	Oak Park	Yes	x		x		x		
VA Northern California Health Care System	Mather	Yes	x	x	x				
Volunteers of America-Northern California & Norther Nevada	Arden-Arcade	Yes		x					
WALK Sacramento	Downtown Sacramento	Yes					x		
WarmLine Family Resource Center	Downtown Sacramento	Yes	x	x					

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
WEAVE	Midtown, South Sacramento	Yes		x	x				x
Wellness and Recovery Center- Consumer Self Help	Rancho Cordova	Yes			x				
WellSpace Health	Downtown, Midtown, North Highlands, Rancho Cordova	Yes	x	x	x	x			x
WellSpace Health Residential Treatment Center	North Sacramento	Yes			x				
West Sacramento Community Center	West Sacramento	Yes					x		
Western Career College Dental Clinic	Rosemont	Yes	x						
WIC Sacramento	South Sacramento	Yes	x			x	x		
Wind Youth Services	Midtown Sacramento	Yes		x	x				
Winter's Healthcare Foundation	Winters	Yes	x		x				
Women's Empowerment	Midtown Sacramento	Yes		x	x				
Women's Health Specialists	Arden-Arcade, Rancho Cordova	Yes	x						

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities
Woodland Community & Senior Center	Woodland	Yes		x			x		
Woodland Healthcare	Woodland	Yes	x		x	x		x	
YMCA of Superior California	Downtown Sacramento	Yes		x			x		x
Yolo Adult Day Health Center	Woodland	Yes	x	x	x	x			
Yolo Center for Families	Davis, Knights Landing, West Sacramento, Woodland	Yes	x	x			x		x
Yolo County Children's Alliance	Davis	Yes	x	x					
Yolo County Health and Human Services	Woodland	Yes	x	x	x	x	x		
Yolo County Housing Office	Woodland	Yes		x					
Yolo County WIC	Woodland, West Sacramento	Yes	x			x	x		
Yolo Food Bank	Woodland	Yes		x					
Yolo Healthy Aging Alliance	Woodland	Yes			x				
YWCA	Midtown Sacramento	Yes		x	x				

Additional Assets	Resource Guides
	211 Sacramento http://www.211sacramento.org/211/online-database/
	Community Resources for Older Adults http://ssvmsa.org/resources/Documents/1116554_CommunityResources_073115.pdf
	People's Guide to Health, Welfare and Other Services: Sacramento County (2014-2015) http://www.sachousingalliance.org/wp-content/uploads/2012/10/Peoples-Guide-FINAL-Draft-7-21-14.pdf
	SACPROS Mental Health Resources http://www.sacpros.org/Pages/default.aspx
	Sacramento Steps Forward: Resource Guide for People Experiencing Homelessness http://sacramentostepsforward.org/wp-content/uploads/2013/08/Resource-Guide_1.pdf
	Yolo County Health and Human Services Resource Guide http://www.yolocounty.org/home/showdocument?id=26314
	Yolo Healthy Aging Alliance Resource Page http://yhaa.nfshost.com/?page_id=36

Additional Assets	Community Assets *Reported in Key Informant Interviews and Focus Groups*
	Churches and faith-based organizations
	Federally Qualified Health Care Centers
	Legislation (Mental Health Services Act, Older Adults Act)
	Public libraries
	Recreational opportunities (parks, rivers, trails)
	Senior services: adult day health centers, caregiver respite services

Sources include: Primary data from community input (key informant interviews and focus groups), the CHNA 2013 Resource Section, and organizations that contributed to the 2016 CHNA process.