2016 Community Health Needs Assessment

Kaiser Foundation Hospital Roseville
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September 21, 2016

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CHNA REPORT FOR KFH-ROSEVILLE

Acknowledgements

This report was prepared by Valley Vision on behalf of Kaiser Foundation Hospital-Roseville 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 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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Table of Contents

List of Tables

List of Figures

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 and substance abuse)** is a significant health need in the Kaiser Foundation Hospital (KFH)-Roseville Hospital Service Area (HSA). Ten of 13 indicators (77%) pertaining to mental health and eight of 12 indicators (67%) pertaining to substance abuse compare unfavorably to state benchmarks or demonstrate racial/ethnic disparities in health status. The issue of mental health is marked by high rates of suicide, a low rate of mental health providers, high rates of emergency department (ED) visits for mental health conditions and self-inflicted injury, and high hospitalization (H) rates for mental health conditions. The death rate from Alzheimer's disease is also high compared to the state rate for Alzheimer's mortality. Substance abuse issues are evident from high percentages of alcohol consumption and expenditures, high rates of tobacco usage for teens and adults, and high ED/H rates for substance abuse and Chronic Obstructive Pulmonary Disease (COPD) compared to the state. Of 51 key informant interviews and community member focus groups, 50 mention health issues or drivers related to access to behavioral health services as a health need. Input from service providers and community members indicate 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-Roseville HSA, with 17 of 30 indicators (57%) performing poorly compared to state benchmarks or demonstrating racial/ethnic disparities related to HEAL. The need for healthy eating and active living is marked by a slightly higher rate of adults who report being obese as compared to the state, and higher rates of overweight and obesity for Black and Hispanic/Latino youth compared to other racial/ethnic groups and the overall rate for the HSA. The need for a focus on HEAL is evident in measures of the food environment: there are fewer grocery stores and a larger number of people living in areas designated as food deserts compared to the rest of the state. In addition, a greater percentage of the population depends on a car for transportation and a higher percentage of workers commute alone in their cars relative to the state. Of 51 key informant interviews and community member focus groups, 50 mention health issues or drivers related to HEAL as a health need. Input from service providers and community members indicate that there is a need for affordable and accessible options for healthy eating and active living.

3. **Disease prevention, management and treatment** is a significant health need in the KFH-Roseville HSA. Thirty-six of 64 indicators (56%) related to the need for disease prevention and management compare unfavorably to state benchmarks, including 20 of 31 (65%) cancer indicators and eight of 13 (62%) asthma indicators. Incidence rates for breast cancer, prostate cancer and lung cancer all exceed state rates, and ED/H rates also exceed state benchmarks for these cancers. The need for asthma prevention, management and treatment is also evident; the HSA has a higher prevalence of asthma and higher rates of ED visits for asthma compared to the state. Related health issues that demonstrate the need to focus on disease prevention and management include a high rate of adult obesity in the HSA as well as a high rate of tobacco usage by teens and adults. Environmental factors that may contribute to the need include poor air quality from elevated ozone and particulate matter levels as well as secondhand smoke from tobacco usage. Of 51 key informant interviews and community member focus groups, 40 mention health issues or drivers related to disease prevention and management as a health need. Service providers and community members most frequently mention breast and colorectal cancer as sources of concern and express the need for education, prevention and screening services to be more widely available.

4. **Safe, violence-free communities** are a significant health need in the KFH-Roseville HSA. Fifteen of 26 indicators (58%) pertaining to violence and safety perform poorly compared to state benchmarks, particularly for racial/ethnic minorities in the HSA. The HSA rates for unintentional injury ED/H are also above the state benchmark, and crime statistics for major crimes (violence crimes, property crimes and arson) and domestic violence are elevated compared to the state. Specific geographic areas within the HSA are disproportionately affected by violence; for example, ED/H rates for assault are particularly high in the Foothill Farms/Antelope/Citrus heights and Placerville areas. Additional indicators that may relate to violence and safety include a high percentage of alcohol consumption and expenditures, a high rate of school suspensions for youth, and high ED/H rates for substance abuse compared to the state. Of 51 key informant interviews and community member focus groups, 42 mention health issues or drivers related to safe, crime and violence-free communities as a health need. Input from service providers and community members indicate that substance abuse is a major contributor to violence and lack of real and perceived safety in neighborhoods.

5. **Affordable and accessible transportation** is a significant health need in the KFH-Roseville HSA. Six of eight indicators (75%) pertaining to transportation compare unfavorably to state benchmarks. The need for public transportation is marked by low access to public transportation, a higher percentage of workers who commute alone in their cars, and a greater percentage of the population that is car-dependent relative to the state. The lack of public transportation can affect access to timely healthcare and employment options and contribute to air pollution owing to over-reliance on transportation in personal vehicles. There is also a need for active transportation options, demonstrated by a low percentage of the population that commutes to work by walking or riding a bike and a low percentage of children and teens who report walking, biking or skating to school compared to the state. Active commutes to work and school can improve physical activity levels and reduce the risk of cardiovascular disease, obesity, and hypertension as well as decrease air pollution. Of 51 key informant interviews and community member focus groups, 37 mention health issues or drivers related to transportation as a health need. Service providers and community members frequently mention that the lack of transportation options creates barriers to accessing health care services, healthy food options and employment opportunities.

6. **Access to high quality health care and services** is a significant health need in the KFH-Roseville HSA. Nine of 32 indicators (28%) pertaining to access to care perform poorly compared to state benchmarks, particularly for racial/ethnic minorities in the HSA. The need for improved access to dental care is marked by high percentages of adults with poor dental health and high percentages of youth who haven't had a dental exam in the last year compared to the state. ED/ H rates for dental/oral disease are also high for the HSA relative to the state. The portion of El Dorado County

that falls within the HSA is designated as a provider shortage area for primary care, and a high percent of uninsured reside in the Foothill Farms and Antelope areas as well as more rural communities such as Olivehurst, Sheridan, Georgetown, Greenwood and Garden Valley. Of 51 key informant interviews and community member focus groups, 51 mentioned health issues or drivers related to access to health care services as a health need. Input from service providers and community members indicates that access to primary care services and specialty care providers is a challenge, particularly for patients with Medi-Cal coverage.

7. **Pollution free living and work environments** are a significant health need in the KFH-Roseville HSA. Sixteen of 26 indicators (62%) relating to pollution compare unfavorably to state benchmarks. Air quality is a significant issue; a high percentage of days per year exceed ozone and particulate matter standards compared to the state. Contributors to poor air quality may include the high road network density, low access to public transportation and a higher percentage of workers who commute alone in their cars. Related health issues may include: a high prevalence and rate of ED visits for asthma, high rates of mortality for Chronic Lower Respiratory Disease and ED/H rates for Chronic Obstructive Pulmonary Disorder, and high rates of mortality and ED visits for Heart Disease compared to the state. Pollution burden scores are worst in the following areas of the HSA: Old/Central Roseville close to the rail yards; areas of high traffic density around Interstate 80; and agricultural and rural areas such as Wheatland, Olivehurst, Shingle Springs and the town of El Dorado. Of 51 key informant interviews and community member focus groups, 25 mention health issues or drivers related to pollution free living and work environments as a health need. Community input suggests that poor air quality is particularly acute in the foothills during the summer months owing to grass and forest fires that have increased with the California drought and that the poor air quality contributes to and exasperates asthma, COPD and other respiratory conditions.

8. **Basic needs (food, housing, employment and education)** are a significant health need in the KFH-Roseville 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. In the KFH-Roseville HSA, seven of 25 indicators (28%) pertaining to basic needs perform poorly compared to state benchmarks, particularly for racial/ethnic minorities in the HSA. Poverty is highest in the Foothill Farms, Citrus Heights, Placerville, Wheatland and Olivehurst areas; life expectancy is lowest in the Antelope, Citrus Heights, Garden Valley, Auburn, Applegate, Wheatland and Olivehurst areas. Of 51 key informant interviews and community member focus groups, 51 mention themes related to basic needs such as food, housing, employment and education. Community input on vulnerable locations points to areas such as North Sacramento and North Highlands as well as “pockets” of poverty throughout Placer County including Lincoln, Central/Old Roseville, North Auburn and small foothill communities. Themes relating to unmet basic needs include the high cost of living in Placer County, lack of affordable housing, and coverage gaps for middle-income families who do not quality for public assistance benefits but struggle to make ends meet. Providers and community members suggest that improved public education and employment opportunities, affordable housing and comprehensive health care coverage are needed to improve the socio-economic prospects and health of vulnerable populations and locations within the HSA.

C. Summary of Needs Assessment Methodology and Process

The Community Health 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 from these major health systems including three Kaiser Foundation Hospitals (KFH): 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, an initial set of data looking at upstream indicators, such as poverty and educational attainment, were compiled and analyzed at the census tract and ZIP code levels as well as mapped by GIS systems. Focus Communities were identified within the HSA from analysis of these socio-economic inequity variables and from a first phase of primary data collection which included interviews with the public health officer and key service providers 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 then used to help the second phase of primary data collection which included additional key informant interviews and Focus Groups with medically-underserved, low-income and minority populations.

To assess overall health status and disparities in health outcomes, indicators were identified 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-Roseville 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, all eight were validated as significant for the KFH-Roseville 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-Roseville 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 Roseville 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.

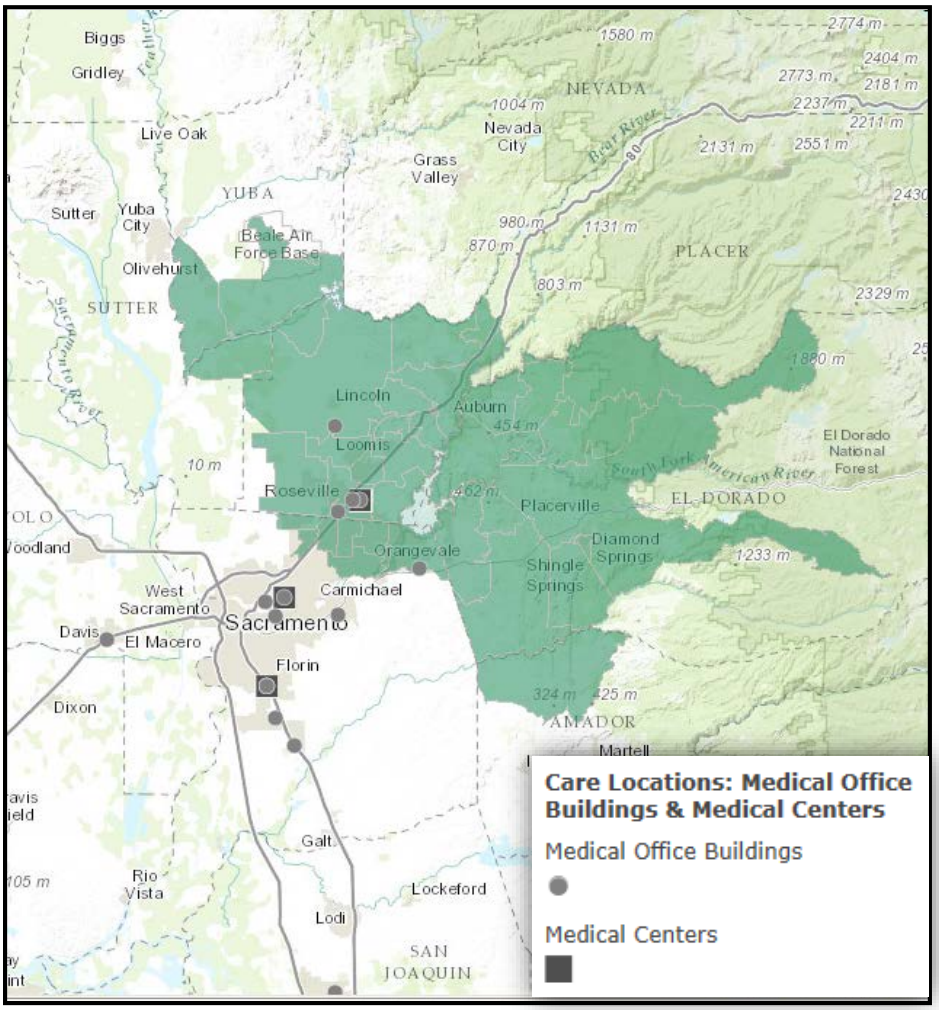
III. COMMUNITY SERVED

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-Roseville Hospital Service Area (HSA)



ii. Geographic description of the community served – KFH Roseville HSA

The KFH-Roseville HSA extends into parts of seven counties: Amador, El Dorado, Nevada, Placer, Sacramento, Sutter, and Yuba, with the highest concentration of the population residing in the Sacramento Valley. Geographically, the HSA principally includes Placer and El Dorado counties. The HSA has a very diverse geography: from urban cities such as North Highlands/Foothill Farms and Citrus Heights to suburban cities such as El Dorado Hills, Roseville, Lincoln and Auburn to more rural cities and towns such as Placerville and Olivehurst as well as numerous small communities throughout the Sierra foothills.

iii. Demographic profile of community served – KFH Roseville HSA

Table 1. KFH-Roseville Demographic Data	
Total Population	817,737
White	80.74%
Black	2.77%
Asian	6.5%
Native American/ Alaskan Native	0.82%
Pacific Islander/ Native Hawaiian	0.28%
Some Other Race	3.99%
Multiple Races	4.9%
Hispanic/Latino	13.8%

Table 2. KFH-Roseville Socio-economic Data	
Living in Poverty (<200% FPL)	25.32%
Children in Poverty	13.72%
Unemployed	7.9
Uninsured	10.29%
No High School Diploma	7.9%

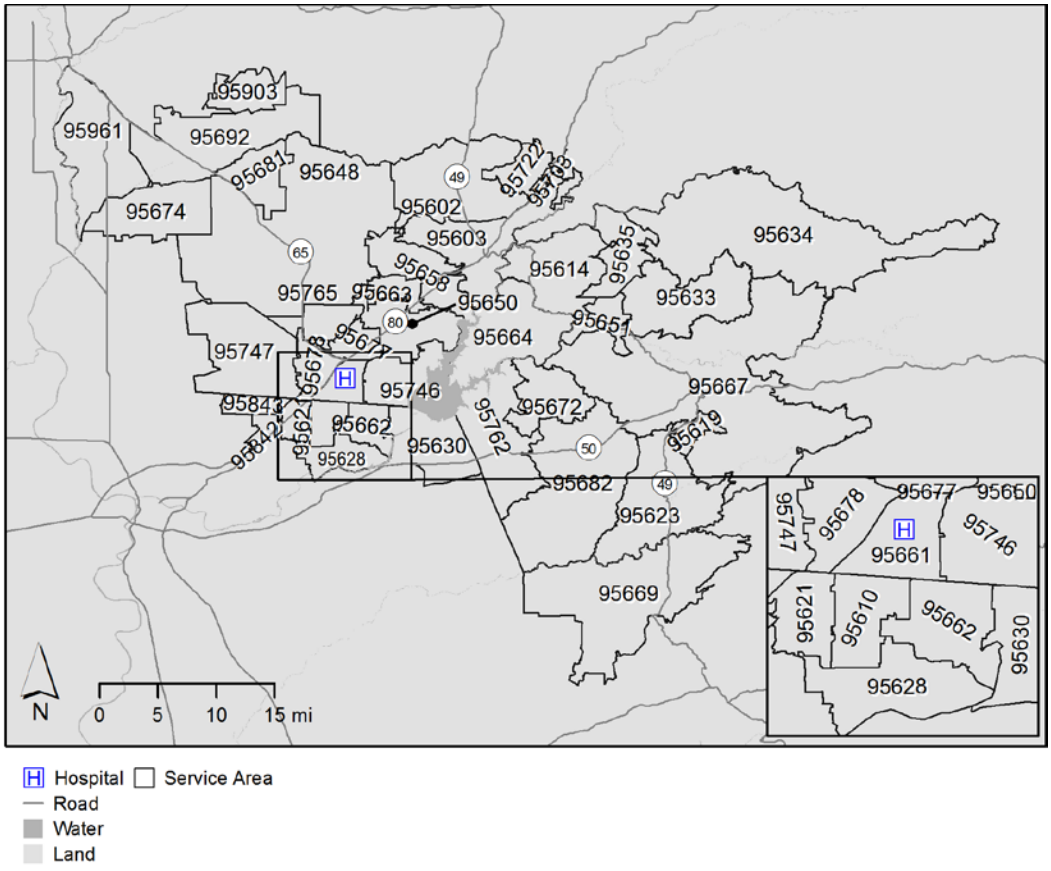


Figure 2. Map of the KFH-Roseville Hospital Service Area (HSA) by ZIP code

Table 3. Population, Median Age, Median Income and Percent Minority for All ZIP Codes in the HSA				
ZIP	**Population**	**Median Age**	**Med. Income**	**% Minority**
95842	31689	31.2	45537	44.8
95843	46775	32.5	65779	43.35
95903	1981	22.4	40000	34.98
95961	26753	29.9	46144	46.94
95692	4992	33.4	61627	34.25
95703	1055	45	75217	18.29
95722	4583	51.6	69231	9.92
95746	24012	44.7	127736	19.98
95747	53452	37.7	86595	28.66
95762	40829	40.7	119382	22.92
95765	35914	34.8	84417	31.54
95602	18049	49.6	64329	15.88
95603	28054	46.6	57779	16.6
95610	43333	36.4	50928	28.25
95614	4341	41.1	92721	3.87
95619	4893	40.1	57340	22.01
95621	41573	37.4	53134	27.32
95623	3913	47.6	62321	12.72
95628	40921	44.2	73720	21.16
95630	72462	37.7	98547	36.26
95633	3441	46.2	65603	17.98
95634	3080	48.2	56528	11.98
95635	921	52.9	43542	4.45
95648	48243	41.8	71713	27.23
95650	11741	44.6	79743	13.37
95651	451	48	55446	4.43
95658	6522	51.1	64821	13.7
95661	30269	42.1	69703	24.95
95662	31411	41.9	64991	16.87
95663	2332	45.4	125303	19.59
95664	1095	47.6	89141	15.15
95667	35924	48.9	57468	16.99
95669	2864	48.6	67770	13.23
95672	5273	49	93209	19.43
95674	739	43.2	78929	27.87
95677	22675	38.8	68160	21.02
95678	42606	32.7	60513	32.18
95681	992	44.7	73229	16.93
95682	29590	43.7	77718	17.59
El Dorado	180982	44.1	69297	20.27
Placer	355924	40.4	72725	24.55

Sacramento	1435207	35.1	55064	52.05
Yuba	72574	31.9	44902	42.11
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 Roseville, KFH Sacramento, KFH South Sacramento
- **Sutter Health Sacramento Sierra Region**: Sutter Auburn Faith Hospital, Sutter Center for Psychiatry, Sutter Davis Hospital, Sutter Medical Center – Sacramento, Sutter Roseville 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 35 organizations assisted the KFH-Roseville 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 their CHNA process and reports, as well as in 2010 and 2007 for the 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 Anna Rosenbaum, MSW, MPH, Project Lead for the CHNA project. Additional CHNA team members included: Amelia Lawless, CHES, ASW, MPH, Alan Lange, MPA, Giovanna Forno, BS, Katie Strautman, MSW, and Sarah Underwood, MPH. 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-Roseville 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-Roseville service area. Finally, resources available to address the significant health needs were compiled and the final report was written.

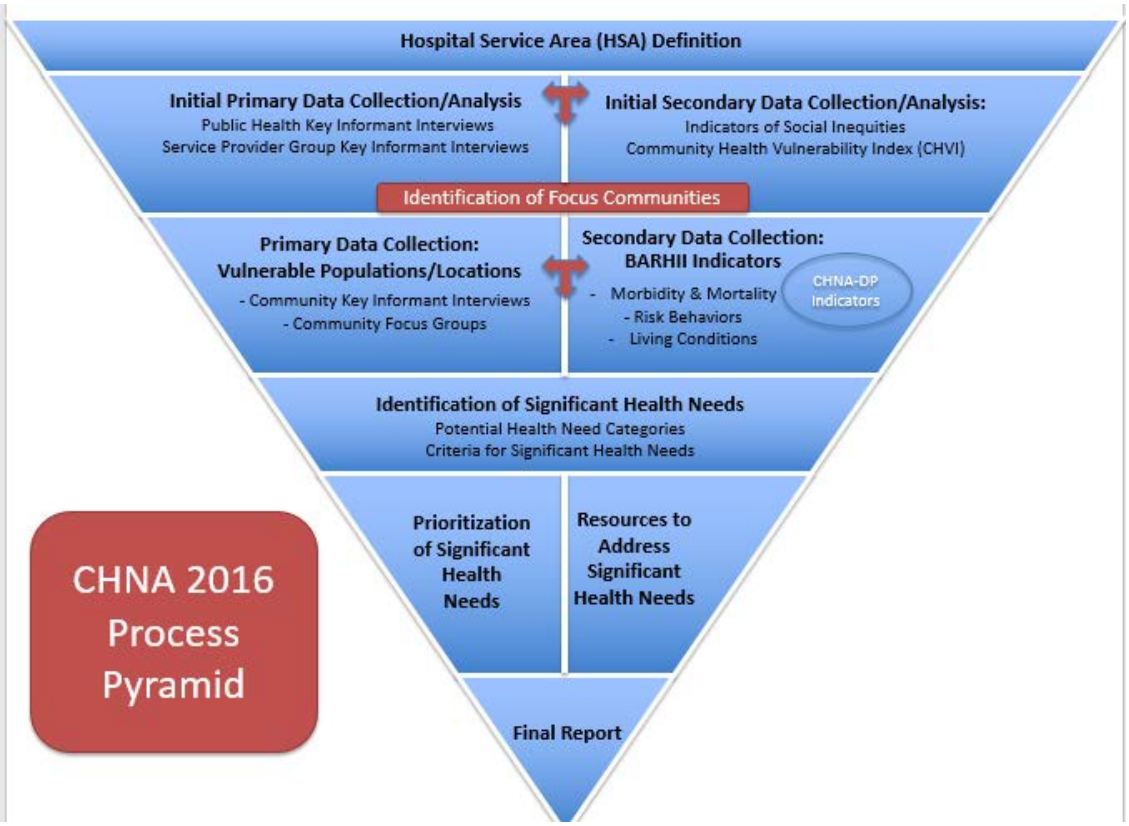


Figure 3. CHNA Process Model

The Focus Communities determined for KFH-Roseville 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-Roseville	
Community	**ZIP Code**
North Auburn	95602
Auburn	95603
Citrus Heights; Orangeville	95610
Citrus Heights; Antelope	95621
Lincoln	95648
Placerville	95667
Old/Central Roseville	95678
Foothill Farms; North Highlands	95842

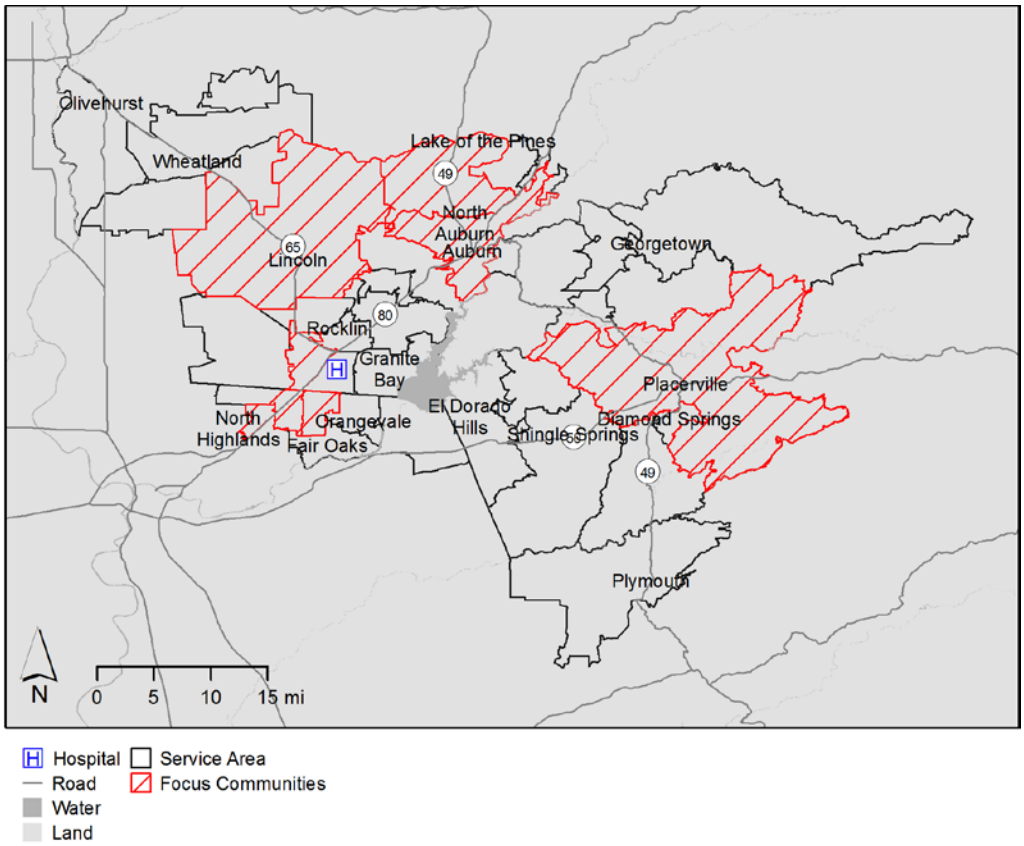


Figure 4. Map of Focus Communities

A. Secondary data

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

KFH Roseville 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, were 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) (see 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-Roseville 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.

ii. Methodology for collection and interpretation

Primary data were collected from May 2015-November 2015. Instruments used in primary data collection included a participant informed consent, a demographic questionnaire, the interview question guide and a project summary sheet. All participants were given an informed consent form prior to their participation that provided information about the project, asked for permission to record the interview, and listed the potential benefits and risks for involvement in the interview (Appendix E). Participants were also asked to complete a voluntary questionnaire to compile the demographics of all key informant and focus group participants (Appendix F). The same interview guide was used for key informant interviews and community focus groups with slight modifications for focus groups conducted in Spanish and focus groups with youth or low-literacy populations. In brief, the guide prompted participants to share: (1) the quality of life in their communities; (2) the health issues they see and experience in their communities; (3) the most urgent or priority health needs of their communities; and (4) the resources available to help address health needs (see Appendix G for full interview guide). A project summary sheet (Appendix H) was also given to all participants to provide them with information about the project as well as contact information for the CHNA staff leading the interviews.

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 37 key informant interviews were completed for the KFH-Roseville HSA with a cumulative total of 48 service providers participating in these interviews, which are listed in Appendix B. Primary data collection began with key informant interviews of hospital service experts, followed by interviews with service providers and focus groups with community members. Key informants represented the following sectors: academic research (4%), community based organizations (48%), health care (21%), public health (19%), and social services (15%), with some individuals representing multiple sectors. Of the 48 key informants, 27 (56%) indicated that they were senior leadership or upper management within their organizations or agencies. The key informants reported working with the following populations: low-income (94%), medically underserved (88%), and racial or ethnic minorities (75%). In addition, key informants specified working with the following racial and ethnic minority groups: Latino/Hispanic, African American, Asian Pacific Islander, Filipino, Native American/Alaska Native, Slavic and refugees from the former the Soviet Union. Key informants also specified working with the following

vulnerable sub-groups: people experiencing homelessness, individuals diagnosed with a developmental disability, individuals diagnosed with serious mental illness and/or substance abuse disorders, pregnant women, teen parents, single parents, undocumented individuals, those with language barriers, children ages 0-5, seniors, and individuals identifying as lesbian, gay, bisexual, and/or transgender (LGBT).

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-Roseville HSA, 15 focus groups were conducted with 152 participants representing medically underserved, minority and low-income populations and/or community members living in vulnerable locations. Of the approximately 144 participants who completed demographic data cards, the median age was 42 with a gender breakdown of 77% identified as female, 19% as male and 4% as other. In addition, 23% indicated they were not high school graduates, 14% indicated they were not covered by health insurance, and 63% received some form of public assistance. The self-identified racial composition of focus group participants is presented in Figure 5 below.

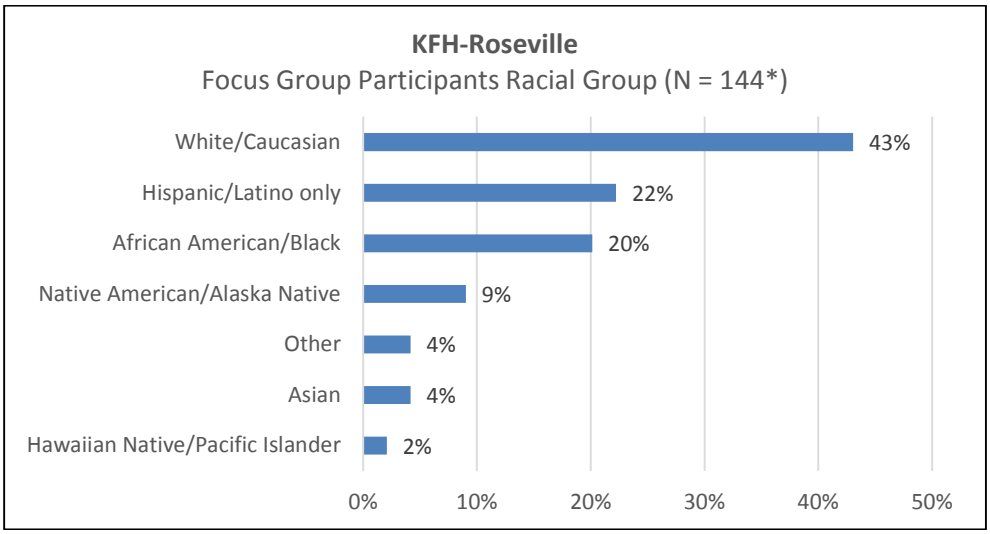


Figure 5. Participant Race/Ethnicity
*Demographic surveys were not completed by all participants.

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 need 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 Roseville 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-Roseville 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 preliminary health need categories in the KP CHNA data platform (CHNA-DP); 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 a PHN 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 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	72%	98%	**2**	**73%**
2. HEAL	57%	98%	**2**	**37%**
3. Disease Prevention/Management	56%	78%	**2**	**31%**
4. Safe Communities	58%	82%	**2**	**22%**
5. Transport	75%	73%	**2**	**6%**
6. Access to Care	28%	98%	**1**	**47%**
7. Basic Needs	25%	98%	**1**	**12%**
8. Pollution Free Communities	62%	49%	**1**	**0%**

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 and substance abuse)** is a significant health need in the Kaiser Foundation Hospital (KFH)-Roseville Hospital Service Area (HSA). Ten of 13 indicators (77%) pertaining to mental health and eight of 12 indicators (67%) pertaining to substance abuse compare unfavorably to state benchmarks or demonstrate racial/ethnic disparities in health status. The issue of mental health is marked by high rates of suicide, a low rate of mental health providers, high rates of emergency department (ED) visits for mental health conditions and self-inflicted injury, and high hospitalization (H) rates for mental health conditions. The death rate from Alzheimer's disease is also high compared to the state rate for Alzheimer's mortality. 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 also report needing mental health services compared to other groups and the HSA as a whole. Substance abuse issues are evident from high percentages of alcohol consumption and expenditures, high rates of tobacco usage for teens and adults, and high ED/H rates for substance abuse and Chronic Obstructive Pulmonary Disease (COPD) compared to the state.

   Of 51 key informant interviews and community member focus groups, 50 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: suicide among young adults, women and the elderly; heroin and opioid/prescription drug use; homelessness; acute mental health issues; 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, 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 (HEAL)** is a significant health need in the KFH-Roseville HSA, with 17 of 30 indicators (57%) performing poorly compared to state benchmarks or demonstrating racial/ethnic disparities related to HEAL. The need for healthy eating and active living is marked by a slightly higher rate of adults who report being obese as compared to the state, and higher rates of overweight and obesity for Black and Hispanic/Latino youth compared to other racial/ethnic groups and the overall rate for the HSA. The need for a focus on HEAL is evident in measures of the food environment: there are fewer grocery stores and a larger number of people living in areas designated as food deserts compared to the rest of the state. In addition, a greater percentage of the population depends on a car for transportation and a higher percentage of workers commute alone in their cars relative to the state. Health behaviors that may contribute to the need include low percentages of breastfeeding among Black, Asian and Hispanic/Latino mothers and high rates of physical inactivity among Black and Hispanic/Latino youth compared to other racial/ethnic groups and to the HSA.

Of 51 key informant interviews and community member focus groups, 50 (98%) mention health issues or drivers related to HEAL as a health need. Input from service providers and community members indicate that there is a need for affordable and accessible options for healthy eating and active living. Barriers to HEAL include the high cost of healthy foods, particularly for people on fixed incomes, and the relatively lower cost of unhealthy options such as fast food. Additional barriers include having to travel a long distance to buy healthy foods, sedentary lifestyles and lack of incentive to cook or exercise. In some urban areas concerns for personal physical safety can be a deterrent to exercise outdoors and rural communities may lack the infrastructure for active transportation options such as walking and biking. Providers and community members suggest that more health education is needed to promote healthy eating and active living, along with incentives to support behavior change and affordable and accessible recreation opportunities for all ages and ability levels.

3. **Disease prevention, management and treatment** is a significant health need in the KFH-Roseville HSA. Thirty-six of 64 indicators (56%) related to the need for disease prevention and management compare unfavorably to state benchmarks, including 20 of 31 (65%) cancer indicators and eight of 13 (62%) asthma indicators. The need for cancer prevention, detection and treatment is marked by a high overall death rate for cancer compared to the state, with even higher rates of cancer mortality among Non-Hispanic Whites, Blacks and Native Hawaiian/Pacific Islanders compared to other racial/ethnic groups and the rate for the HSA. Incidence rates for breast cancer, prostate cancer and lung cancer all exceed state rates, and ED/H rates also exceed state benchmarks for these cancers. The need for asthma prevention, management and treatment is also evident; the HSA has a higher prevalence of asthma and higher rates of ED visits for asthma compared to the state. Related health issues that demonstrate the need to focus on disease prevention and management include a high rate of adult obesity in the HSA as well as a high rate of tobacco usage by teens and adults. Environmental factors that may contribute to the need include poor air quality from elevated ozone and particulate matter levels as well as secondhand smoke from tobacco usage.

   Of 51 key informant interviews and community member focus groups, 40 (78%) mention health issues or drivers related to disease prevention and management as a health need. Service providers and community members most frequently mention breast and colorectal cancer as sources of concern and express the need for education, prevention and screening services to be more widely available. In particular, populations that are uninsured, underinsured, or speak a language other than English may have difficulty accessing preventative education and screening services. Poor air quality in the Sacramento Valley may also result in asthma and other respiratory issues that disproportionately affect vulnerable populations such as children, the elderly, and low-income populations. Input from providers and community members suggest that a focus on primary and secondary prevention is needed to lessen the burden of cancer and asthma in the HSA.

4. **Safe, violence-free communities** is a significant health need in the KFH-Roseville HSA. Fifteen of 26 indicators (58%) pertaining to violence and safety perform poorly compared to state benchmarks, particularly for racial/ethnic minorities in the HSA. Mortality rates for motor vehicle accidents and pedestrian accidents are higher for Blacks and homicide rates are higher for Blacks and Native Hawaiian/Pacific Islanders compared to rates for other racial/ethnic groups, the HSA and the state. The HSA rates for unintentional injury ED/H are also above the state benchmark, and crime statistics for major crimes (violence

crimes, property crimes and arson) and domestic violence are elevated compared to the state. Specific geographic areas within the HSA are disproportionately affected by violence; for example, ED/H rates for assault are particularly high in the Foothill Farms/Antelope/Citrus heights and Placerville areas. Additional indicators that may relate to violence and safety include a high percentage of alcohol consumption and expenditures, a high rate of school suspensions for youth, and high ED/H rates for substance abuse compared to the state.

Of 51 key informant interviews and community member focus groups, 42 (82%) mention health issues or drivers related to safe, crime and violence-free communities as a health need. Input from service providers and community members indicate that substance abuse is a major contributor to violence and lack of real and perceived safety in neighborhoods. Safety issues connected to substance abuse appear to be most prevalent among individuals experiencing homelessness, youth and rural populations; domestic violence is also frequently mentioned in conjunction with substance abuse. Additional vulnerable populations include seniors at risk of bullying/senior abuse and children at risk of child abuse/neglect and other adverse childhood experiences. Gang violence is also mentioned as an issue in the North Highlands/Foothill Farms area, particularly for adolescent youth. Providers and community members suggest that more substance abuse treatment options, peer education and harm reduction strategies, and employment opportunities are needed to reduce substance abuse and crime and improve neighborhood safety.

5. **Affordable and accessible transportation** is a significant health need in the KFH-Roseville HSA. Six of eight indicators (75%) pertaining to transportation compare unfavorably to state benchmarks. The need for public transportation is marked by low access to public transportation, a higher percentage of workers who commute alone in their cars, and a greater percentage of the population that is car-dependent relative to the state. The lack of public transportation can affect access to timely healthcare and employment options and contribute to air pollution owing to over-reliance on transportation in personal vehicles. There is also a need for active transportation options, demonstrated by a low percentage of the population that commutes to work by walking or riding a bike and a low percentage of children and teens who report walking, biking or skating to school compared to the state. Active commutes to work and school can improve physical activity levels and reduce the risk of cardiovascular disease, obesity, and hypertension as well as decrease air pollution.

   Of 51 key informant interviews and community member focus groups, 37 (73%) mention health issues or drivers related to transportation as a health need. Service providers and community members frequently mention that the lack of transportation options creates barriers to accessing health care services, healthy food options and employment opportunities. Community input suggests that the public transportation systems in the Sacramento region lack a coordinated infrastructure, which results in multiple transfers and longer commute times for riders. The suburban cities and rural towns are generally car-dependent communities that may be lacking public transportation options entirely. Transportation needs are particularly acute for the elderly, disabled and low-income individuals for whom the cost of transportation creates a financial hardship. Providers and community members suggest that shuttle services and/or bus tokens would be useful to facilitate access to health care and other services.

6. **Access to high quality health care and services** is a significant health need in the KFH-Roseville HSA. Nine of 32 indicators (28%) pertaining to access to care perform poorly compared to state benchmarks, particularly for racial/ethnic minorities in the HSA. A higher percentage of Blacks and Hispanic/Latinos experience a lack of a consistent source of primary care and a higher percentage of Blacks, Hispanic/Latinos and Native Hawaiian/Pacific Islanders lack health insurance coverage compared to other racial/ethnic groups and percentages for the HSA as a whole. Data indicate that there are low percentages of breastfeeding among Black, Asian and Hispanic/Latino mothers and that the rate of all women in the HSA who receive prenatal care in the first trimester is also low compared to the state rate. The need for improved access to dental care is marked by high percentages of adults with poor dental health and high percentages of youth who haven't had a dental exam in the last year compared to the state. ED/ H rates for dental/oral disease are also high for the HSA relative to the state. The portion of El Dorado County that falls within the HSA is designated as a provider shortage area for primary care, and a high percent of uninsured reside in the Foothill Farms and Antelope areas as well as more rural communities such as Olivehurst, Sheridan, Georgetown, Greenwood and Garden Valley.

   Of 51 key informant interviews and community member focus groups, 51 mentioned health issues or drivers related to access to health care services as a health need. Input from service providers and community members indicate that access to primary care services and specialty care providers is a challenge, particularly for patients with Medi-Cal coverage. Barriers to accessing care include long wait times, insurance coverage gaps, the cost of co-pays and prescription medications, lack of transportation to health services, and distance to access specialty care services. Service providers reference a high number or preventable hospital events and impacted emergency departments (EDs); community members identify numerous barriers in navigating health care systems and note that going to the ED may still be their easiest option for care. In particular, undocumented populations have very limited access to health services owing to their inability to purchase or qualify for health insurance coverage. A lack of culturally and linguistically appropriate services creates additional barriers for Limited English Proficiency populations; interpretation and translation services may be inadequate and the cultural sensitivity of providers is also perceived as low. Other vulnerable populations include seniors living in poverty who may have difficulty affording co-pays and medications as well as low-income pregnant women in the Auburn area owing to the lack of prenatal care availability there. Access to dental care is also particularly limited for low-income children. Providers and community members suggest that greater continuity of care within and between health systems is needed as well as more affordable and comprehensive insurance coverage options. Better access to culturally and linguistically appropriate services, patient navigation and health education services may also help to improve access to care and encourage preventative and help-seeking behaviors.

7. **Pollution free living and work environments** are a significant health need in the KFH-Roseville HSA. Sixteen of 26 indicators (62%) relating to pollution compare unfavorably to state benchmarks. Air quality is a significant issue; a high percentage of days per year exceed ozone and particulate matter standards compared to the state. Contributors to poor air quality may include the high road network density, low access to public transportation and a higher percentage of workers who commute alone in their cars. Related health issues may include: a high prevalence and rate of ED visits for asthma, high rates of mortality for Chronic Lower Respiratory Disease and ED/H rates for Chronic Obstructive Pulmonary Disorder, and high rates of mortality and ED visits for Heart

Disease compared to the state. Heart Disease rates are also higher among Non-Hispanic Whites, Blacks and Native Hawaiian/Pacific Islanders compared to other racial/ethnic groups and the rate for the state. Other health issues that may relate to environmental pollutants include high adult obesity rates and disparities in physical activity levels among youth. High rates of tobacco usage for teens and adults may also lead to exposure to secondhand smoke. Pollution burden scores are worst in the following areas of the HSA: Old/Central Roseville close to the rail yards; areas of high traffic density around Interstate 80; and agricultural and rural areas such as Wheatland, Olivehurst, Shingle Springs and the town of El Dorado.

Of 51 key informant interviews and community member focus groups, 25 mention health issues or drivers related to pollution free living and work environments as a health need. Community input suggests that poor air quality is particularly acute in the foothills during the summer months owing to grass and forest fires that have increased with the California drought; the poor air quality contributes to and exasperates asthma, COPD and other respiratory conditions. Poor air quality may also disproportionally affect vulnerable populations including children and low-income populations. In the North Highlands/Foothill Farms areas, illegal dumping and other pollutants are mentioned as negatively impacting the number of safe places to play and exercise outdoors. Providers and community members suggest that better enforcement of anti-smoking laws and smoking cessation programs are needed to reduce exposure to secondhand smoke and that safe, pollutant-free living options are needed for low-income populations.

8. **Basic needs (food, housing, employment and education)** are a significant health need in the KFH-Roseville 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. In the KFH-Roseville HSA, seven of 25 indicators (28%) pertaining to basic needs perform poorly compared to state benchmarks, particularly for racial/ethnic minorities in the HSA. A higher percentage of Blacks, Native American/Alaska Natives, people identifying as Mixed Race and Hispanic/Latinos live below 100% of the Federal Poverty Level (FPL) compared to other racial/ethnic groups, the HSA, and the state; similarly, a higher percentage of children aged 0-17 who are Black, Native American/Alaska Native, Native Hawaiian/Pacific Islander, and Hispanic/Latino live below 100% FPL. Blacks and Hispanic/Latinos have lower high school graduation rates compared to HSA and state rates; Blacks, Hispanic/Latinos and Native American/Alaska Natives also have higher percentages of children who read below proficiency level and higher percentages of adults aged 25 and older who do not have a high school diploma. Poverty is highest in the Foothill Farms, Citrus Heights, Placerville, Wheatland and Olivehurst areas; life expectancy is lowest in the Antelope, Citrus Heights, Garden Valley, Auburn, Applegate, Wheatland and Olivehurst areas.

   Of 51 key informant interviews and community member focus groups, 51 mention themes related to basic needs such as food, housing, employment and education. Community input on vulnerable locations points to areas such as North Sacramento and North Highlands as well as “pockets” of poverty throughout Placer County including Lincoln, Central/Old Roseville, North Auburn and small foothill communities. Themes relating to unmet basic needs include the high cost of living in Placer County, lack of affordable housing, and coverage gaps for middle-income families who do not quality for public assistance benefits but struggle to make ends meet. Additional populations and issues of concern include seniors living in poverty, lower educational attainment for Latino youth, food insecurity, and lack of living wage employment opportunities. In general, health and

wellness may be diminished for low-income populations with scarce resources that need to prioritize meeting basic needs for food, housing and transportation. Providers and community members suggest that improved public education and employment opportunities, affordable housing and comprehensive health care coverage are needed to improve the socio-economic prospects and health of vulnerable populations and locations within the HSA.

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, more than 140 resources were identified pertaining to the significant health needs for KHF-Roseville. The final list of resources is available in Appendix I, and the methodology for resource identification is further detailed in Appendix D.

VII. KFH-ROSEVILLE 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy evaluation of impact

KFH-Roseville'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-Roseville'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-Roseville in the 2013 Implementation Strategy Report.

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

KFH-Roseville 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-Roseville tracks outcomes, including behavior and health outcomes, as appropriate and where available.

As of the documentation of this CHNA Report in March 2016, KFH-Roseville had evaluation of impact information on activities from 2014 and 2015. While not reflected in this report, KFH-Roseville 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 Roseville awarded 132 grants totaling $1,594,984 in service of 2013 health needs. Additionally, KP Northern California Region 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-Roseville service area. During 2014-2015, a portion of money managed by this foundation was used to award 29 grants totaling $356,948 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-Roseville 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: 14,661 Medi-Cal members* • *2015: 14,729 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 - $6,273,339* • *2014: 4,740 applications approved* • *2015: KFH - Dollars Awarded By Hospital - $5,251,492* • *2015: 4,234 applications 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: 3,144 members receiving CHC* • *2015: 2,779 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 62 active KFH grants totaling $908,405 addressing Access to Care in the KFH-Roseville service area.[1] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 16 grants totaling $263,300 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Latino Leadership Council (LLC)	$55,000 over 2 years $25,000 in 2014 $30,000 in 2015	Support of Creer En Tu Salud to improve access to existing health resources including medical, dental, and vision services, and associated wellness programs for Latino adults and their families.	Over 2 years, 257 individuals were screened for high blood pressure and body mass index; 29 were identified as needing labs and received free lab work. 58 individuals were connected to Chapa De or Wellspace Health for primary care. In addition, LLC provided 15 individuals with dental work, 31 with eye exams and delivered 514 flu shots and 93 Tdap vaccinations.

[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.

Powerhouse Ministries	$55,000 over 2 years $25,000 in 2014 $30,000 in 2015	Supports Health Links, which helps low-income clients overcome barriers that inhibit their access to primary health (medical, dental, and mental) services.	During 2014 and 2015 over 115 patients met with a doctor; 102 clients received ongoing case management; a blood pressure clinic and weekly weight loss support group were established; and a partnership with an area dentist resulted in no-cost dental care for five patients. 26 clients were provided 253 visits with mental health care providers.
Seniors First	$47,500 over 2 years $25,000 in 2014 $22,500 in 2015	Supports Health Express, which provides transportation to non-emergency medical appointments for at-risk populations (i.e., the elderly, disabled, uninsured and otherwise underserved) in Placer County.	During 2014 and 2015 clients were transported on 8536 trips. 98% of the trips were completed on-time with a perfect safety record.
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%
Central Valley Health Network (CVHN)	$250,000 over 2 years $125,000 in 2014 & 2015 This grant impacts 6 KFH hospital service areas in Northern California Region.	Grant will provide funding for CVHN to support core operational functions, and policy and advocacy activities that support CVHN member health centers in their goal of providing quality health care.	• CVHN reached 14 member health centers that serve 687,620 patients • collaborating with Fresno County and local health care stakeholders, CVHN developed a way to continue funding the county's program to assure health care access for documented and undocumented residents • to increase access to health care services in farmworker communities, CVHN partnered with National Center for Farmworker Health (NCFH) to bring technical assistance and resources to member health centers • 51 staff from CVHN member health centers were trained on the intake/policy implications of registering farmworkers

			• CVHN coordinated Growing Health Leaders youth conferences in Merced and Fresno counties, and the two conferences drew more than 500 students
*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.
Placer Community Health Initiative (CHI)	Placer CHI's mission is to connect children and families with low- and no-cost health insurance and to educate and advocate for access to health care.	Greater Sacramento CB Manager is a Placer CHI member. Thousands of families and children were educated about and enrolled in health insurance as a result of this collaborative.
Placer Collaborative Network (PCN)	PCN's purpose is to connect nonprofit and social service providers that serve Placer County to improve the health and wellbeing of the community.	Greater Sacramento CB Manager is on PCN's administrative team. PCN held multiple public forums on topics such as health care reform and community needs assessment findings, which drew hundreds of residents, raised community awareness, and strengthened the network of health/social service providers.
Placer Partnership for Public Health (PPPH)	PPPH is a group of diverse public health stakeholders working to strengthen Placer County's public health system. It serves as an advisory body to Placer County Public Health Division and its efforts include conducting health assessments, developing improvement	Greater Sacramento CB Manager is a PPPH member. A committee has been identified to conduct a local public health needs assessment that will begin 2016.

	plans, and supporting strategic planning.	

In-Kind Resources Highlights

Recipient	Description of Contribution and Purpose/Goals
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-Roseville service area

Intermediate Goal:

- 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 35 active KFH grants totaling $250,608 addressing Healthy Eating Active Living in the KFH-Roseville service area.[2] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 6 grants totaling $37,381 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Hope Centers United	$10,000 in 2015	Supports Folsom STARS, an afterschool enrichment program for at-risk students that integrates life skills and academics through tutoring, health education, and recreation at elementary school two sites.	• program served 45 to 50 students per day • test scores increased an average of 20% in English Language Arts and 22% in math
Community Resource Council, Inc. (dba Placer County Foodbank [PCF])	$50,000 over 2 years $25,000 in 2014 & 2015	Supports PCF's pilot, a school pantry program (mobile market/client choice model). The mobile pantry will deliver food to schools and afterschool programs at least twice per month. Families select their own items, but 25% must be fresh fruits and vegetables.	Over 2 years, at least 14,634 low-income individuals received 92,965 pounds of fresh produce via their mobile pantry at six distribution sites/month. Each stop included cooking demonstrations, nutrition education and SNAP outreach
Folsom Cordova Unified School District	$32,942 over 2 years $21,500 in 2014 $11,442 in 2015	Supports the HEAL program's 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 learning.	In 2014 FCUSD partnered with SBF to continue to cultivate gardens at Theodore Judah, Peter J. Shields, Natoma Station, and Cordova Gardens elementary schools. Teachers utilized the gardens and link to California Department of Education curriculum standards to apply the learning in the classroom. In 2015 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

[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.

			set of crops
Health Education Council (HEC)	$68,465 over 2 years $51,450 in 2014 (split with South Sac & Sac) $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.

Collaboration/Partnership Highlights		
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**
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.
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.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Placer Food Bank	KFH-Roseville's nutrition manager and a health educator conducted health education presentations where seniors learned how to select healthy food on a limited budget, read food labels, and understand portion size. KFH also donated 1,500 lunches purchased for an event that was cancelled to the Placer Food Bank.
Folsom Cordova Unified School District	• In partnership with the Sacramento Kings, a Kaiser Permanente physician led a series of fun physical activities, including Get Fit clinics and PE Takeover days, at Cordova Villa and Williamson elementary schools and Cordova High School. Approximately 800 students participated. • KFH-Roseville physicians mentored fifth graders at schools in FCUSD in both 2014 & 2015. Each of the 34 participating physicians each year mentored one child. Activities included email and face-to-face contact.

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

Long Term Goal:

- Improve mental health and behavioral health among high-risk populations in the KFH-Roseville 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 27 active KFH grants totaling $419,275 addressing Limited Access to Mental Health Care Services in the KFH-Roseville service area.[3] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 2 grants totaling $13,095 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Capitol Community Health Network	$20,000 in 2014 (even split with So. Sac and Sacramento)	Support implementation of the Behavioral Health Joint Operating Committee (BHJOC) to coordinate delivery of integrated primary and behavioral health services at member clinic sites.	Two BHJOC members created integrated behavioral health practices that rapidly ramped up access to those services is. Three BHJOC members developed integrated services implementation plans. To increase primary behavioral health care, El Hogar was engaged as a subcontractor to create direct contractual relations with the three health plans, develop billing and credentialing protocols, and hire staff and saw 170 patients.
KidsFirst	$50,000 over 2 years $25,000 in 2014 & 2015	Support trauma-informed therapy and education for children 0 to 11 who are victims of abuse, including domestic violence, sexual abuse, and neglect.	In 2014 and 2015 KidsFirst served a total of 799 individuals. Therapy and case management services were provided to 149 children and their families; 567 individuals received information and referral services; and 36 children participated in afterschool care. They also hosted 4 community collaborative meetings focused on Child Abuse Prevention efforts with a total of 96 attendees.
Lighthouse Counseling and Family Resource Center	$31,422 in 2015	Supports Building Mental Health and Wellness, which helps individuals through psycho-education support groups and individual counseling.	As of December 1: • 43 clients participated in group counseling (20 in Spanish and 23 in English) • 58 received individual counseling

[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.

People of Faith Together	$39,253 over 2 years $19,253 in 2014 $20,000 in 2015	Supports Mental Health Wellness for All, which trains clergy and key congregational and community leaders on mental health first aid, a first step response to individuals with mental health-related issues or in crisis, those seeking supportive services related to mental health, and their family members.	Over 2 years, 13 multi-faith pastors / key leaders participated and completed 2 day intensive mental health first aid training. 15 outreach and education events were held and more than 200 individuals received mental health awareness/stigma reduction materials and community resources.
WellSpace Health	$147,652 over 2 years $99,000 in 2014 (split with Sacramento) $48,652 in 2015	Supports T3 (triage, transport, and treat) Foothills, a program designed to meet the complex medical, behavioral, and psychosocial needs of homeless high-utilizers of emergency health services.	The program served 100 individuals with intensive case management 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.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Latino Leadership Council; Powerhouse Ministries; Folsom Cordova Unified School District; and North Roseville Recreation Center	KFH-Roseville helped provide tickets for underserved youth and their families (60 in 2014 and 70 in 2015) 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.
The Gathering Inn (TGI)	The KFH-Roseville leadership team organized and served dinner to 70 of TGI's homeless guests. KFH-Roseville also provided to U.S. Senior Open tickets, which TGI used to increase donations to the organization.

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 8 Workforce Development grants totaling $16,696 that served the KFH-Roseville service area.[4] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 3 grants totaling $11,830 that address this need. In addition, KFH Roseville provided trainings and education for 116 residents in their Graduate Medical Education program in 2014 and 109 residents in 2015, 25 nurse practitioners or other nursing beneficiaries in 2014 and 10 in 2015, and 41 other health (non-MD) beneficiaries as well as internships for 21 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.

Grant Highlights

Grantee	Grant Amount	Project Description	Results to Date
*The Regents of the University of California	$75,000 in 2015 This grant impacts all KFH hospital service areas in Northern California Region	UC Berkeley's Health Careers Opportunity Program (HCOP) aims to diversify the health professions workforce by working directly with 600 students from underrepresented groups through direct student counseling at UC Berkeley, through visits and outreach to local community colleges, and through the Public Health and Primary Care, a UC Berkeley class taught by HCOP staff.	• HCOP supported programs and workshops throughout Northern California that reached more than 600 underrepresented students • through mentoring, classes on biostatistics and public health research analytical concepts, professional development on oral and written communication, and business professionalism, HCOP served nine Summer Scholars (underrepresented students) • eight other students enrolled in and completed Kaplan's GRE preparation course
*Stiles Hall	$75,000 in 2015 This grant impacts all KFH hospital service areas in Northern California Region	Stiles' Experience Berkeley Program aims to promote admission of low-income, first-generation students of color, specifically Black, Latino, and Native American high school students, to University of California Berkeley (UCB) through mentorship by UCB students and admissions officers, academic counseling, and active recruitment of underrepresented high school and community college students.	Anticipated outcomes for the 260 mentored Experience Berkeley students include: • 100% of mentees apply for admission to UCB • 52% UCB admission rate for high school program participants • 87% UCB admission rate for community college program participants • 65% of those admitted from high school will attend UCB • 95% of those admitted from community college will attend UCB • program participants maintain an average GPA of 3.3; average GPA for students of color not enrolled in the program is 2.9)

[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.

*Physicians Medical Forum (PMF)	$150,000 (over 2 years) This grant impacts 16 KFH hospital service areas in Northern California Region	PMF's Doctors On Board (DOB) Pipeline and Community Health Ambassadors (CHA) programs aim to 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.	Anticipated outcomes include: • 250 DOB students mentored annually by faculty, physicians, medical students, 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 hospital service areas in Northern California	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 management, the health of children, working age adults, and the elderly, health care reform, and cost	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 CHIS 2015 data collection that achieved the adult target of 20,890 completed interviews. CHIS 2016 data

	Region.	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.	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 Brown	HEAL
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.* **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.*	**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 **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 Sources and Dates**

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
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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. 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.

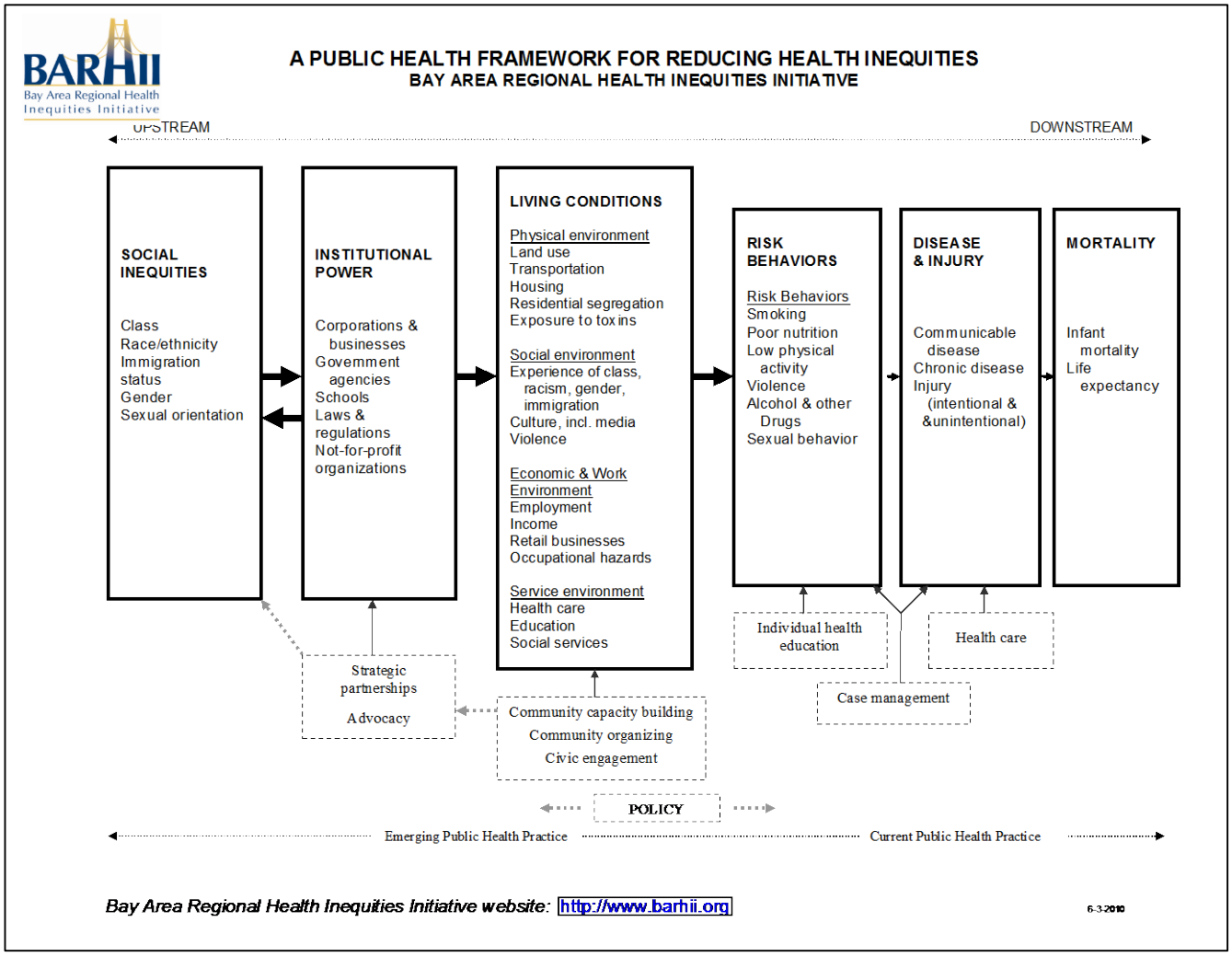


Figure 6. BARHII Framework

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

[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
Average Population per Housing Unit	Total population in Occupied Housing Units	2013 American Community Survey 5-year Estimate Table B25008
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-

Derived Indicator Name	Source Indicator Names	Source
		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
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

Derived Indicator Name	Source Indicator Names	Source
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)

[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
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)
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 11 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)
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 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

[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

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.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.

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

[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.

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 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.

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

[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

[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

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 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 food.

[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 Groups 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	Key Informant Interview	Director of Health and Human Services	El Dorado County Public Health Dept.	1	Public Health Department Representative	Leader	05/20/15
3	Key Informant Interview	Health Officer	El Dorado County Public Health Dept.	1	Public Health Department Representative	Leader	05/20/15
4	Key Informant Interview	Epidemiologist	El Dorado County Public Health Dept.	1	Public Health Department Representative	Leader	05/20/15
5	Key Informant Interview	Director of Nursing	El Dorado County Public Health Dept.	1	Public Health Department Representative	Leader	05/20/15
6	Key Informant Interview	Public Health Officer	Placer County Public Health Dept.	1	Public Health Department Representative	Leader	05/22/15
7	Group Key Informant Interview	Director Care Coordination	Mercy Hospital of Folsom	1	Hospital Representatives	Representative	06/01/15
8	Group Key Informant Interview	Palliative Care Nurse Coordinator	Mercy Hospital of Folsom	1	Hospital representative	Representative	06/01/15
9	Group Key Informant Interview	Continuity of Care Service Director, Discharge Planning and Social Services Departments	Kaiser Permanente Roseville Medical Center	1	Hospital representative	Representative	06/01/15
10	Group Key Informant Interview	Continuum Administrator	Kaiser Permanente Roseville Medical Center	1	Hospital representative	Representative	06/01/15
11	Group Key Informant Interview	Social Work Supervisor	Sutter Roseville Medical Center	1	Hospital representative	Representative	06/10/15
12	Group Key Informant Interview	Manager, Case Management	Sutter Roseville Medical Center	1	Hospital representative	Representative	06/10/15
13	Key Informant Interview	Director	Chapa-De Indian Health	1	Minority, Medically Underserved, Low-Income	Representative	06/16/15

	Data Collection Method	Title/Name	Organization	Number	Target Groups Represented	Role in Target Group	Date Input was Gathered
14	Key Informant Interview	Chief Operating Officer	Chapa-De Indian Health	1	Minority, Medically Underserved, Low-Income	Representative	06/16/15
15	Key Informant Interview	Director of Residential & Crisis Response Services	WEAVE	1	Minority, Medically Underserved, Low-Income	Representative	06/26/15
16	Key Informant Interview	Family Resource Center Manager	Lighthouse Counseling & Family Resource Center	1	Minority, Medically Underserved, Low-Income	Representative	06/30/15
17	Key Informant Interview	Outreach Specialist	Lighthouse Counseling & Family Resource Center	1	Minority, Medically Underserved, Low-Income	Representative	06/30/15
18	Key Informant Interview	Coordinator	Latino Leadership Council	1	Minority, Medically Underserved, Low-Income	Representative	06/30/15
19	Key Informant Interview	Director	Sacramento Department of Human Assistance	1	Minority, Medically Underserved, Low-Income	Representative	07/02/15
20	Key Informant Interview	Executive Director	Health Education Council	1	Minority, Medically Underserved, Low-Income	Representative	07/07/15
21	Key Informant Interview	Deputy Director	Community Recovery Resources	1	Minority, Medically Underserved, Low-Income	Representative	07/08/15
22	Key Informant Interview	Executive Director	El Dorado Community Health Center	1	Minority, Medically Underserved, Low-Income	Representative	07/15/15
23	Key Informant Interview	Assistant Director of Health Services	El Dorado County Mental Health Clinic	1	Minority, Medically Underserved, Low-Income	Representative	07/15/15
24	Key Informant Interview	Development Director	TLCS Inc.	1	Minority, Medically Underserved, Low-Income	Representative	07/16/15
25	Key Informant Interview	Executive Director	Folsom Cordova Community Partnership	1	Minority, Medically Underserved, Low-Income	Representative	07/16/15
26	Key Informant Interview	Director	Slavic Assistance Center-Sacramento	1	Minority, Medically Underserved, Low-Income	Representative	07/20/15
27	Key Informant	Chief Executive Officer	WellSpace Health	1	Minority, Medically Underserved, Low-	Representative	07/22/15

	Data Collection Method	Title/Name	Organization	Number	Target Groups Represented	Role in Target Group	Date Input was Gathered
	Interview				Income		
28	Key Informant Interview	Managing Attorney	Legal Services for Northern California-Health	1	Minority, Medically Underserved, Low-Income	Representative	07/22/15
29	Key Informant Interview	Executive Director	Sacramento Covered	1	Minority, Medically Underserved, Low-Income	Representative	07/23/15
30	Key Informant Interview	Program Manager	Sacramento Covered	1	Minority, Medically Underserved, Low-Income	Representative	07/23/15
31	Key Informant Interview	Executive Director	Sacramento LGBT Center	1	Minority, Medically Underserved, Low-Income	Representative	07/23/15
32	Key Informant Interview	Executive Director	First 5 Placer	1	Minority, Medically Underserved, Low-Income	Representative	07/23/15
33	Key Informant Interview	Director of Public Health Nursing	Placer County Public Health	1	Minority, Medically Underserved, Low-Income	Representative	07/24/15
34	Key Informant Interview	Executive Director	St. Paul de Vincent Society of Placer County	1	Minority, Medically Underserved, Low-Income	Representative	07/28/15
35	Key Informant Interview	Financial Manager	St. Paul de Vincent Society of Placer County	1	Minority, Medically Underserved, Low-Income	Representative	07/28/15
36	Key Informant Interview	Executive Director	Mercy Housing	1	Minority, Medically Underserved, Low-Income	Representative	07/29/15
37	Key Informant Interview	Executive Director	The Gathering Inn	1	Minority, Medically Underserved, Low-Income	Representative	07/29/15
38	Key Informant Interview	Lead Case Manager	The Gathering Inn	1	Minority, Medically Underserved, Low-Income	Representative	07/29/15
39	Key Informant Interview	Director	Placer County Adult System of Care	1	Minority, Medically Underserved, Low-Income	Representative	07/29/15
40	Key Informant Interview	Executive Director	Life Matters	1	Minority, Medically Underserved, Low-Income	Representative	08/03/15
41	Key Informant Interview	Executive Director	El Hogar	1	Minority, Medically Underserved, Low-Income	Representative	08/06/15
42	Key Informant Interview	Executive Director	Eskaton	1	Minority, Medically Underserved, Low-Income	Representative	08/07/15

	Data Collection Method	Title/Name	Organization	Number	Target Groups Represented	Role in Target Group	Date Input was Gathered
43	Key Informant Interview	Associate Director	Child Abuse Prevention Center	1	Minority, Medically Underserved, Low-Income	Representative	08/10/15
44	Key Informant Interview	Co-founder and Agency Administrator	Roberts Family Development Center	1	Minority, Medically Underserved, Low-Income	Representative	08/11/15
45	Key Informant Interview	Auburn SDA Community Services-Community Outreach	Auburn Renewal Center	1	Minority, Medically Underserved, Low-Income	Representative	08/11/15
46	Key Informant Interview	Co-executive Director & Clinical Director	Strategies for Change	1	Minority, Medically Underserved, Low-Income	Representative	08/14/15
47	Key Informant Interview	Executive Director	Turning Point	1	Minority, Medically Underserved, Low-Income	Representative	08/19/15
48	Key Informant Interview	Executive Director	Seniors First	1	Minority, Medically Underserved, Low-Income	Representative	08/21/15
49	Focus Group	LGBTQ Focus Group	Gender Health Center	8	Minority, Medically Underserved, Low-Income	Member	08/21/15
50	Focus Group	Service Provider Focus Group	Placer County Public Health	10	Minority, Medically Underserved, Low-Income	Representatives	08/26/15
51	Focus Group	Service Provider Focus Group	Sacramento Covered	6	Minority, Medically Underserved, Low-Income	Representatives	09/04/15
52	Focus Group	Diabetes Prevention Program Focus Group	Chapa-De Indian Health Programs in Auburn	9	Minority, Medically Underserved, Low-Income	Member	09/09/15
53	Focus Group	Latina Mothers Focus Group	Latino Leadership Council	9	Minority, Medically Underserved, Low-Income	Member	09/15/15
54	Focus Group	Latina Mothers Focus Group	Latino Leadership Council	3	Minority, Medically Underserved, Low-Income	Member	09/16/15
55	Focus Group	Mothers in Recovery Focus Group	Community Recovery Resources	9	Minority, Medically Underserved, Low-Income	Member	09/22/15
56	Focus Group	Slavic/Ukrainian /Russian Community Member Focus Group	Slavic Assistance Center	10	Minority, Medically Underserved, Low-Income	Member	09/28/15
57	Focus Group	Community Member	Folsom Cordova	10	Minority, Medically Underserved, Low-	Member	09/30/15

	Data Collection Method	Title/Name	Organization	Number	Target Groups Represented	Role in Target Group	Date Input was Gathered
		Mothers Focus Group	Community Partnership		Income		
58	Focus Group	Low-Income Senior Residents Focus Groups	Valley Oaks Independent Living Facility in Auburn	7	Minority, Medically Underserved, Low-Income	Member	10/08/15
59	Focus Group	Service Provider Focus Group	Sierra Health Foundation-Respite Care Partnership	5	Minority, Medically Underserved, Low-Income	Representatives; members	10/12/15
60	Focus Group	Homeless Community Focus Group	The Gathering Inn	8	Minority, Medically Underserved, Low-Income	Member	10/15/15
61	Focus Group	Community in Recovery Focus Group	Strategies for Change- North Sacramento	9	Minority, Medically Underserved, Low-Income	Member	10/15/15
62	Focus Group	Community Member Focus Group	Greater Sacramento Urban League	21	Minority, Medically Underserved, Low-Income	Member	10/20/15
63	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-Roseville 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. Disease Prevention, Management and Treatment 4. Safe, Crime and Violence Free Communities 5. Access to Affordable and Accessible Transportation 6. Access to High Quality Health Care and Services 7. Basic Needs (Food, Housing, Employment, Education) 8. 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/percentage that is an undesirable difference from the KFH-Roseville service area and green color coding is used to signify 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 CORE INDICATORS	Contributing Factors RELATED INDICATORS
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 (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.	**MENTAL HEALTH** **Mortality – Suicide (per 100,000)** • HSA 13.34**// CA 9.8 • Non-Hispanic White 16.51**// HSA 13.34 **Access to Mental Health Providers (per 100,000)** • HSA 132**// CA 157 **Mental Health - Needing Mental Health Care** • HSA 15.20%// CA 15.90% • Hispanic/ Latino (Any Race 25.79%**// HSA 15.20% **Health Prof Shortage Area - Mental Health** • *See map - below* **Mental Health (ED)** • HSA 231.94**// CA 149.93 **Mental Health (H)** • HSA 200.95**// CA 186.92 **Self-Inflicted Injury (ED)** • HSA 10.33*// CA 8.18 **Self-Inflicted Injury (H)** • HSA 4.44 // CA 4.40 **SUBSTANCE ABUSE/TOBACCO** **Alcohol - Excessive Consumption** • HSA 18.40%* // CA 17.20% **Alcohol – Expenditures** • HSA 15.02%** // CA 12.93% **Substance Abuse (ED)** • HSA 334.53** // CA 253.80 **Substance Abuse (H)** • HSA 156.10* // CA 145.00 **Tobacco Usage (Teens and Adults)** • HSA 19.20** // CA 10.80	**MENTAL HEALTH** • Alzheimer's Disease – MORT • Life Expectancy at Birth **SUBSTANCE ABUSE/TOBACCO** • Chronic Lower Resp Disease – MORT • COPD (ED) • COPD (H)

Sources: o http://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health o http://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse o http://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use o http://www.who.int/mental_health/management/info_sheet.pdf		

Primary Data: 50 of 51 sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to access to behavioral health services (substance abuse and mental health) as a health need. Themes related to the health need were as follows:

General

- Both mental health and substance abuse services are in high demand and the resources available do not come close to meeting the need; services may not be covered by insurance or available in languages other than English; the impact on the ER owing to untreated behavioral health issues is high
- Mental health and substance abuse issues are frequently high among homeless populations; homelessness makes effective treatment difficult; the homeless have a difficult time accessing behavioral health services
- Stigma around mental health and substance use issues impedes funding for services, preventative education and help-seeking behaviors; maternal mental health (e.g. postpartum depression) and gender identity issues are particularly stigmatized
- Mental health and substance abuse also contribute to physical health issues; co-morbidity and tri-morbidity of substance abuse, mental health and physical health issues are common
- Poverty impacts mental health and substance use; lack of basic needs can result in poor coping mechanisms or difficulty accessing/treating behavioral health issues

Substance Abuse

- Smoking rates are high among homeless, prenatal, middle age and elderly populations; local ordinances should be enacted or enforced restricting smoking near schools and the display/sale of tobacco related products (including e-cigarettes)
- Heroin and opioid/prescription drug use has been increasing, particularly among youth and homeless populations
- Substance abuse appears to be particularly prevalent among homeless, youth and low-income populations, as well as in rural areas where people don't have a lot to do
- More substance abuse treatment options as well as preventative education, peer education and harm reduction strategies are needed. Stigma must also be addressed; community members in recovery often feel they experience discrimination from the medical community when seeking treatment for substance abuse-related physical health issues

Mental Health

- There is a high rate of suicides, both attempts and successful, among young adults/teenagers (particularly young white males) and the elderly; completed suicide by firearms is also nearly as high for women as for men; substance abuse issues can also result in suicide from overdose
- People with severe mental health issues such as schizophrenia and bipolar disorder face specific challenges particularly if they are homeless, women or people of color; 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
- Adverse childhood experiences and/or trauma over the life course can contribute to mental health issues and social and developmental challenges
- Stress is an issue that can result in ongoing depression and anxiety, in particular for low-income populations trying to survive on a low wage, people living in unsafe communities, and seniors experiencing transitions as they age

- Opportunities for social engagement are limited for youth, seniors and women; activities for youth may be cost-prohibitive; seniors may experience social isolation and depression owing to lack of family, inability to drive, or lack of knowledge about available social activities; adult children caring for their parents need caregiver support; women from immigrant cultures may be restrained from socializing by their husbands; social and community supports are essential to well-being and resiliency but are lacking for many

Geographic Impact

Rates for Mental Health and Substance Abuse – Emergency Department (ED) visits and Mental Health – Hospitalization (H) are particularly high in the following ZIP codes:

Table 13. ZIP codes with the worst 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	95603*	319.93	284.28
	95610*	318.32	255.85
	95619	278.84	283.25
	95621*	332.21	259.23
	95651	290.59	149.62
	95661	321.58	259.13
	95662	294.74	256.19
	95667	252.38	258.67
	95703	222.58	390.84
	95842*	282.15	220.67
	KFH-Roseville	231.94	200.95
	El Dorado	196.33	184.40
	Placer	238.01	201.97
	Sacramento	271.38	227.04
	Yuba	272.41	234.44
	California	149.93	186.92

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

* Indicates Focus Community

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

	Zip Code	ED	Hospitalization
SUBSTANCE ABUSE	95619	722.32	287.00
	95623	534.56	249.22
	95634	479.68	254.23
	95635	466.36	238.41
	95651	635.93	272.10
	95667*	588.22	221.76
	95669	602.31	197.68
	95681	536.28	284.70
	95703	420.03	314.10
	95842*	527.76	244.66
	95961	573.35	233.51
	KFH- Roseville	334.53	156.10
	El Dorado	473.71	165.17
	Placer	299.45	138.86
	Sacramento	438.58	196.37
	Yuba	686.42	269.78
	California	253.80	145.00

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

* Indicates Focus Community

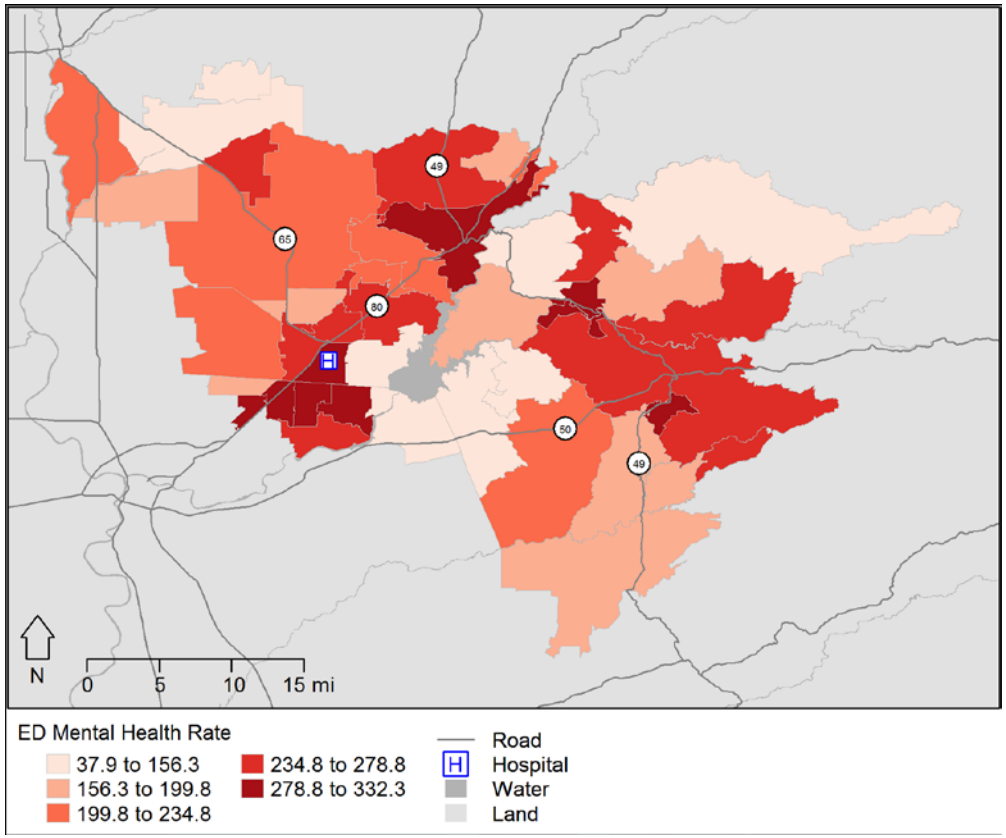


Figure 7. Map of mental health Emergency Department by ZIP Code

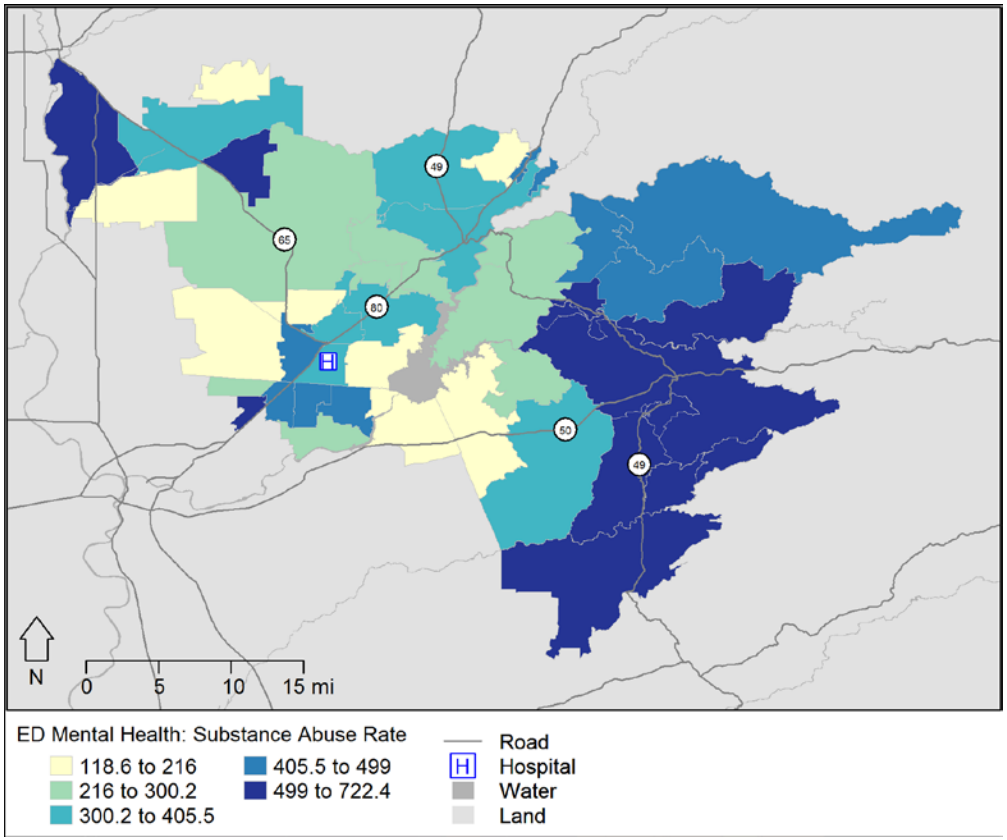


Figure 8. Map of mental health Hospitalization rates by ZIP Code

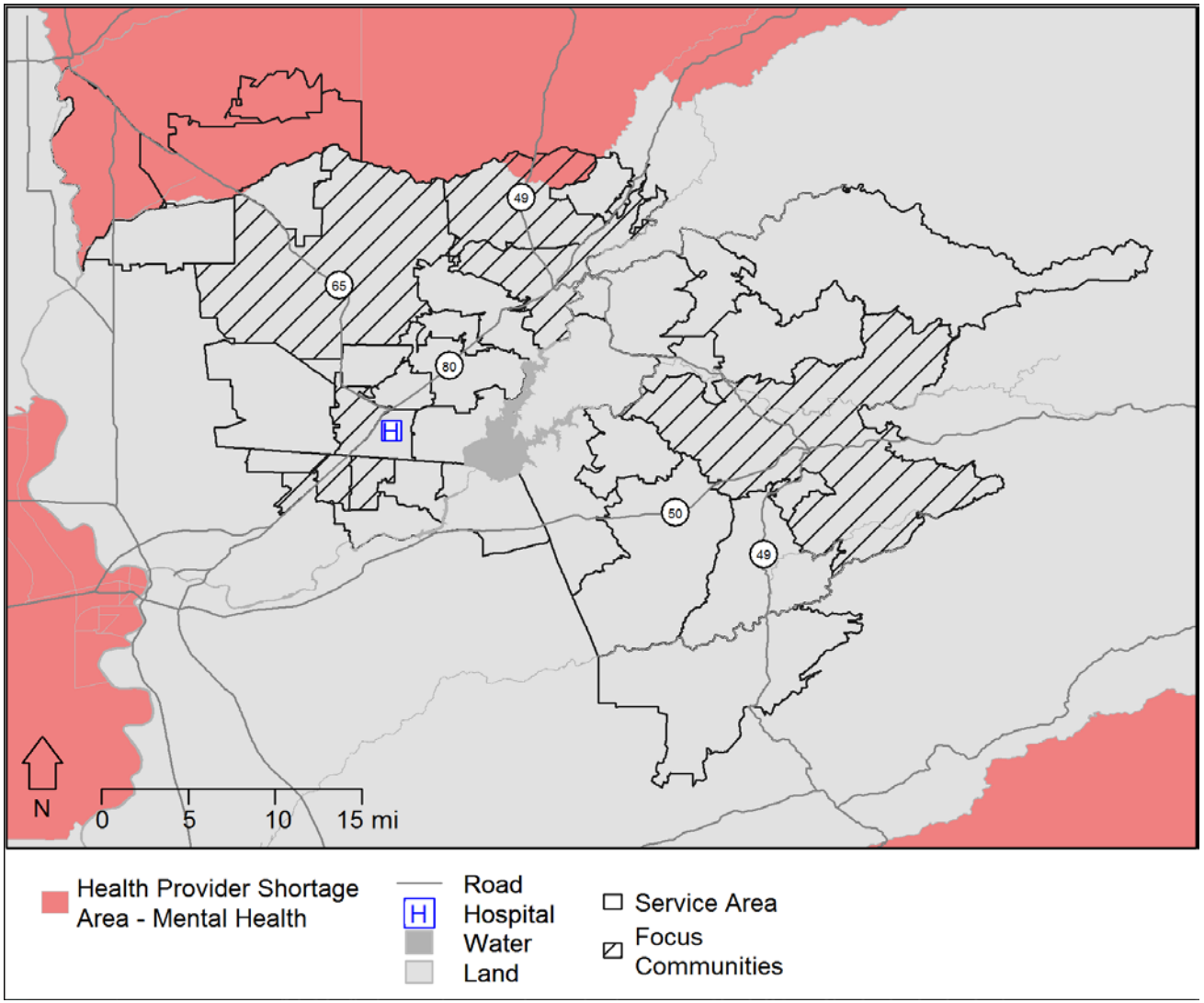


Figure 9. Map of Health Provider Shortage Area – Mental Health

Healthy Eating and Active Living

Rationale	Health Outcomes Indicators CORE INDICATORS	Contributing Factors RELATED INDICATORS
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: o http://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status o http://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity	**Obesity (Adult)** • HSA 23.40%* // CA 22.30%	• Low Fruit/Vegetable Consumption (Youth) (1 racial/ethnic disparity) • Physical Inactivity (Youth) (3 racial/ethnic disparities) • Breastfeeding (Any) (3 racial/ethnic disparities) • Breastfeeding (Exclusive) (5 racial/ethnic disparities) • Food Environment - Grocery Stores** • Food Environment - WIC-Authorized Food Stores** • Food Security - Food Desert Population** • Park Access** • Transit – Walkability** • Commute to Work - Walking/Biking* • Commute to Work - Alone in Car** • Walking/Biking/Skating to School** (1 racial disparity) • Overweight (Youth) (2 racial/ethnic disparities) • Obesity (Youth) (2 racial/ethnic disparities) • Osteoporosis (ED) • Osteoporosis (H)

Primary Data: 50 of 51 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 the health need were as follows:

Healthy Eating

- Healthy choices are expensive, particularly for people on fixed incomes (seniors, mothers on WIC, Cal Fresh-eligible individuals etc.); it's difficult to eat healthy when you can't afford it
- 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
- 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)
- In rural/suburban areas people have to travel a long ways to find fresh, healthy foods; transportation barriers make it difficult for people to be able to get to places that provide healthy food options
- Many neighborhoods are food deserts that don't have grocery stores or have a surplus of unhealthy food options such as fast food outlets and liquor stores
- Health education and literacy is needed for people to know how to prepare healthy foods and shop healthy on a budget

Physical Activity

- There is a lack of safe places to play and exercise; real and perceived threats of violence are also a deterrent to people being physically active in their neighborhoods

- Unsafe streets (lack of lighting, sidewalks etc.) are a deterrent to active transportation such as walking and biking
- There is good access to the natural environment (parks, trails etc.) however a strong parks and recreation infrastructure is lacking; in low-income areas parks are less well maintained or may be unsafe; in some cases cost is a barrier to access nature areas (e.g. need to pay for parking)
- Many people have sedentary lifestyles and it's difficult to get motivated or incentivized to exercise; long work hours are also a barrier to exercise

Geographic Impact

Rates for Diabetes – Mortality are particularly high in the following ZIP codes:

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

DIABETES	95602*	2.58
	95628	2.50
	95650	2.51
	95658	2.38
	95661	2.54
	95662	2.38
	95669	2.37
	95703	2.25
	KFH-Roseville	1.83
	Placer	1.97
	El Dorado	1.05
	Sacramento	2.26
	Yuba	0.97
	CALIFORNIA	2.11

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

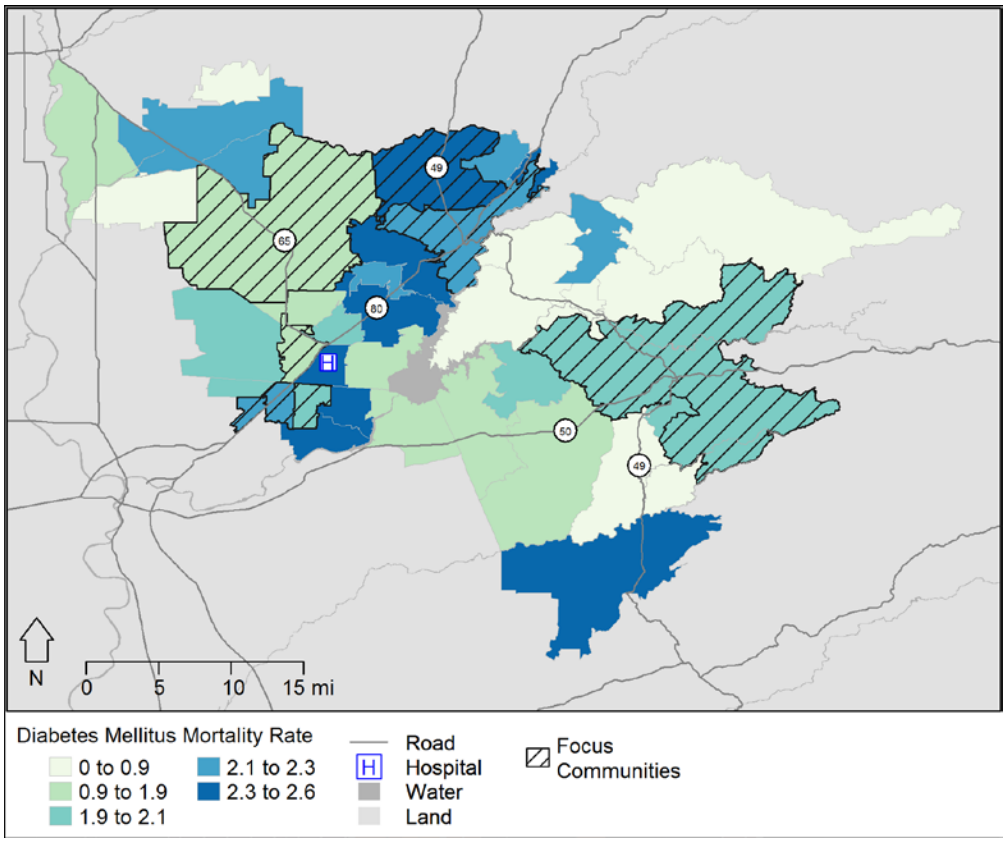


Figure 10. Map of diabetes mellitus mortality rate by ZIP code

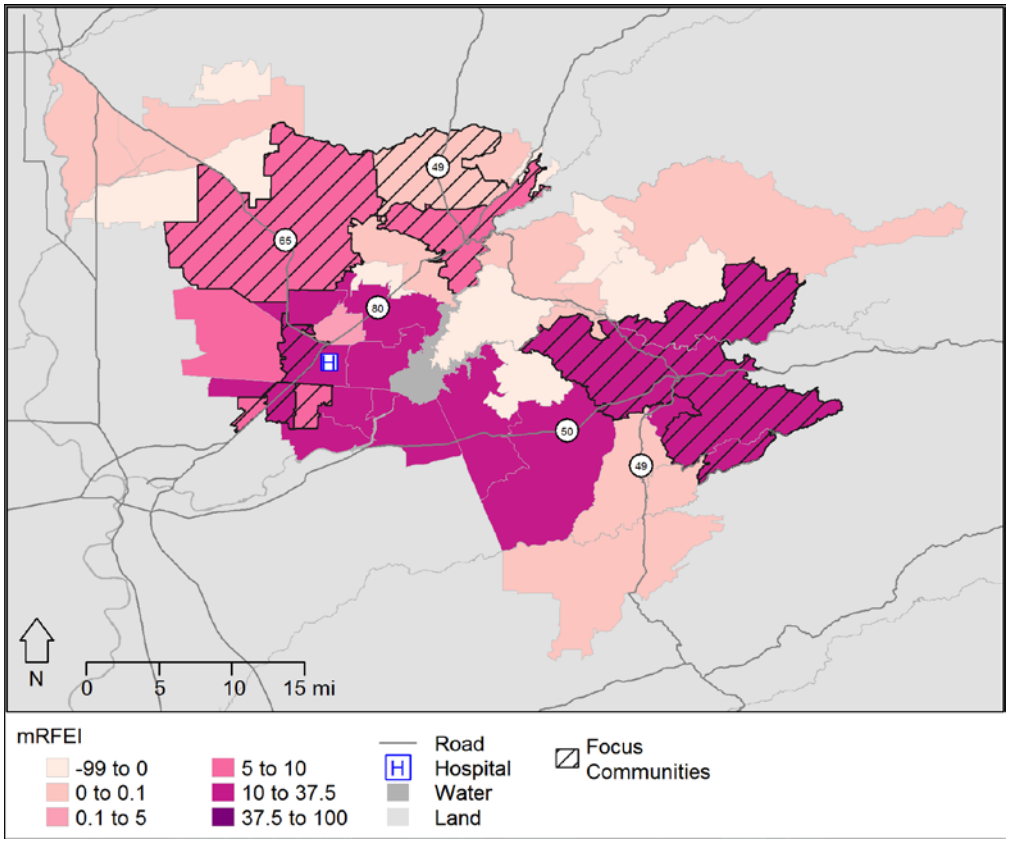


Figure 11. Map of Modified Retail Environment Index by ZIP code

Disease Prevention, Management and Treatment

Rationale	Health Outcomes Indicators CORE INDICATORS	Contributing Factors RELATED INDICATORS
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. **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. **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. Sources: o http://www.cdc.gov/Features/PreventionStrategy o http://www.healthypeople.gov/2020/topics-objectives/topic/cancer o http://www.healthypeople.gov/2020/topics-objectives/topic/respiratory-diseases	**CANCER** **Cancer Incidence – Breast** • HSA 134.58** // CA 122.4 **Mortality – Cancer** • HSA 162.51** // CA 157.1 • Non-Hispanic White 168.2** // HSA 162.51 • Black Alone 207.41** // HSA 162.51 • Native Hawaiian/ Pacific Islander Alone 197.24** // HSA 162.51 **Cancer Incidence – Cervical** • HSA 7.07 // CA 7.8 • Hispanic/Latino (Any Race) 11** // HSA 7.07 • Asian 9.3** // HAS 7.07 **Cancer Incidence - Colon and Rectum** • HSA 42 // CA 41.5 • Black Alone 53.8** // HSA 42 **Cancer Incidence – Prostate** • HSA 141.91** // CA 136.4 • Black Alone 201.7** // HSA 141.91 **Cancer Incidence – Lung** • HSA 56.08** // CA 49.5 • Black Alone 62.1** // HSA 56.08 **Breast Cancer (ED)** • HSA 10.05** // CA 6.59 **Breast Cancer (H)** • HSA 12.97* // CA 11.07 **Colorectal Cancer (ED)** • HSA 2.39 // CA 1.85 **Colorectal Cancer (H)** • HSA 6.59 // CA 6.43 **Lung Cancer (ED)** • HSA 3.70* // CA 2.68 **Lung Cancer (H)** • HSA 9.28* // CA 7.95 **Prostate Cancer (ED)**	**CANCER** • Alcohol - Excessive Consumption* • Alcohol – Expenditures** • Obesity (Adult)* • Food Security - Food Desert Population** • Air Quality - Particulate Matter 2.5** • Tobacco Usage (Teens and Adults) **ASTHMA** • Air Quality – Ozone (O3)* • Air Quality – Particulate Matter 2.5** • Obesity (Adult)* • Obesity (Youth) (2 racial/ethnic disparities) • Overweight (Youth) (2 racial/ethnic disparities) • Tobacco Usage (Teens and Adult)

	• HSA 9.12** // CA 5.79 **Prostate Cancer (H)** • HSA 13.09 // CA 12.37 **ASTHMA** **Asthma – Prevalence** • HSA 15.90%* // CA 14.20% **Asthma (ED)** • HSA 188.15** // CA 148.86	

Primary Data: 40 of 51 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to disease prevention and management as a health need. Themes related to the health need were as follows:

Cancer

- 17 of 51 of sources mentioned cancer or related factors as a health need
- Breast cancer and colorectal cancer were most frequently mentioned; advanced cancers are common amongst those that lack access to care
- Education/prevention services and access to screening need to be more widely available; programs such as Every Woman Counts are greatly valued but additional free/subsidized screening options are needed; proximity to oncologists and cancer specialists can be an issue as people are frequently referred several counties away for treatment

Asthma

- 14 of 51 of sources mentioned asthma or related factors as a health need
- There is generally poor air quality in the Sacramento Valley which extends up into the foothills; smoke from grass and forest fires exasperate the issue; poor air quality results in elevated rates of asthma and children and low-income populations are particularly affected
- Other contributors to asthma include smoking and secondhand smoke from tobacco and marijuana products

CVD/Stroke

- 27 of 51 of sources mentioned CVD/Stroke or related factors as a health need
- High blood pressure/hypertension and heart disease were most frequently mentioned; both service providers and community members noted these conditions as being very prevalent; increased awareness, education and management services pertaining to CVD/Stroke are needed to improve health

HIV/AIDS/STIs

- 8 of 51 of sources mentioned HIV/AIDS/STIs or related factors as a health need
- HIV/AIDS, HEP C and syphilis were noted as issues particularly for men who have sex with men and for intravenous drug users; youth are also at high risk of STDs. Health education and harm reduction services such as needle exchanges are needed to decrease the burden of HIV/AIDS and STDs

Geographic Impact:

Table 16. Cancer mortality compared to hospital service area, county and state benchmarks (rates per 10,000 population)		
CANCER MORTALITY RATE	95602*	26.66
	95603*	24.32
	95621*	22.16
	95623	22.99
	95628	23.97
	95648*	26.12
	95667*	22.23
	KFH-Roseville	18.32
	El Dorado	20.20
	Placer	18.01
	Sacramento	17.24
	Yuba	13.98
	California	15.41
Sources: Mortality CDPH, 2010-2012; 2013 American Community Survey 5-year Estimate *Indicates Focus Community		

Table 17. 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	95610*	259.89	104.04
	95619	265.15	103.61
	95621*	274.73	118.95
	95623	226.92	124.17
	95635	190.46	105.49
	95662	218.06	93.89
	95674	204.06	123.04
	95681	212.68	104.27
	95703	215.60	141.93
	95842*	325.39	102.44
	95961	248.35	99.19
	KFH-Roseville	188.15	82.77
	El Dorado	161.90	71.69
	Placer	166.81	79.21
	Sacramento	235.95	101.20
	Yuba	255.20	108.47
	California	148.86	70.55
Sources: ED visits and hospitalizations: OSHPD, 2011-2013 *Indicates Focus Community			

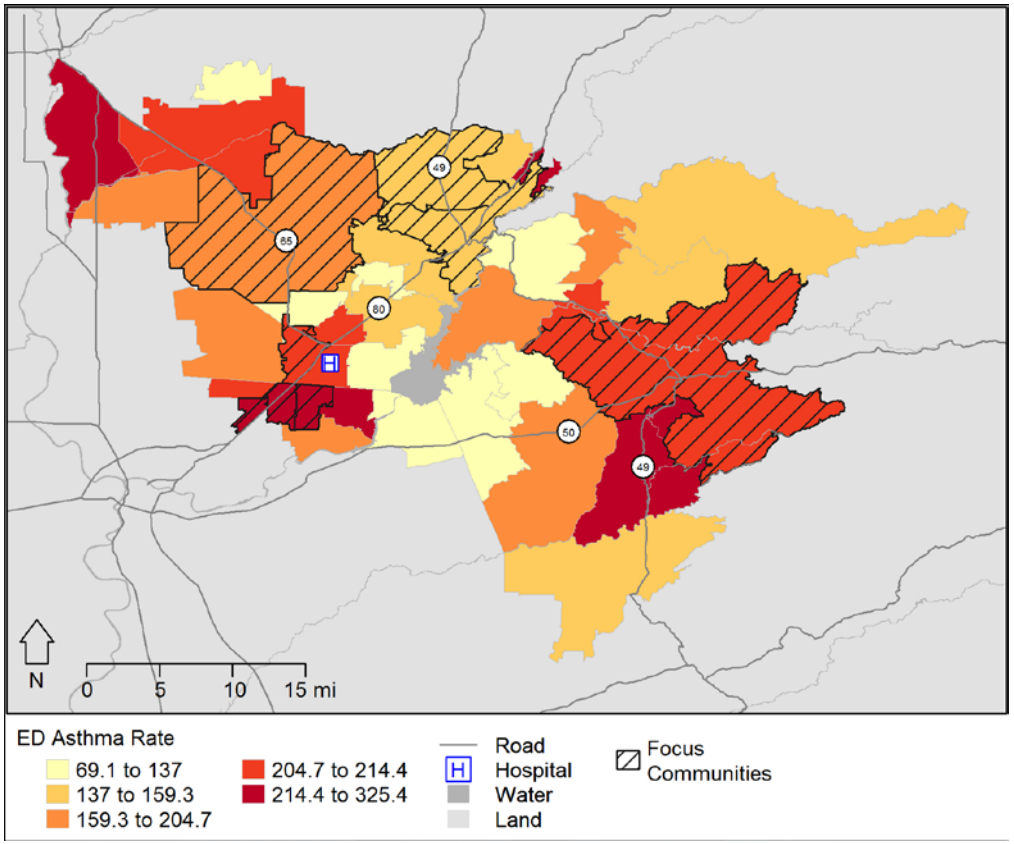


Figure 12. Map of asthma Emergency Department rates by ZIP Code

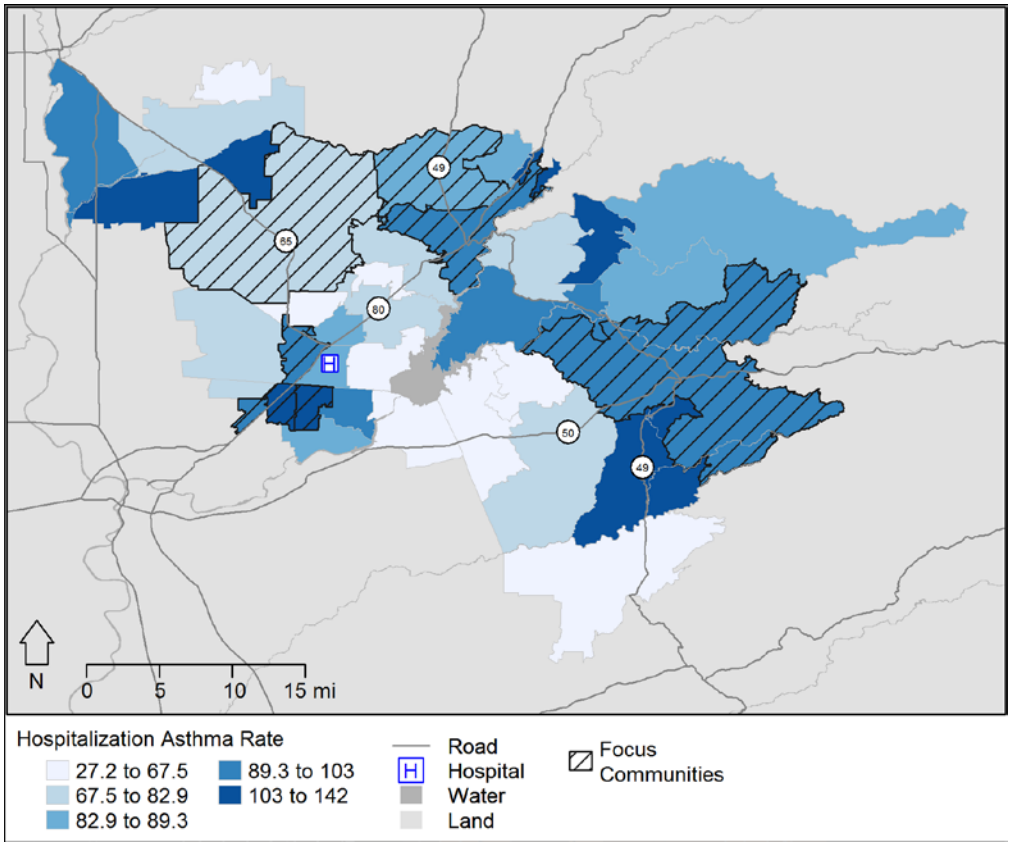


Figure 13. Map of asthma Hospitalization rates by ZIP Code

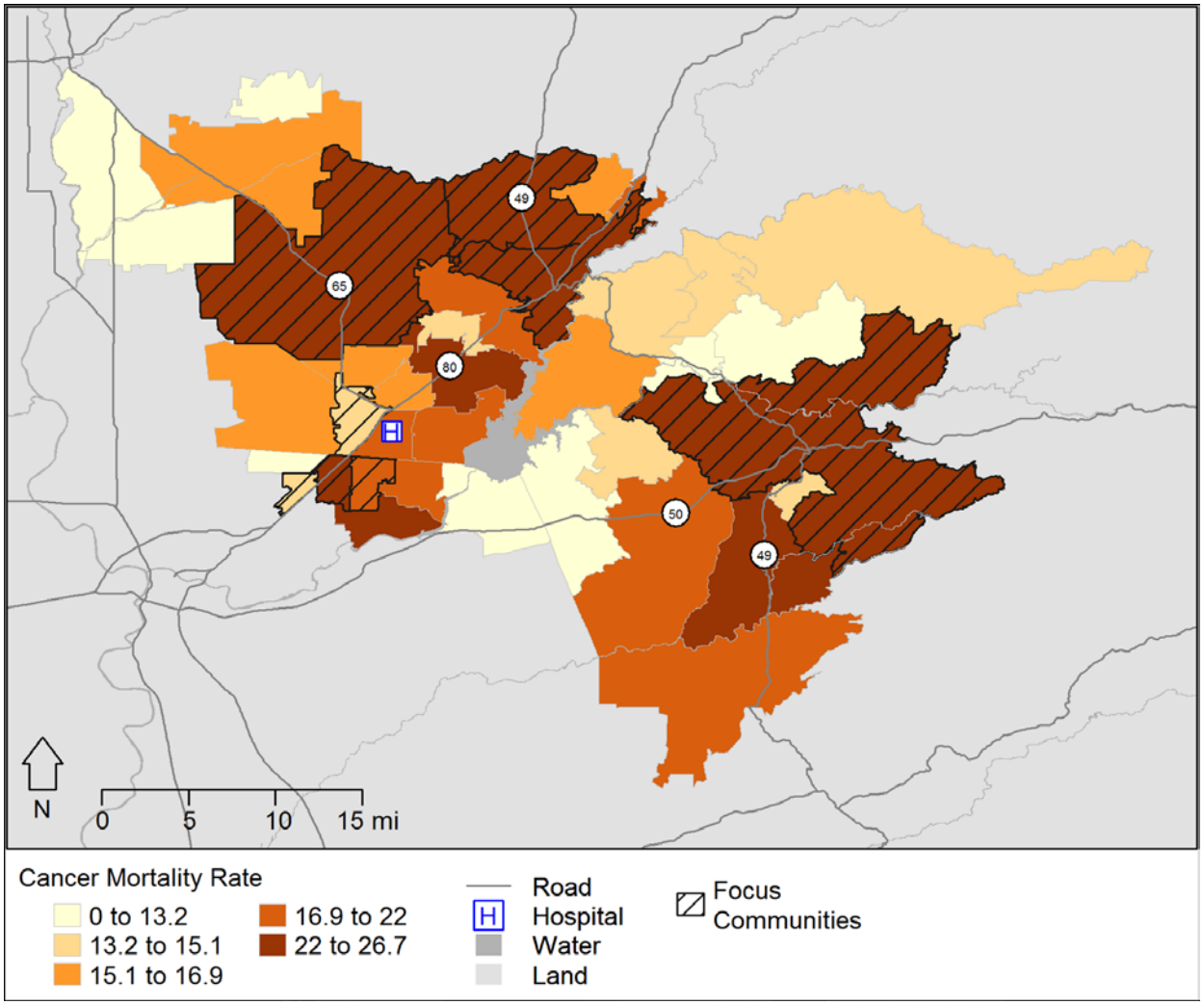


Figure 14. Map of cancer mortality rates by ZIP Code

Safe, Crime and Violence-Free Communities

Rationale	Health Outcomes Indicators CORE INDICATORS	Contributing Factors RELATED INDICATORS
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** • HSA 2.63 // CA 5.15 • Black Alone 14.45** // HSA 2.63 • Native Hawaiian/ Pacific Islander Alone 5.17** // HSA 2.63 **Mortality - Motor Vehicle Accident** • HSA 3.02 // CA 5.18 o Black Alone 7.2** // HSA 3.02 **Mortality - Pedestrian Accident** • HSA 1.62 // CA 1.97 o Black Alone 4.4** // HSA 1.62 **Violence - Youth Intentional Injury** • HSA 740.2* // CA 738.7 **Major Crimes** • HSA 354.67** // CA 312.65 **Unintentional Injury (ED)** • HSA 712.31** // CA 666.38 **Unintentional Injury (H)** • HSA 181.95** // CA 154.85 **Domestic Violence** • HSA 127.17** // CA 40.18	• Alcohol – Expenditures** • Alcohol - Excessive Consumption* • Violence - School Suspensions** • Substance Abuse (ED) • Substance Abuse (H) • Transit – Walkability** • Physical Inactivity (Youth) (3 racial/ethnic disparities)

Primary Data: 42 of 51 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 the health need were as follows:

- Substance abuse (including alcohol abuse) compromises public safety and perceptions of safety for communities in the service area; substance abuse is often connected to domestic violence and other health and safety issues; street sales of drugs compromise the safety of schools, parks and other public areas; substance abuse appears to be particularly prevalent among homeless, youth and low-income populations, as well as in rural areas where people don't have a lot to do
- More substance abuse treatment options as well as preventative education, peer education and harm reduction strategies are needed; stigma must also be addressed; community members in recovery often feel they experience discrimination from the medical community when seeking treatment for substance abuse-related physical health issues.
- Domestic violence is frequently mentioned in conjunction with substance abuse, trauma, stress and CPS removals of children from their homes; domestic violence is noted as particularly high among Native American populations and also for rural areas; people with limited transportation and access to services and immigrant populations may be especially at risk.
- Child abuse/neglect and adverse childhood experiences (ACEs) are issues that adversely affect health; seniors dependent on their families or living in senior housing may also experience abuse or bullying and related poor health outcomes.

- Gang violence is mentioned as an issue most specifically in the North Sacramento/North Highlands/Del Paso heights area; gangs have an especially negative impact on youth; gang violence prevents people from being physically active in their neighborhoods.

Geographic Impact

Rates for Assault and Unintentional Injury – Emergency Department (ED) visits and Mental Health – Hospitalization (H) and are particularly high for the ZIP codes below.

Table 18. ZIP codes with the worst 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	95610*	31.42	4.25
	95619	38.70	1.07
	95621*	31.02	4.40
	95630	16.91	4.55
	95662	25.49	3.48
	95667*	28.30	2.70
	95681	34.89	4.61
	95703	22.67	3.42
	95842*	48.92	7.42
	95961	34.20	4.67
	KFH-Roseville	21.10	2.63
	El Dorado	23.24	1.72
	Placer	17.10	1.48
	Sacramento	39.09	5.78
	Yuba	36.82	4.75
	California	30.36	3.88

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

* Indicates Focus Community

Table 19. 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	95619	1137.02	280.42
	95621*	811.30	224.45
	95623	1032.68	261.13
	95634	830.61	246.95
	95635	940.30	181.90
	95651	1047.63	257.09
	95658	684.17	241.24
	95667*	951.64	228.70
	95669	879.37	190.24
	95703	1061.14	383.56
	95842*	876.85	187.93
	KFH-Roseville	712.31	181.95
	El Dorado	806.32	179.30
	Placer	718.98	186.36
	Sacramento	761.56	176.40
	Yuba	894.47	203.57
	California	666.38	154.85

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

*Indicates Focus Community

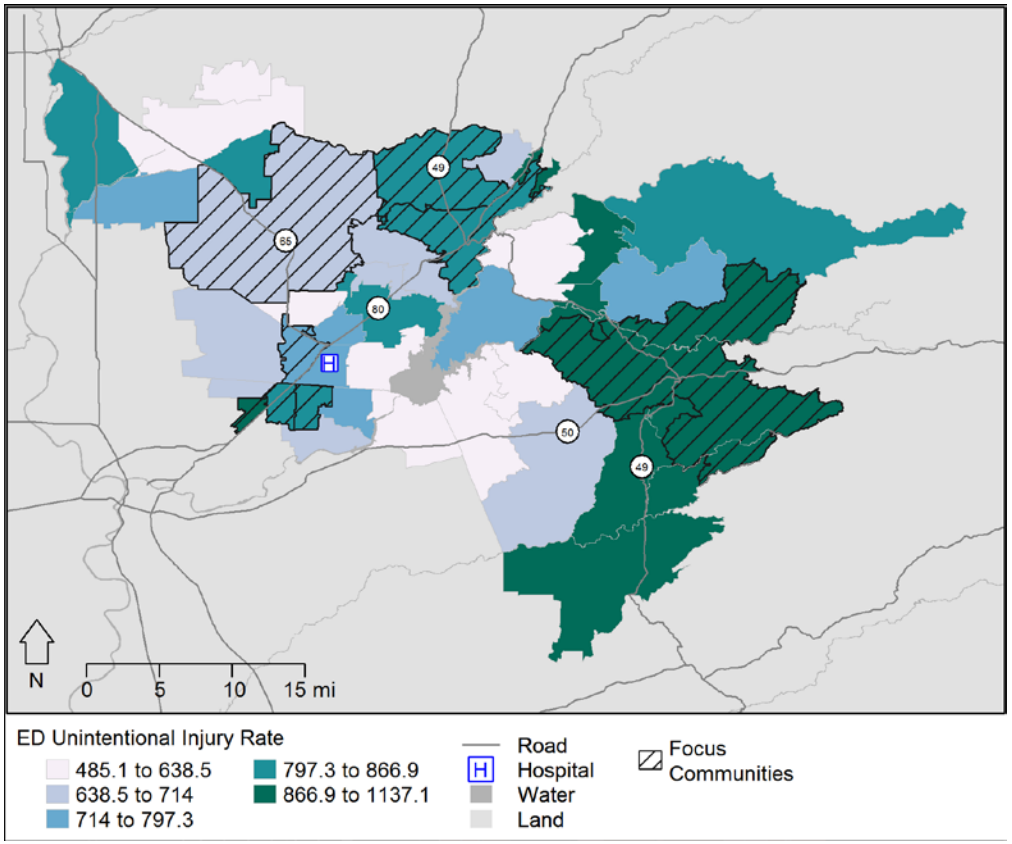


Figure 15. Map of unintentional injury Emergency Department rates by ZIP

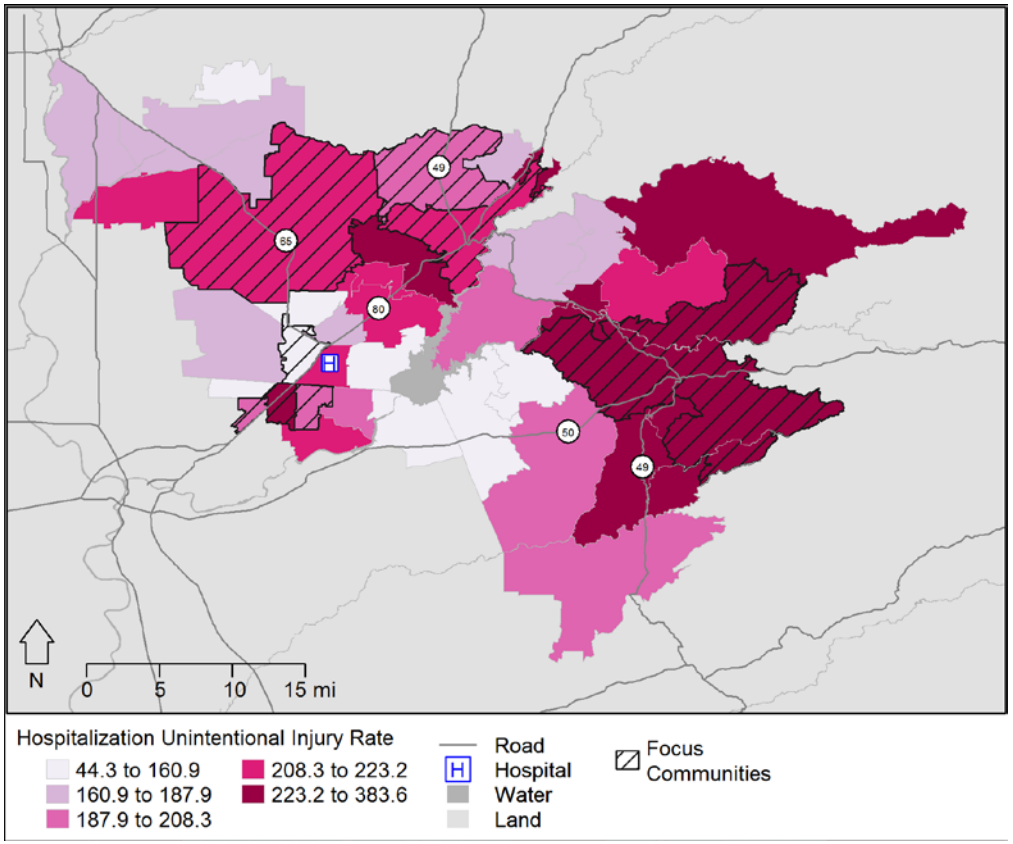


Figure 16. Map of unintentional injury Hospitalization rates by ZIP Code

Affordable and Accessible Transportation

Rationale	Health Outcomes Indicators CORE INDICATORS	Contributing Factors RELATED INDICATORS
Affordable and accessible transportation options help people to live safely in their communities, reach essential destinations, and lead more rewarding and productive lives. This is especially important for people who may have difficulty with transportation to health care services including older adults, people with disabilities, and people with low incomes. Increasing access to a wide variety of transportation options helps people to maintain active lifestyles and can also lead to reductions in traffic congestion and air pollution, resulting in a healthier environment. Transportation options such as mass transit, paratransit and walking and biking helps to reduce dependency on automobiles and improve air quality and health. Sources: o http://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf	**Transit - Public Transit within 0.5 Miles** • HSA 10.65%** // CA 15.53% **Commute to Work - Alone in Car** • HSA 78.90%** // CA 73.16%	• Disability • Transit – Walkability** • Commute to Work - Walking/Biking* • Walking/Biking/Skating to School** (1 racial/ethnic disparity)

Primary Data: 37 of 51 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to transportation as a health need. Themes related to the health need were as follows:

- Health services are often located far away from residents (especially specialty care)
- Public transportation is lacking - both in general and as relates to accessing health services; residents have a hard time making it to doctor's appointments owing to lack of transportation
- In urban centers the public transportation system is ineffective; the suburban cities and rural towns are car-driven communities that may be entirely lacking public transportation options
- The urban public transportation infrastructure lacks coordination, resulting in multiple transfers and a lot of time wasted on transit
- Transportation needs are particularly acute for the elderly, disabled and low-income individuals and families
- Shuttle services and/or bus tokens would be useful to facilitate access to health care and other services
- Lack of transportation may be a barrier to accessing healthy food options; people experiencing financial hardship may need to choose between spending money on transportation or medications and other health necessities

Geographic Impact
As evidenced in the map below, there are very few locations within the ZIP codes within the HSA that intersect census tracks where the population lives close to a public transit stop.

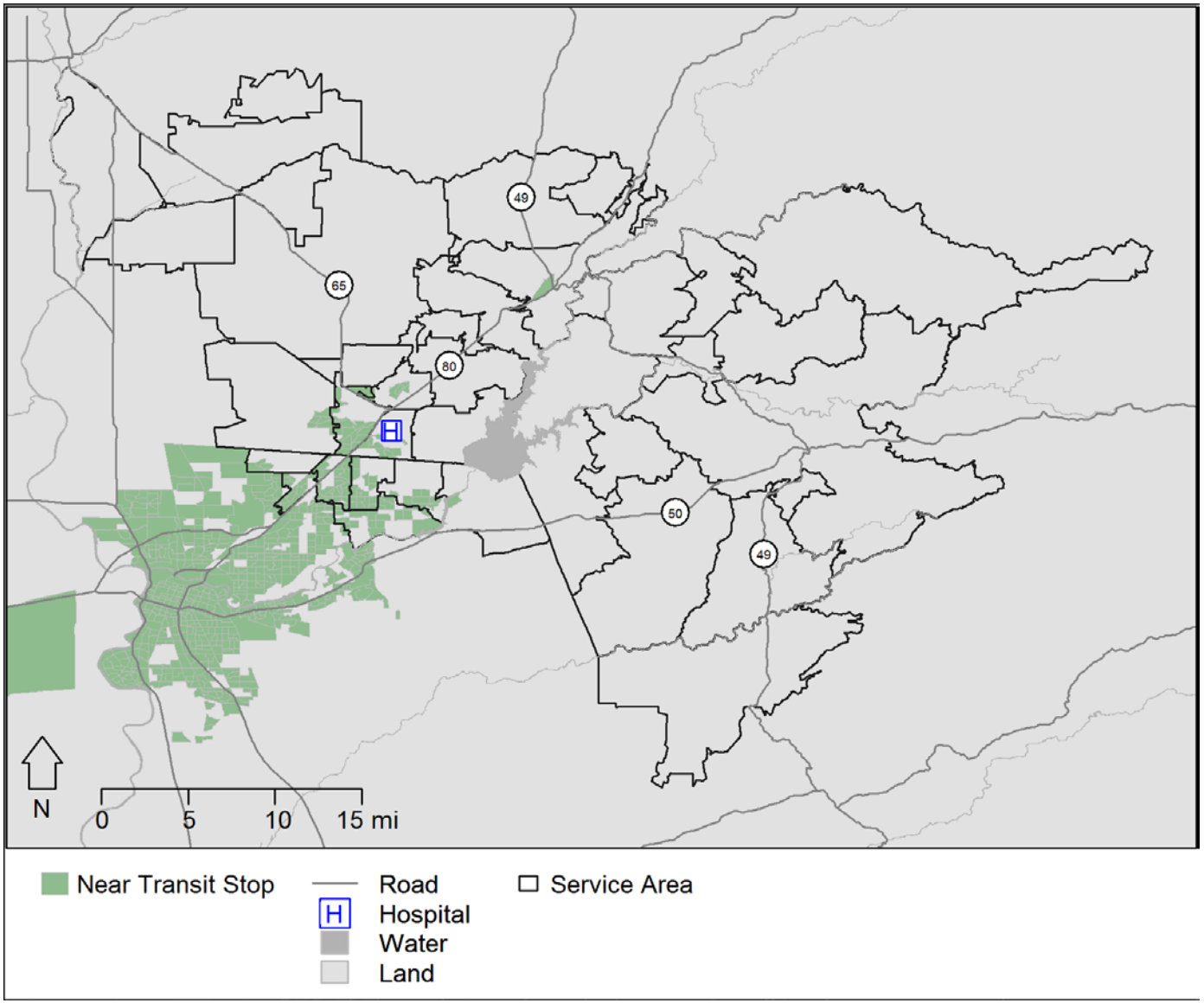


Figure 17. Map of population living near a transit stop by ZIP code

Access to High Quality Health Care and Services

Rationale	Health Outcomes Indicators CORE INDICATORS	Contributing Factors RELATED INDICATORS
o **Access to Care – General:** 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. o **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 disparities in maternal, infant and child health. o **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: o http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services o http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health o http://www.healthypeople.gov/2020/topics-objectives/topic/oral-health	**ACCESS TO CARE - GENERAL** **Lack of a Consistent Source of Primary Care** • HSA 11.62% // CA 25.18% • Non-Hispanic Black 18.31%** // HSA 11.62% • Hispanic/ Latino (Any Race) 22.58%** HSA 11.62% **ACCESS TO CARE – MATERNAL AND INFANT HEALTH** **Prenatal Care** • HSA 81.62 // CA 83.6 **ORAL HEALTH** **Poor Dental Health** • HSA 12.40%* // CA 11.30% **Dental Care - No Recent Exam (Youth)** • HSA 14.90% // CA 18.50% • Non-Hispanic White 21.24%** // HSA 14.90% • Hispanic/ Latino (Any Race) 38.91%** // HSA 14.90% **Dental/Oral Diseases (ED)** • HSA 44.66 // CA 41.34 **Dental/Oral Diseases (H)** • HSA 8.45 // CA 7.81	**ACCESS TO CARE - GENERAL** • Insurance - Uninsured Population (4 racial/ethnic disparities) **ACCESS TO CARE – MATERNAL AND INFANT HEALTH** • Breastfeeding (Any) (3 racial/ethnic disparities) • Breastfeeding (Exclusive) (5 racial/ethnic disparities)

o http://www.gao.gov/new.items/d081121.pdf		

Primary Data: 50 of 51 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to access to health care services (primary, specialty, oral and prenatal care) as a health need. Themes related to the health need were as follows:

General

- Specialty care providers are in short supply, particularly for Medi-Cal patients; people have to travel a long distance to access specialty care and may be referred to providers that are hours away; dental/vision are both lacking; lack of specialty care is particularly acute for the undocumented
- 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; recruiting physicians to the rural areas presents a challenge; people end up using the ER since they can't get in to see their PCP
- Access to care is often limited by distance and transportation barriers; health care facilities are often far from where people are living and/or cannot be accessed by public transportation without significant time or cost burden
- Health system capacity has been highly impacted by the Affordable Care Act; many patients wait months before being able to see a doctor; there are very few providers that accept Medi-Cal; many hospital ERs are overwhelmed and over-utilized since the newly insured may not know how to use/access their doctor or wait times are so long
- Undocumented populations have very limited access to care; this lack of access is a huge barrier in terms of health and wellness; primary and specialty care is especially difficult to access and the ER may be their only option for care
- There are numerous coverage gaps for both Medi-Cal and non Medi-Cal populations; people don't understand their insurance coverage; middle-income individuals and families fall through the cracks if they don't qualify for Medi-Cal or other subsidized care but the cost burden of insurance/treatment is high; prescription medications and co-pays are unaffordable for many
- Access to quality care is limited or compromised by a lack of coordinated care between and within health systems; mental and physical health services are in siloes which leads to fragmented care for patients with co-morbid conditions; patient-centered care and medical homes are often lacking or not robust enough to ensure continuity of care; coordination between health care, public health and social service systems is lacking, particularly as relates to discharge planning, STD detection/treatment and postpartum services; case management and patient navigation are needed to assist patients with care transitions, referrals and follow up
- There is a lack of preventative care and health education services; many children are behind on immunizations; the newly insured often don’t know how to navigate health care systems and may use the ER as a one-stop-shots to get their health needs met; patient navigators are essential to help people access the care they need; health education for chronic disease prevention and management is essential to health but these services are often not available or accessible
- The lack of culturally and linguistically appropriate services is a barrier to care for ESL and LEP populations; interpretation and translation services are often lacking or inadequate; providers need more cultural sensitivity training for working with diverse populations according to race/ethnicity, immigration status, sexual orientation and gender identity, etc.; the health care workforce often lacks diversity; navigating Medi-Cal is particularly difficult if English is a second language
- 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; preventative care (e.g. fall prevention and medication management are also lacking)

Maternal and Infant Health

- Prenatal care options are lacking, particularly in the Auburn area; women are presenting with late or no prenatal care; many women need to travel to Sacramento for prenatal care and delivery; disparities in prenatal care access are acute for Latino and Medi-Cal populations

- Many children are behind on immunizations owing to lack of access, knowledge or personal exemption beliefs

Dental

- Access to dental care is limited, particularly for Medi-Cal populations; there are few dental providers that accept Medi-Cal
- Oral health for children is particularly important but many low-income children do not receive regular check-ups; in some places the water isn't fluoridated

Geographic Impact

Rates for Oral and Dental Disease – Emergency Department (ED) visits and Mental Health – Hospitalization (H) and are particularly high for the ZIP codes below. In addition, ZIPs with the lowest percent of live births for mothers for which mother received prenatal care in the first trimester are included. As illustrated in the map of primary care provider shortage areas, El Dorado County is disproportionally affected by a lack of primary care providers.

Table 20. ZIP codes with the worst ED visit and Hospitalization rates for oral and dental diseases compared to hospital service area, county and state benchmarks (rates per 10,000 population)

	Zip Code	ED	Hospitalization
ORAL AND DENTAL DISEASES	95603*	53.30	10.50
	95610*	74.40	10.33
	95619	86.41	9.75
	95621*	68.09	10.50
	95623	71.90	12.04
	95633	46.30	11.93
	95634	55.05	11.78
	95635	69.03	8.14
	95662	47.44	10.68
	95667*	66.90	8.60
	95703	56.76	13.12
	95842*	113.90	8.87
	95961	64.53	8.31
	KFH-Roseville	44.66	8.45
	El Dorado	60.46	7.65
	Placer	36.32	8.19
	Sacramento	72.66	9.77
	Yuba	81.94	9.37
	California	41.34	7.81

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

* Indicates Focus Community

Table 21. ZIP codes with the lowest percent of live births for which mothers received prenatal care during the first trimester compared to hospital service area, county and state benchmarks

Prenatal Care	95602*	75.09
	95603*	76.88
	95619	74.58
	95633	75.97
	95667*	70.29
	95674	77.42
	95842*	72.21
	95961	71.95
	KFH-Roseville	81.62
	El Dorado	78.60
	Placer	85.30
	Sacramento	81.40
	Yuba	69.80
	California	83.60

Sources: Mortality CDPH, 2010-2012

* Indicates Focus Community

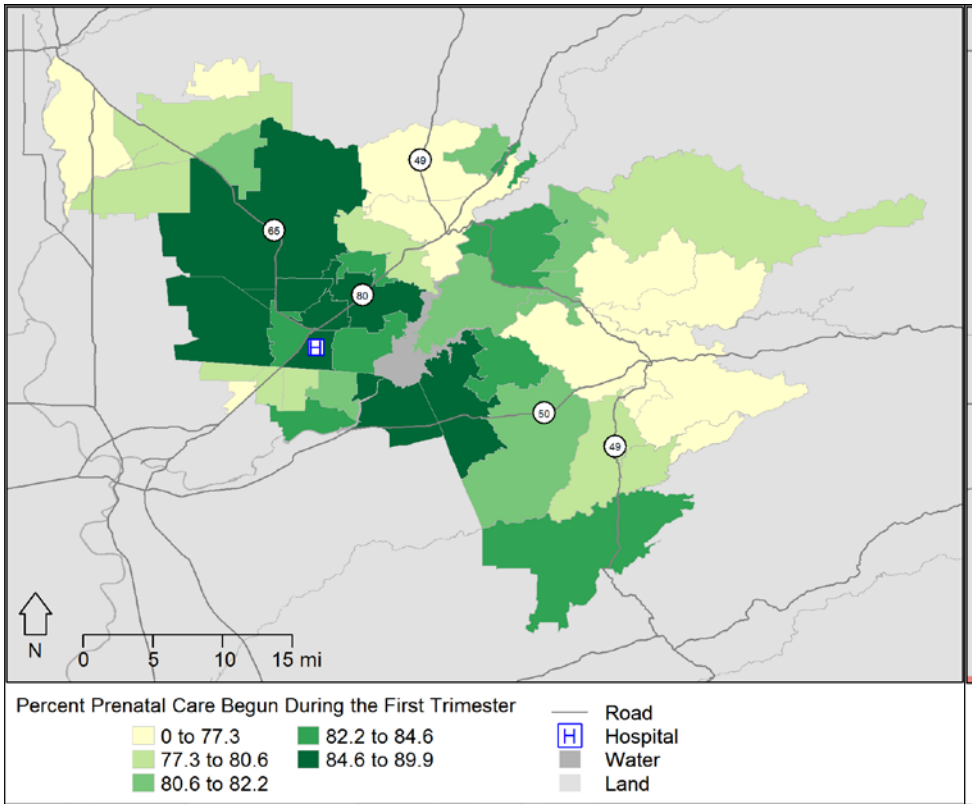


Figure 18. Map of prenatal care begun in the 1st trimester by ZIP code

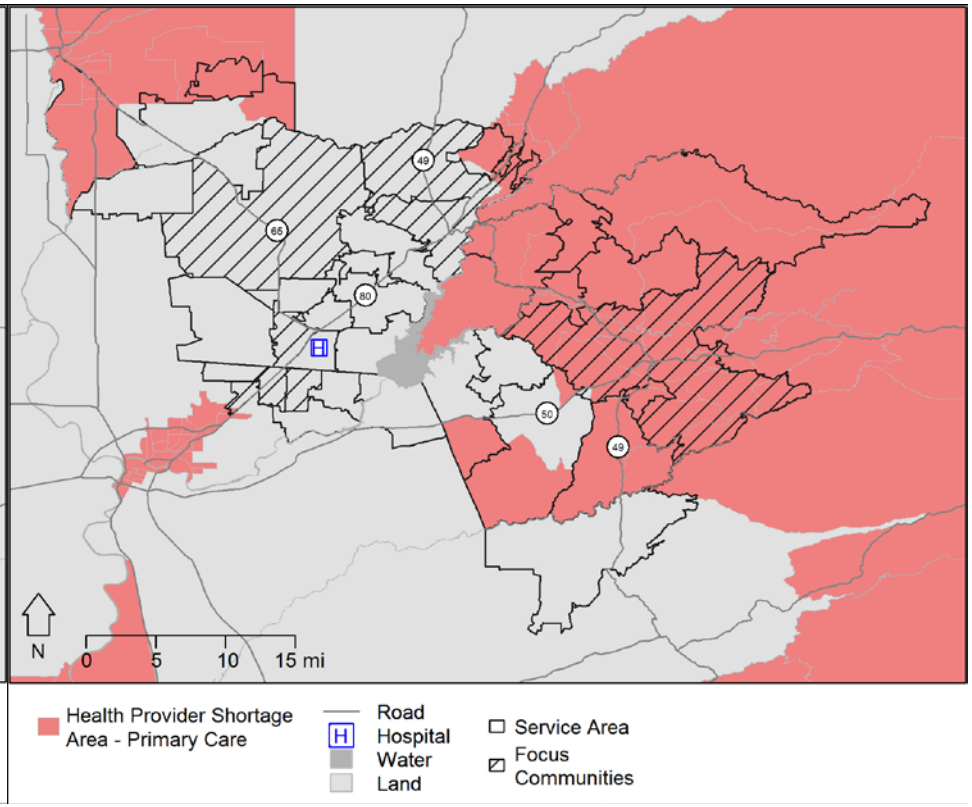


Figure 19. Map of Health Provider Shortage Area – Primary Care

Basic Needs

Rationale	Health Outcomes Indicators CORE INDICATORS	Contributing Factors RELATED INDICATORS
Basic Needs 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 10.05% // CA 15.94% • Black Alone 20.51%** // HSA 10.05% • Native American/ Alaskan Native Alone 20.55%** // HSA 10.05% • Some Other Race Alone 20.98%** // HSA 10.05% • Multiple Race 14.01%** // HSA 10.05% • Hispanic/Latino (Any Race) 18.07%** // HSA 10.05% **Poverty - Children Below 100% FPL** • HSA 13.17% // CA 22.15% • Black Alone 27.60%** // HSA 13.17% • Native American/ Alaskan Native Alone 25.65%** // HSA 13.17% • Native Hawaiian/ Pacific Islander Alone 20.15%** // HSA 13.17% • Some Other Race Alone 29.53%** // HSA 13.17% • Hispanic/Latino (Any Race) 33.04%** // HSA 10.05%	• Education - High School Graduation Rate (3 racial/ethnic disparities) • Education - Reading Below Proficiency (4 racial/ethnic disparities) • Education - Less than High School Diploma (or Equivalent) (4 racial/ethnic disparities) • Insurance - Uninsured Population (3 racial/ethnic disparities) • Life Expectancy at Birth

Primary Data: 50 of 51 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to basic needs such as food, housing, employment and education as a health need. Themes related to the health need were as follows:

- Economic security is an issue within the HSA, particularly for the North Sacramento/North Highlands area, “pockets” of poverty in Placer County such as Lincoln, Central/Old Roseville, North Auburn and small foothill communities; unemployment and underemployment are issues that negatively impacts quality of life; employment opportunities may be scarce, far away from where people are living or pay very low wages; the cost of living is high and healthy food and recreation options are often prohibitively expensive; low-income populations may have to make difficult decisions between food and health care needs; middle-income families may not qualify for benefits such as childcare and food stamps and struggle to make ends meet, particularly multi-generational households; seniors on fixed incomes have difficulty affording food, housing and health care costs; people who have health insurance may still not be able to access care if they can’t cover the cost of co-pays, deductibles or prescription medications; health and wellness may be diminished for populations with scarce resources that need to prioritize meeting needs for food, housing and transportation

- Affordable and low-income housing options are greatly needed within the service area; the rental market is extremely competitive and expensive; families may live in overcrowded situations, substandard housing or unsafe neighborhoods since they can't afford better living conditions; more Section 8 housing and subsidized housing for low-income seniors are especially needed; there are few shelters for the homeless and many of these operate with very limited hours and scarce resources
- Education opportunities such as vocational training and adult education to improve employment prospects are lacking or unaffordable; educational attainment is lagging for minorities such as Latino youth; educational opportunities in languages other than English are often lacking; education beyond traditional health education is needed for issues such as parenting, budgeting and navigating health care systems; public education and work opportunities are needed to break cycles of poverty and improve the socio-economic prospects and health of future generations
- Food insecurity is pervasive among people without a lot of disposable income; public assistance benefits such as CalFresh don't last through the month and need to be supplemented with assistance from food banks and pantries; access to affordable healthy foods is limited, particularly for people living in food deserts

Geographic Impact

Table 22. 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%
95603*	78.32	10.87
95610*	77.86	14.92
95621*	79.09	14.92
95633	78.61	6.52
95667*	79.50	12.62
95681	80.20	16.33
95692	78.33	17.03
95703	78.69	7.1
95842*	79.45	25.73
95843	79.02	12.06
95961	78.52	18.38
KFH-Roseville	80.34	9.95
El Dorado	80.81	9.01
Placer	80.63	8.73
Sacramento	78.74	17.59
Yuba	76.47	21.59
California	80.53	15.94

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

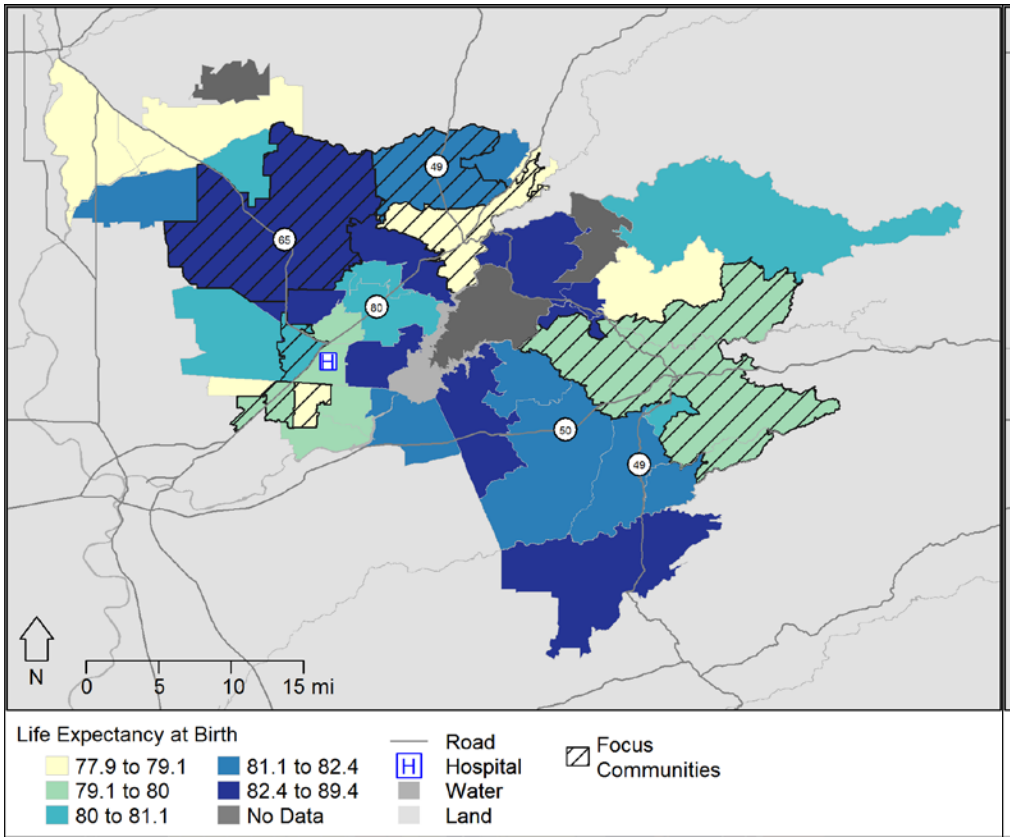


Figure 20. Map of life expectancy at birth (in years) by ZIP code

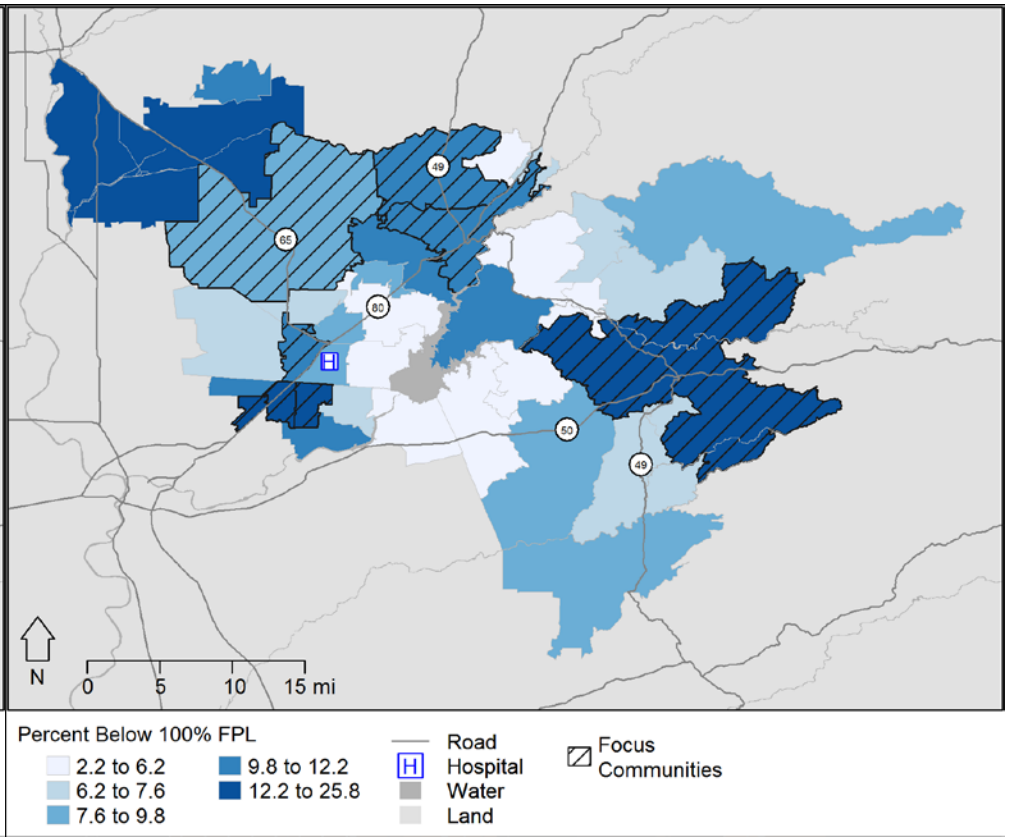


Figure 21. Map percent below 100% FPL by ZIP code

Pollution Free Living and Work Environments

Rationale	Health Outcomes Indicators CORE INDICATORS	Contributing Factors RELATED INDICATORS
A healthy, pollution-free environment is central to good health status, quality of life and years of healthy life lived. Societal and environmental factors that increase the likelihood of exposure and disease include poor outdoor air quality, water contamination, exposure to toxic substances and hazardous waste, and indoor pollutants such as lead-based paint. Poor air quality is linked to premature death and cancer; secondhand smoke contributes to heart disease and lung cancer in nonsmoking adults. Environmental factors may also particularly impact people whose health status is already at risk, such as people with asthma that may be triggered or exasperated by poor air quality or secondhand smoke. An environment free of pollutants helps prevent disease and other health problems. Sources: • http://www.healthypeople.gov/2020/topics-objectives/topic/environmental-health • http://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Environmental-Quality	**Air Quality - Particulate Matter 2.5** • HSA 10.52%** // CA 4.17% **Air Quality - Ozone (O3)** • HSA 4.14%* // CA 2.47% **Asthma – Prevalence** • HSA 15.90%* // CA 14.20%	• Transit - Road Network Density** • Transit - Public Transit within 0.5 Miles** • Commute to Work - Alone in Car** • Obesity (Adult)* • Mortality - Ischemic Heart Disease (3 racial/ethnic disparities) • Obesity (Youth) (2 racial/ethnic disparities) • Physical Inactivity (Youth) (3 racial/ethnic disparities) • Asthma (ED) • Asthma (H) • Chronic Lower Resp Disease - MORT • COPD (ED) • COPD (H) • Tobacco Usage (Teens and Adults) • Heart Disease (ED)

Primary Data: 25 of 51 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 the health need were as follows:

- Poor air quality in the service area negatively impacts health; there are elevated rates of asthma and children and low-income populations are particularly affected
- Bad air quality is particularly acute in the foothills during the summer months owing to grass and forest fires that have increased with the California drought; fire smoke contributes to and exasperates COPD and other respiratory conditions
- Secondhand smoke from cigarettes and marijuana acts as a pollutant; better enforcement of anti-smoking laws and smoking cessation programs are needed
- In the North Sacramento/North Highlands area illegal dumping and other pollutants are an issue

Geographic Impact: The two zip codes that have disproportionally high levels of pollution burden are: 95678* (Roseville – Central), and 95692 (Wheatland).

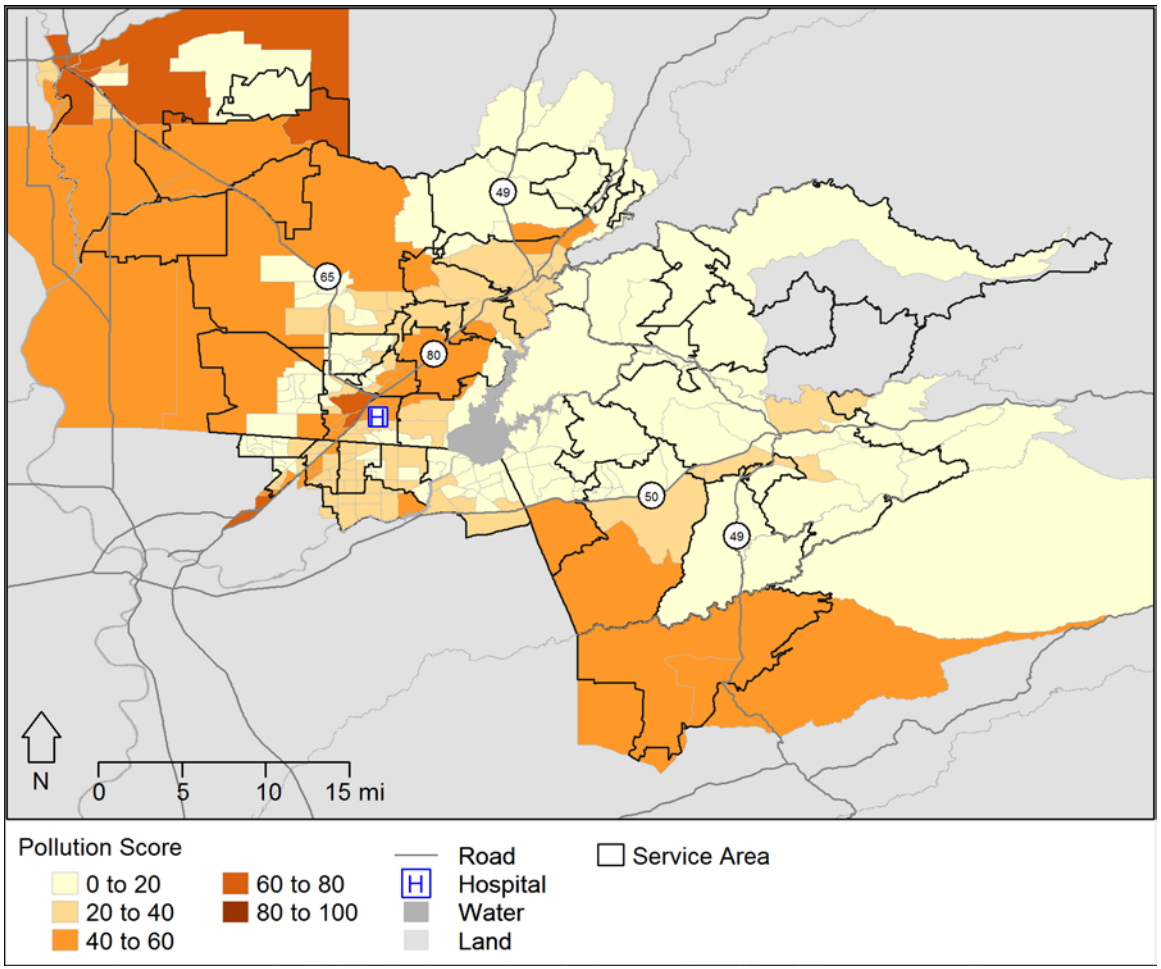


Figure 22. Map of Pollution Burden Score for KFH-Roseville

APPENDIX D: Detail 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) (See 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 23.

Table 23. 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 24. Indicators were sourced from the CHNA-DP and as outlined in Appendix A.

Table 24. 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>
</table>

Basic Needs	
Quantitative Indicators	Qualitative Indicators
• 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	<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
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	

<table>
<tr><th colspan="2">Disease Prevention, Management and Treatment</th></tr>
<tr><td>Quantitative Indicators</td><td>Qualitative Indicators</td></tr>
<tr><td>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)</td><td rowspan="2">• Air pollution/contamination
• Anti-smoking laws and regulations
• Cost of asthma medications
Environmental triggers (dust, mites, cockroaches, mold)
• Secondhand smoke (cigarettes/marijuana)
• Smoke shops</td></tr>
<tr><td>VV sourced indicators
• Asthma (ED)
• Pollution Burden Score
• Tobacco Usage (Adults & Teens)</td></tr>
<tr><td>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)</td><td rowspan="2">• 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</td></tr>
<tr><td>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)</td></tr>
</table>

<table>
<tr><th colspan="2">Disease Prevention, Management and Treatment (continued)</th></tr>
<tr><td>Quantitative Indicators</td><td>Qualitative Indicators</td></tr>
<tr><td>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</td><td rowspan="2">• Congestive heart failure (CHF)
• Cost of medication
• CVD/Stroke
• Diagnosis, management, and treatment
• Lack of healthy eating and active living opportunities
• Hypertension
• Stroke</td></tr>
<tr><td>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)</td></tr>
<tr><td>HIV/AIDS/STDs
• HIV/AIDS (ED)
• STD - Chlamydia
• STD - HIV Hospitalizations
• STD - HIV Prevalence
• STD - No HIV Screening</td><td rowspan="2">• 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</td></tr>
<tr><td>VV sourced indicators
• STIs (ED/H)</td></tr>
</table>

<table>
<tr><th colspan="2">Healthy Eating and Active Living (HEAL)</th></tr>
<tr><td>Quantitative Indicators</td><td>Qualitative Indicators</td></tr>
<tr><td>• 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</td><td rowspan="2">• 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</td></tr>
<tr><td>VV sourced indicators
• Diabetes Mellitus – MORT
• Modified Retail Food Environment Index (MRFEI)
• Osteoporosis (ED/H)</td></tr>
<tr><th colspan="2">Pollution-Free Living and Work Environments</th></tr>
<tr><td>• 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</td><td>• Air quality
• Environmental hazards/toxins (cockroaches, mold, mildew, asbestos)
• Respiratory conditions (asthma, COPD, infections, allergies)
• Second hand smoke (tobacco and marijuana)
• Transportation</td></tr>
</table>

<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 25 below.

Table 25. 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	Exceeds State

	County	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 HAS
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	Exceeds State

	rates	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 26.

Table 26. 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	72%	98%	**2**	**73%**
2. HEAL	57%	98%	**2**	**37%**
3. Disease Prevention/Management	56%	78%	**2**	**31%**
4. Safe Communities	58%	82%	**2**	**22%**
5. Transport	75%	73%	**2**	**6%**
6. Access to Care	28%	98%	**1**	**47%**
7. Basic Needs	25%	98%	**1**	**12%**
8. Pollution Free Communities	62%	49%	**1**	**0%**

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 27), 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-Roseville are listed in Table 27 along with socio-demographic data for these communities that can be compared to the county and state benchmarks.

Table 27. Demographics of KFH-Roseville Focus Communities

NAME	ZIP	TPOP	MINO	LENG	NDIP	UEMP	PVFC	PVEL	PVSF	RENT	UINS
North Auburn	95602	18,049	15.88%	2.59%	9.09%	11.2%	16.4%	2.52%	31.7%	25.3%	11.2%
Auburn	95603	28,054	16.6%	1.26%	8.59%	11.5%	9.9%	2.99%	19.7%	35.2%	11.7%
Citrus Heights; Orangeville	95610	43,333	28.25%	5.95%	10.7%	13.7%	15.9%	1.32%	29.3%	50%	18.4%
Citrus Heights; Antelope	95621	41,573	27.32%	3.22%	10.9%	15.2%	19.9%	1.7%	34.2%	37.7%	13.3%
Lincoln	95648	48,243	27.23%	3.35%	6.59%	10.7%	12%	2.09%	34.4%	21%	9.4%
Placerville	95667	35,924	16.99%	1.29%	7.4%	15.3%	15.5%	2.25%	30.6%	26.2%	10%
Old/Central Roseville	95678	42,606	32.18%	3.56%	9.5%	10.9%	10.7%	1.5%	29.3%	46%	13.4%
Foothill Farms; North Highlands	95842	31,689	44.8%	8.7%	15.8%	14.5%	31.1%	1.53%	53.1%	45.7%	17.7%
El Dorado		180982	20.27%	1.83%	6.8%	12%	9.5%	1.34%	24.6%	25.2%	10.2%
Placer		355924	24.55%	2.45%	6.4%	10%	9.4%	1.89%	26.4%	29.4%	9.9%
Sacramento		1435207	52.05%	7.12%	14.1%	13.7%	20.1%	1.92%	37.6%	43.3%	14.6%
California		37,659,181	60.33	10.78%	18.8%	11.5%	17.8%	2.26%	36.8%	44.7%	17.8%

TPOP	Total Population	PVFC	Percent Families with Children in Poverty
MINO	Percent Minority	PVEL	Percent Households 65 years or Older in Poverty
LENG	Population 5 Years or Older who speak Limited English	PVSF	Percent Single Female Headed Households in Poverty
NDIP	Percent 25 or Older Without a High School Diploma	RENT	Percent Renter Occupied Households
UNEMP	Percent Unemployed	UINS	Percent Uninsured

Source: 2013 American Community Survey 5-year Estimate

Table 28 – 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

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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

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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!

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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?

☐Sí ☐No

¡Gracias por participar!

APPENDIX H: Interview Guides

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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

Dignity Health · Kaiser Permanente · Sutter Health We Plus You · UC Davis Health System

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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

- **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

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

¡Usted está invitado a un grupo de enfoque!

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

¿Preguntas? Llame a Giovanna Forno de Valley Vision, 916.325.1630

APPENDIX J – Resources Available to Address Significant Health Needs for KFH-Roseville

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	Transportation
Auburn Urgent Care Clinic- Sutter Health	Auburn	Yes	X							
A Community for Peace	Citrus Heights	Yes							X	
Acres of Hope	Auburn	Yes		X						
Agency on Aging-Area 4	Arden-Arcade	Yes	X	X	X	X			X	
Alternatives Pregnancy Center	Arden-Arcade	Yes	X		X					
Alzheimer's Association	North Sacramento	Yes		X	X	X			X	
Asian Resources Inc.	Citrus Heights	Yes		X						
Auburn Interfaith Food Closet	Auburn	Yes		X			X			
Auburn Renewal Center	Auburn	Yes	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	Transportation
Birth and Beyond Programs	North Highlands; North Sacramento	Yes	X	X	X					
Boys and Girls Club of Placer County	Auburn	Yes		X	X		X		X	
Breathe California of Sacramento- Emigrant Trails	Sacramento (Downtown)	Yes	X			X		X		
Brookdale Citrus Heights (Formerly Emeritus at Citrus Heights)	Citrus Heights	Yes								
Casa Willow	Citrus Heights	Yes		X	X					
Center for AIDS Research, Education and Services- CARES Community Health	Sacramento (Midtown)	Yes	X		X		X			
Chapa-De Indian Health	Auburn	Yes	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	Transportation
Child Abuse Prevention Center	North Highlands	Yes		X					X	
Community Recovery Resources (CoRR)	Auburn	Yes		X	X				X	
Cordova Lane Center - Folsom Cordova Unified School District	Rancho Cordova	Yes		X	X					
Cycles 4 Hope	Granite Bay	Yes		X						X
Del Oro Caregiver Resource Center	Citrus Heights	Yes		X	X	X			X	
Department of Human Assistance	Arden-Arcade	Yes		X						
Divide Wellness Center	Georgetown	Yes	X							
El Dorado Community Health Center	Cameron Park, Placerville	Yes	X		X	X				
El Dorado County Mental Health	Placerville	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	Transportation
El Dorado County Public Health	Placerville	Yes	X		X	X	X	X		
El Hogar Community Services Inc.	Natomas	Yes		X	X				X	
Eskaton	Numerous	Yes	X	X	X					
Excel Roseville	Roseville	Yes		X						
Firehouse Community Center	North Sacramento	Yes				X				
First 5 El Dorado	Placerville	Yes	X	X	X	X	X		X	
First 5 Placer	Auburn	Yes	X	X	X	X	X		X	
First 5 Sacramento	North Sacramento	Yes	X	X	X	X	X		X	
Folsom Cordova Community Partnership	Rancho Cordova	Yes	X	X	X				X	
Food Bank of El Dorado County	Cameron 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	Transportation
Forgotten Soldier Program	Auburn	Yes	X		X		X			
Gender Health Center	Sacramento (Oak Park)	Yes	X	X	X				X	
Goodwill- Sacramento Valley & Northern Nevada	Sacramento (Rosemont)	Yes		X						
Greater Sacramento Urban League	North Sacramento	Yes		X						
Green Valley Church	Placerville	Yes		X	X					
Health Education Council	West Sacramento	Yes				X	X		X	
Health For All Community Clinics	North Sacramento	Yes	X	X						
Helping Hearts Foundation Inc.	Rancho Cordova	Yes		X					X	
Home Start	Roseville	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	Transportation
Kids Involuntarily Inhaling Secondhand Smoke (KIISS)	Roseville	Yes						X		
KidsFirst	Auburn	Yes		X	X	X	X		X	
Latino Leadership Council	Auburn	Yes	X	X	X	X	X		X	
Legal Services of Northern California-Health Rights	Sacramento (Downtown)	Yes		X						
Life Matters	North Highlands /Foothill Farms	Yes		X					X	
Lighthouse Counseling & Family Resource Center	Lincoln	Yes	X	X	X	X	X		X	
Meals on Wheels Sacramento	Rocklin	Yes		X	X					
Mercy Folsom	Folsom	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	Transportation
Mexican Consulate General in Sacramento	Natomas	Yes		X					X	
Molina Healthcare	North Sacramento, Citrus Heights	Yes	X							X
Mutual Assistance Network (MAN)	Del Paso Heights	Yes		X	X	X			X	X
My Sister's House	South Sacramento	Yes	X	X	X				X	
Neil Orchard Senior Activities Center	Rancho Cordova	Yes					X			
PEACE for Families	Auburn, Roseville	Yes		X	X				X	
Placer County Adult System of Care	Auburn	Yes	X	X	X				X	
Placer County Dial-A-Ride	Auburn	Yes								X
Placer County Human Services	Auburn	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	Transportation
Placer County Mental Health Services	Auburn	Yes		X	X					
Placer County Public Health Department	Auburn	Yes	X		X	X	X	X		
Placer County Public Health Nursing	Auburn	Yes	X	X	X	X	X	X	X	
Placer County Sexual Assault Response Team (SART)	Roseville	Yes	X						X	
Placer County Veterans Services	Rocklin	Yes		X	X					
Placer County WIC	Auburn	Yes	X			X	X			
Placer Food Bank	Roseville	Yes		X			X			
Placer Independent Resource Services (PIRS)	Auburn	Yes		X						
Placer People of Faith Together	Loomis	Yes	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	Transportation
Planned Parenthood Roseville Health Center	Roseville	Yes	X			X				
Powerhouse Ministries	Folsom	Yes		X						
PRIDE Industries	Fair Oaks, North Sacramento, North Highlands, Placerville	Yes		X						X
Roberts Family Development Center	North Sacramento	Yes		X	X		X		X	
Sacramento Area Congregations Together (Sacramento ACT)	Sacramento (Rosemont)	Yes	X	X						
Sacramento City Unified School District	South 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	Transportation
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	X		
Sacramento Covered	Sacramento (Rosemont)	Yes	X							
Sacramento Employment and Training Agency (SETA)	North Sacramento	Yes		X						
Sacramento Food Bank and Family Services	Sacramento (Oak Park)	Yes		X			X			
Sacramento Housing and Redevelopment Agency (SHRA)	Sacramento (Downtown)	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	Transportation
Sacramento LGBT Community Center	Sacramento (Midtown)	Yes		X					X	
Sacramento Steps Forward	North Sacramento	Yes		X						
Sacramento Works Job Center	Foothill Farms, Rancho Cordova	Yes		X						
Senior Peer Counseling Program	Placerville	Yes		X						
Seniors First	Auburn	Yes		X	X					X
SETA Head Start	North Sacramento	Yes		X			X			
Sierra Foothills Outpatient Clinic	Auburn	Yes			X					
Sierra Forever Families- Placer Kids	Auburn	Yes		X	X				X	
Sierra Health Foundation	North Sacramento	Yes	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	Transportation
Sierra Mental Wellness Group	Auburn	Yes			X					
Slavic Assistance Center	Arden-Arcade	Yes	X	X	X	X	X		X	
Shingle Springs Tribal TANF Program	El Dorado, Shingle Springs	Yes		X						
South Placer Residential Treatment	Auburn	Yes		X	X				X	
St. Vincent DePaul Society of Placer County	Roseville	Yes	X	X	X	X				
Stand Up Placer	Auburn	Yes		X	X				X	
Strategies for Change	North Highlands	Yes		X	X				X	
Sutter Auburn Faith Hospital	Auburn	Yes	X			X				
Sutter Roseville Medical Center	Roseville	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	Transportation
Teens Matter, Inc.	Auburn	Yes			X					
Terra Nova Counseling	Citrus Heights	Yes			X					
The Gateway Mountain Center	Soda Springs	Yes		X	X					
The Gathering Inn	Auburn, Roseville	Yes	X	X	X				X	
The Keaton Raphael Memorial	Roseville	Yes	X			X				
The Lazarus Project, Inc.	Roseville	Yes		X						
The Mental Health Association in California	Sacramento (Midtown)	Yes			X					
The Salt Mine	Lincoln	Yes		X						
The Salvation Army	Auburn	Yes		X			X			
Turning Point Community Programs	Rancho Cordova	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	Transportation
U.S Department of Veterans Affairs- Vet Center	Citrus Heights	Yes		X	X					
Volunteers of America- Northern California & Northern Nevada	Arden-Arcade	Yes		X						
WarmLine Family Resource Center	Rocklin	Yes	X	X						
WEAVE	Sacramento	Yes			X				X	
WellSpace Health	Rancho Cordova, Folsom, Roseville, Citrus Heights	Yes	X		X	X			X	
What Would Jesus Do, Inc.	Auburn	Yes		X						X
Women's Health Specialists	Arden-Arcade,	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	Transportation
	Rancho Cordova									
YMCA of Superior California	Auburn	Yes		X			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
	Folsom Lake College Community Resource Guide http://www.flc.losrios.edu/Documents/Student%20Services/EOPS_CARE_CalWORKS/FLC%20Community%20Resource%20Guide%202012-13.pdf
	Placer County Senior Resource Guide http://www.seniorsfirst.org/wordpress2014/wp-content/uploads/2014/09/Placer-County-Senior-Resource-Guide-20132014.pdf
	Placer Network of Care

	http://placer.networkofcare.org

Additional Assets	Community Assets *Reported in Key Informant Interviews and Focus Groups*
	Affordable Care Act
	Career centers
	Churches and faith-based organizations
	Community centers
	Community cohesion, engagement and collaboration
	Farmer's markets
	Federally Qualified Health Care Centers
	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.