2016 Community Health Needs Assessment

Kaiser Foundation Hospital South Sacramento
License #030000228

Approved by KFH Board of Directors
September 21, 2016

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

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Acknowledgements

This report was prepared by Valley Vision on behalf of Kaiser Permanente of Greater Sacramento and the Sacramento Region CHNA Collaborative. Through the course of the CHNA project, nearly 100 organizations and 600 individuals contributed input on the health issues and conditions impacting their communities or the communities they serve. We gratefully acknowledge the contributions of all these participants, many of whom shared deeply personal challenges and experiences with us. We hope that the contents of this report serve to accurately represent their voices.

Primary Authors: Amelia Lawless, CHES, ASW, MPH and Giovanna Forno, BS
Secondary Authors: Dale Ainsworth, PhD, Heather Diaz, DrPH, Anna Rosenbaum, MSW, MPH, Katie Strautman, MSW, Mathew C. Schmidtlein, PhD and Sarah Underwood, MPH

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I. EXECUTIVE SUMMARY

A. Community Health Needs Assessment (CHNA) Background

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

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

B. Summary of Prioritized Needs

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

1. **Access to Behavioral Health Services (mental health and substance abuse)** is a significant health need in the Kaiser Foundation Hospital (KFH) South Sacramento Hospital Services Area (HSA). Six of 13 indicators (46%) pertaining to mental health perform poorly as compared to State of California benchmarks, and nine of 12 indicators (75%) pertaining to substance abuse also compared unfavorably to benchmarks. The issue of mental health is marked by high rates of emergency department utilization due to self-inflicted injuries. In addition, this HSA experiences high rates of emergency department utilization and hospitalizations due to mental health issues. Substance abuse issues are evidenced by high rates of emergency department utilization and hospitalizations directly related to substance abuse, high rates of excessive alcohol consumption and tobacco usage for teens and adults. Furthermore, this HSA experiences high rates of emergency department utilization and hospitalization due to Chronic Obstructive Pulmonary Disease (COPD).

   Many times participants discussed these two categories together, as there seemed to be belief that the two were connected, including co-morbid physical health and mental health/substance use issues. Depression and anxiety were highlighted as significant mental health issues in this service area, while a focus on co-occurring substance use and mental health issues were frequently discussed. This included the need for additional facilities and services addressing both issues.

   Challenges and concerns of accessing mental health and substance abuse services in an emergency room or hospital specific was mentioned by service providers and community members. Service providers discussed the challenges of serving individuals on 5150 holds in their emergency rooms/hospital beds. A lack of adequate resources as well as provider misunderstandings for appropriate care were often mentioned as barriers to accessing mental health and substance abuse services.

2. **Healthy eating and active living (HEAL)** is a significant health need in the KFH-South Sacramento HSA. Sixteen of 30 indicators (53%) pertaining to healthy eating and active living perform poorly as compared to state benchmarks. Challenges associated with healthy eating and/or active living are indicated by high rates of food deserts, lack of access to recreation and fitness facilities, limited access to Women, Infants, Children (WIC) authorized food stores and high rates of mortality due to diabetes mellitus. Additionally, the percentage of mothers who exclusively breastfeed their infants during post-partum hospital stay is lower in the HSA as compared to the State benchmark.

   Food access issues were discussed related to lack of affordable grocery stores, transportation challenges to and from grocery stores and an abundance of unhealthy food options. There was regular discussion of the challenges of living in communities considered to be food deserts. Community members and service providers suggest the addition of farmer's markets and other healthy food outlets that are affordable and culturally relevant to the area. There is common perception that healthy foods are cost prohibitive for residents living in this service area. The inherent challenges of poverty and being able to purchase healthy foods was mentioned regularly.

3. **Access to high quality healthcare and services** is a significant health need in the KFH-South Sacramento HSA. Sixteen of 32 indicators (50%) pertaining to access to high quality healthcare and services, including maternal, child and infant health and oral/dental services compare unfavorably as compared to state benchmarks. More specifically, six of 13 indicators (46%) pertaining to access to care generally perform poorly to state benchmarks, including five of 10 indicators (50%) pertaining to access to maternal and child health care and five of 10 indicators (50%) pertaining to access to oral health care. Challenges with access to care are evidenced by high rates of the population receiving public insurance and Medicaid compared to other benchmarks.

   Challenges to accessing maternal and child health services are seen in lower rates of accessing prenatal care (as compared to the state benchmark), lower school enrollment for children ages 3-4 years and food insecurity.

   Challenges to accessing oral health care services are evidenced by lack of access to dentists, high rates of emergency department utilization and hospitalizations due to dental/oral diseases and overall poor dental health in the HSA compared to state benchmark.

   Thirty-seven of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to access to care as a health need. Nine of 40 sources mentioned maternal and child health as a health need and 17 of 40 mentioned dental/oral health as a health need. It was shared that health system capacity has changed in light of the Affordable Care Act. It was reported that many patients wait months before being able to see a doctor and that few providers now accept Medi-Cal.

   Additionally, it was discussed that many hospital emergency rooms are overwhelmed and over utilized since the newly insured population may not know how to use/access their doctor and/or are dealing with long wait times. In addition, access to care is often limited by distance and transportation barriers and challenges with the public transportation system (e.g., high cost, lack of routes and limited schedules). Service providers discussed

numerous coverage gaps for both Medi-Cal and non Medi-Cal populations due to a lack of understanding in how to access care.

4. **Disease prevention, management and treatment** related to cancer, cardiovascular diseases (CVD), stroke, asthma and sexually transmitted infections (STIs), including HIV and AIDS are significant health needs in the KFH-South Sacramento HSA. Sixteen of 31 indicators (52%) pertaining to cancer, 16 of 30 indicators (53%) pertaining to CVD/stroke, eight of 13 indicators (62%) pertaining to asthma and five of eight indicators (63%) pertaining to HIV/AIDS/STIs compare unfavorably to benchmarks. Overall, cancer mortality and cancer incidence (breast, colon, rectum, prostate and lung) rates are high in this HSA.

   The percentages of adults with obesity or who use tobacco are higher in this HSA as compared to state benchmark. Additionally, residents in this HSA have higher rates of hospitalization due to hypertension and emergency department utilization related to diabetes as compared to state benchmark. Related, this HSA has lack of access to recreational and fitness facilities. The prevalence of asthma and hospitalizations due to asthma are also higher in this HSA as compared to state benchmark. In addition, there is a high particulate matter score for KFH-South Sacramento that creates air quality concerns in this HSA. It is also noted that there are higher rates of Chlamydia and Gonorrhea along with increased rates of emergency department utilization due to HIV.

   Fifteen of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to cancer as a health need. Various types of cancer were discussed including lung, breast, colon, prostate, cervical and stomach cancers. The possible connection between pesticide exposure and cancer and the importance of cancer screening programs were discussed as well. Challenges associated with cancer were shared related to diagnosis, management and treatment.

   Twenty-seven of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to cardiovascular disease (CVD) or stroke as a health need. The need for diagnosis, management, health education and affordable medication for hypertension were discussed frequently. In addition, congestive heart failure and increases in CVD incidence among youth were discussed.

   Seven of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to asthma as a health need. Asthma was also discussed as a problematic health condition within the service area. It was noted by community members that many people (both youth and adults) are suffering from asthma due to the inhalation of contaminated air and smoke.

   Five of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to sexually transmitted infections as a health need. Sexually transmitted infections (STIs) are also of concern to individuals in this HSA. Stigma related to STIs and acknowledgment that STIs are not always discussed openly, especially between parents and their children were discussed. In addition, participants spoke about the fact that the gay, transgender, and substance using populations suffer a disproportional burden of HIV, syphilis, and Hepatitis C. There was a recommendation for more testing and education of how to manage and treat STIs.

5. **Safe, crime and violence-free communities** is a significant health need in KFH-South Sacramento HSA. Fifteen of 26 indicators (58%) pertaining to safe, crime and violence free communities perform poorly as compared to state benchmarks. Issues related to safety and violence were marked by high rates of homicide, intentional injury, assault, domestic violence, rape and robbery as compared to state benchmarks. The combined rate of all violent crimes, which includes homicide, rape, robbery and aggravated assault, was significantly higher in this HSA as compared to the state. In addition, the rate of school suspensions was higher in this HSA as compared to the state rate.

   Thirty-seven of 40 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. A variety of safety and criminal activities were discussed including, gang violence, gun and knife violence, domestic violence, sexual abuse, drug crime, and challenges with law enforcement.

6. **Pollution free living and work environments** is a significant health need in the KFH-South Sacramento HSA. Seventeen of 26 indicators (65%) pertaining to pollution free living and work environments compare unfavorably as compared to state benchmarks. Challenges with pollution in living and work environments were marked by high rates of tobacco usage, asthma prevalence, air particulate matter, COPD, heart disease, limited canopy cover, dense road network density and lack of transit within 0.5 miles. Additionally, mortality due to ischemic heart disease is high in this HSA.

   Twenty of 40 sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to pollutant free work and school environments as a health need. Community members spoke about poor air quality and air pollution and the connection to high rates of asthma. Interviewees also spoke about poor air quality in relation to second hand smoke from cigarettes and marijuana and the need for more enforcement of anti-smoking laws and smoking cessation programs.

7. **Basic needs (food, housing, employment and education)** are a significant health need in the KFH-South Sacramento HSA. Twelve of 25 indicators (48%) pertaining to basic needs compared unfavorably to state benchmarks. Challenges in accessing basic needs are marked by high rates of children and adults living in poverty (below 100% and/or 200% of the Federal Poverty Level (FPL)), a high percentage of single female headed households in poverty, reading below proficiency level, food insecurity, children eligible for free/reduced price lunch, population receiving supplemental nutrition assistance program (SNAP) and low rates of individuals (five years and older) with limited English proficiency.

   Thirty-nine of 40 sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to basic needs as a health need. Economic insecurity is a significant issue within this HSA. Community members discuss hunger, food insecurity, unemployment and underemployment, lack of affordable housing, lack of transportation, language barriers, lack of vocational skills and training, as issues that negatively impact their quality of life. There were concerns that assistance programs could not provide the true needs of community members, specifically regarding lack of medical access to those utilizing Medi-Cal. Undocumented residents experienced significant barriers in accessing care.

8. **Affordable and accessible transportation** is a significant health need in the KFH-South Sacramento HSA. Four of eight indicators (50%) pertaining to transportation performed poorly as compared to State benchmarks. This HSA encompasses a higher rate of individuals with disabilities, limited access to public transit (within 0.5 miles) and less individuals who commute to work through walking or biking.

   Twenty-five of 40 sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to accessible and affordable transportation as a health need. Input from service providers and community members indicated that transportation related to accessing food, healthcare and education were challenging due to limited access to private vehicles and/or public transportation limitations. Participants noted that those living in poverty have greater barriers in accessing transportation.

C. Summary of Needs Assessment Methodology and Process

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

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

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

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

To meet the project objective, a defined set of data collection and analytic stages were developed. Data collected and analyzed included both primary or qualitative data, and secondary or quantitative data. To determine geographic locations affected by social inequities, data were compiled and analyzed at the census tract and ZIP code levels as well as mapped by GIS systems. From this analysis as well as an initial preview of the primary data, Focus Communities were identified within the HSA. These were defined as geographic areas (ZIP codes) within the HSA that had the greatest concentration of social inequities (e.g. poverty, educational attainment and health disparities) that may result in poor health outcomes. Focus

Communities were important to the overall CHNA methodology because they allowed for a place-based lens with which to consider health disparities in the HSA.

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

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-South Sacramento service area (Appendix C). As a final step, the resources available to address the significant health needs were compiled by using the community assets listed in the KFH-South Sacramento 2013 CHNA report as a foundation. This list was then verified and expanded upon to include those referenced through community input.

II. INTRODUCTION/BACKGROUND

A. ABOUT KAISER PERMANENTE (KP)

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

- Prepaid health plans, which spread the cost to make it more affordable
- A focus on preventing illness and disease as much as on caring for the sick
- An organized coordinated system that puts as many services as possible under one roof—all connected by an electronic medical record

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 10 million members in nine 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-South Sacramento will develop an implementation strategy for the priority health needs the hospital will address. These strategies will build on Kaiser Permanente's assets and resources, as well as evidence-based strategies, wherever possible. The Implementation Strategy will be filed with the Internal Revenue Service using Form 990 Schedule H. Both the CHNA and the Implementation Strategy, once they are finalized, will be posted publicly on our website, www.kp.org/chna.

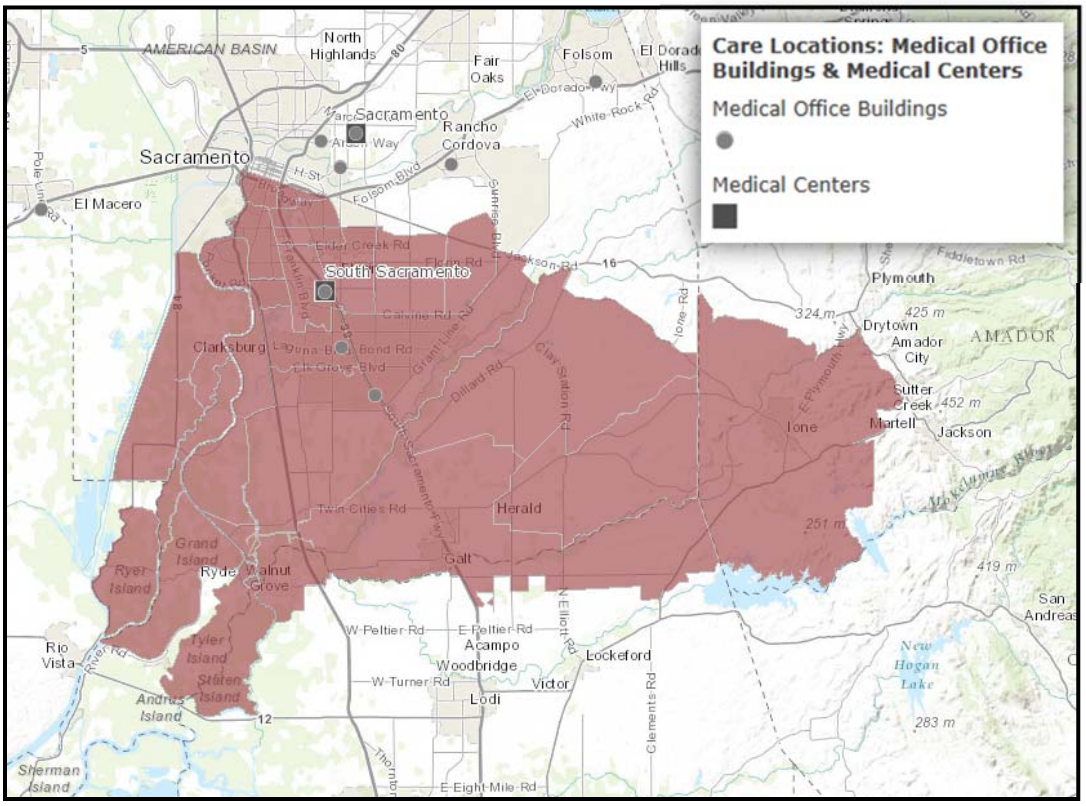
III. COMMUNITY SERVED

A. Kaiser Permanente's Definition of Community Served

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

B. Map and Description of Community Served

i. Figure 1 – Map of the KHF South Sacramento HSA:



ii. Geographic description of the community served:

The KFH-South Sacramento service area comprises a large part of Sacramento County, including the cities of Sacramento, Elk Grove, and Galt, and a portion of Amador County.

iii. Demographic profile of community served – KFH-South Sacramento

Table 1. KFH-South Sacramento Demographic Data	
Total Population	583,763
White	47.74%
Black	13.09
Asian	22.53%
Native American/ Alaskan Native	0.82%
Pacific Islander/ Native Hawaiian	1.51%
Some Other Race	7.04%
Multiple Races	7.26%
Hispanic/Latino	25.7%

Table 2. KFH-South Sacramento Socio-economic Data	
Living in Poverty (<200% FPL)	40.55%
Children in Poverty	27.19%
Unemployed	8.3%
Uninsured	13.63%
No High School Diploma	18%

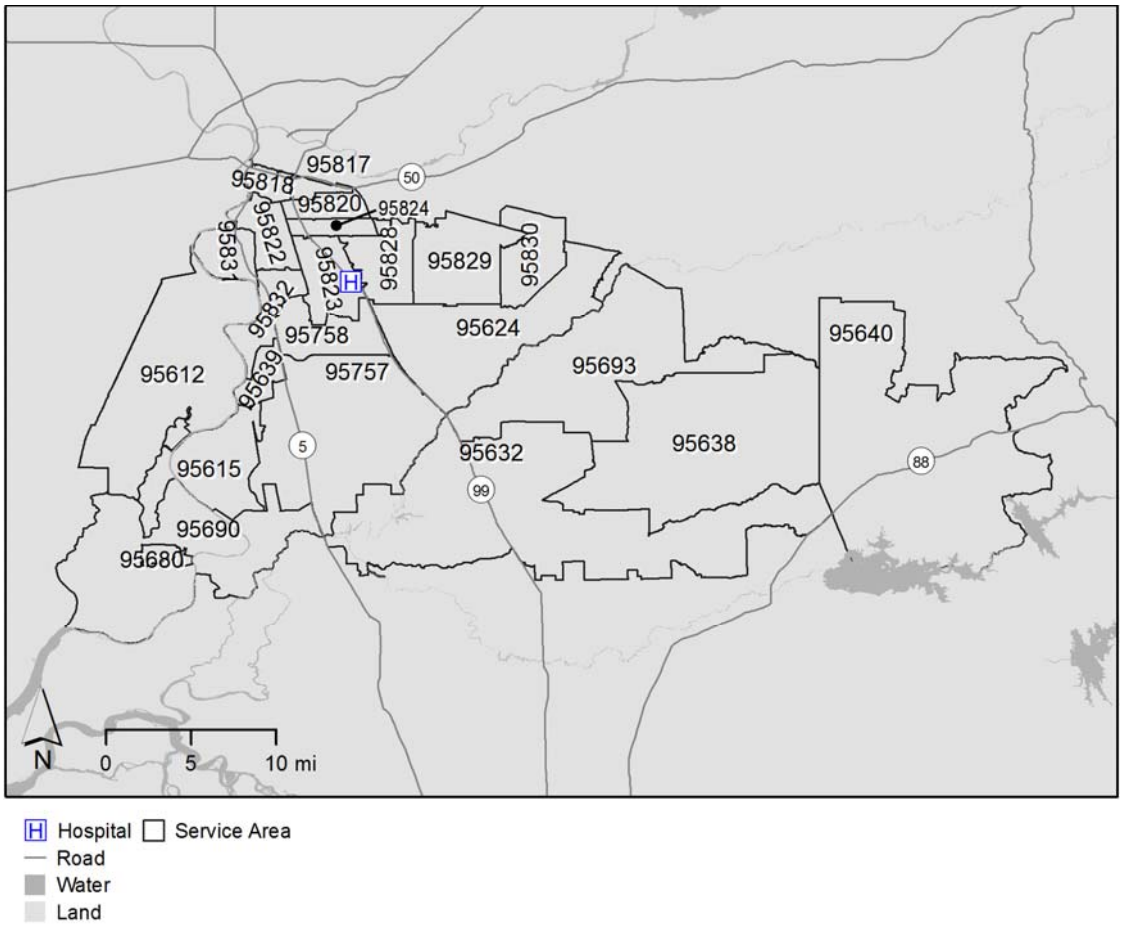


Figure 2. Map of the KFH-South Sacramento Hospital Service Area (HSA) by ZIP code

Table 3. Population characteristic of the KFH-South Sacramento HSA by ZIP code

ZIP	Population	Median Age	Med. Income	% Minority
95612	968	53.3	58147	30.99
95615	999	41.4	74583	39.13
95624	62335	34.6	77652	55.52
95632	29892	34.5	59731	45.17
95638	1984	50.8	88188	24.84
95639	299	49	75870	82.94
95640	10825	42.2	58309	32.84
95680	245	15.6	NA	100
95690	2015	46.1	61150	52.55
95693	5640	48.3	76392	29.78
95757	42752	32.8	84297	72.83
95758	61155	33.7	70616	65.58
95817	14377	31.4	34990	58.89
95818	19960	39.4	57500	40.49
95820	33967	34.1	39295	69.02
95822	43024	37.8	43624	71.45
95823	74154	30.1	37931	84.22
95824	29344	30.7	29771	81.69
95828	60993	31.9	46820	80.16
95829	25565	34	74550	65.25
95830	725	39.7	73333	26.2
95831	41224	45.3	68461	60.51
95832	12051	26.2	39735	85.56
SACRAMENTO	1435207	35.1	55064	52.05
YOLO	202288	30.7	55918	50.62
CALIFORNIA	37659181	35.4	61094	60.33

Source: 2013 American Community Survey 5-year Estimate
* Indicates Focus Community

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:

- **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 South Sacramento, KFH Sacramento, KFH Roseville
- **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**

The CHNA Collaborative contracted with Valley Vision to conduct the CHNA in 2016 and 2013, as well as in 2010 and 2007 for the statewide CAN.

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 37 organizations assisted the KFH-South Sacramento CHNA process through participation in key informant interviews or focus groups, as outlined in Appendix B.

C. Identity and Qualifications of Consultants Used to Conduct the Assessment

The 2016 CHNA was completed 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 to conduct 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 Amelia Lawless, CHES, ASW, MPH, Project Manager. Additional CHNA team members included: 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-South Sacramento according to the geographic area defined by Kaiser Permanente. Once the broader HSA was identified, geographic areas within the HSA that were facing the greatest risk of both social and health inequities were identified. These Focus Communities were defined at the ZIP code level following an analysis of: 1) social determinants of health and inequities (e.g., poverty and educational attainment), 2) values from the Community Health Vulnerability Index (CHVI), 3) initial input from key informant interviews and 4) consideration of Focus Communities in the 2013 CHNA (previously called Communities of Concern).

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

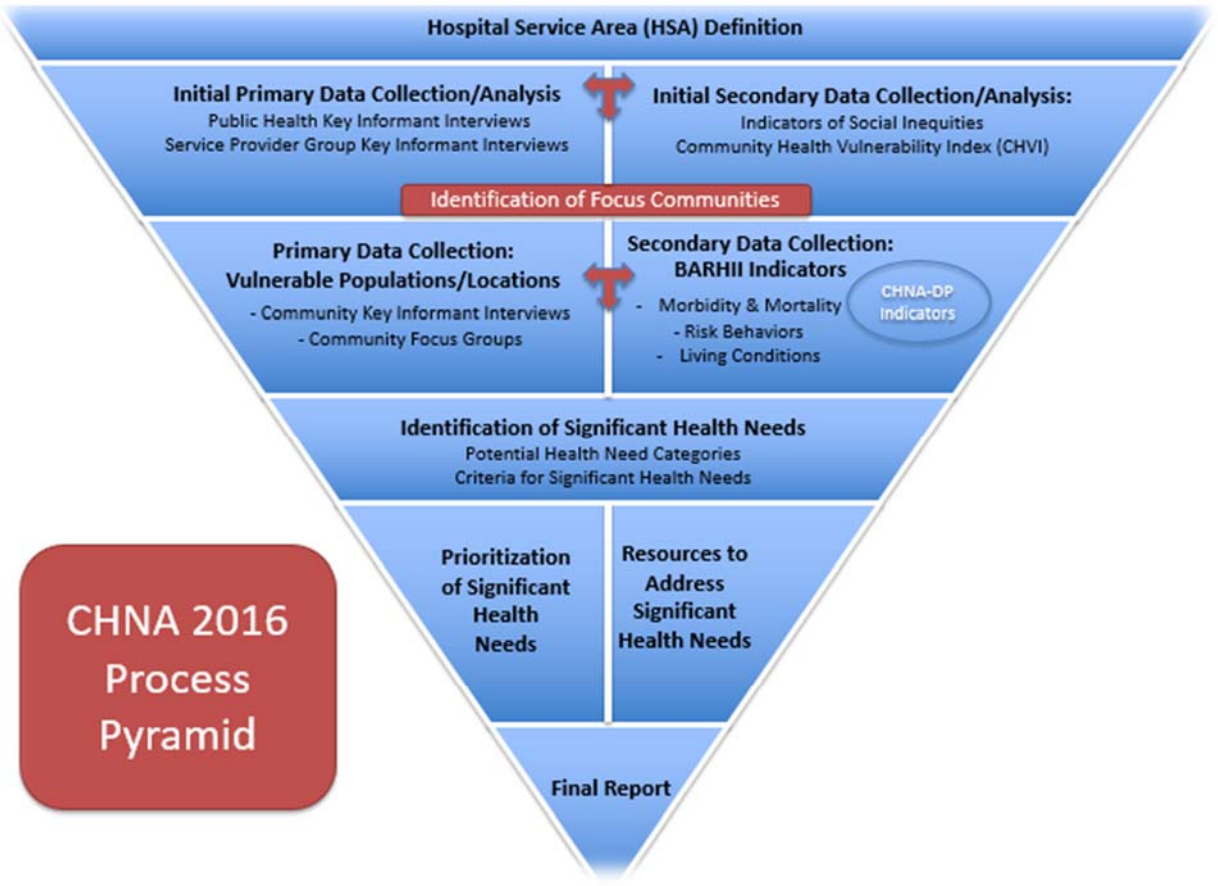


Figure 3. CHNA Process Model

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

Table 4. Focus Communities for KFH-South Sacramento	
Community	**ZIP Code**
North Oak Park	95817
Tahoe Park	95820
Executive Airport/Meadowview	95822
Fruitridge/Mack Road	95823
Parkway	95824
Florin	95828
Freeport/Meadowview	95832

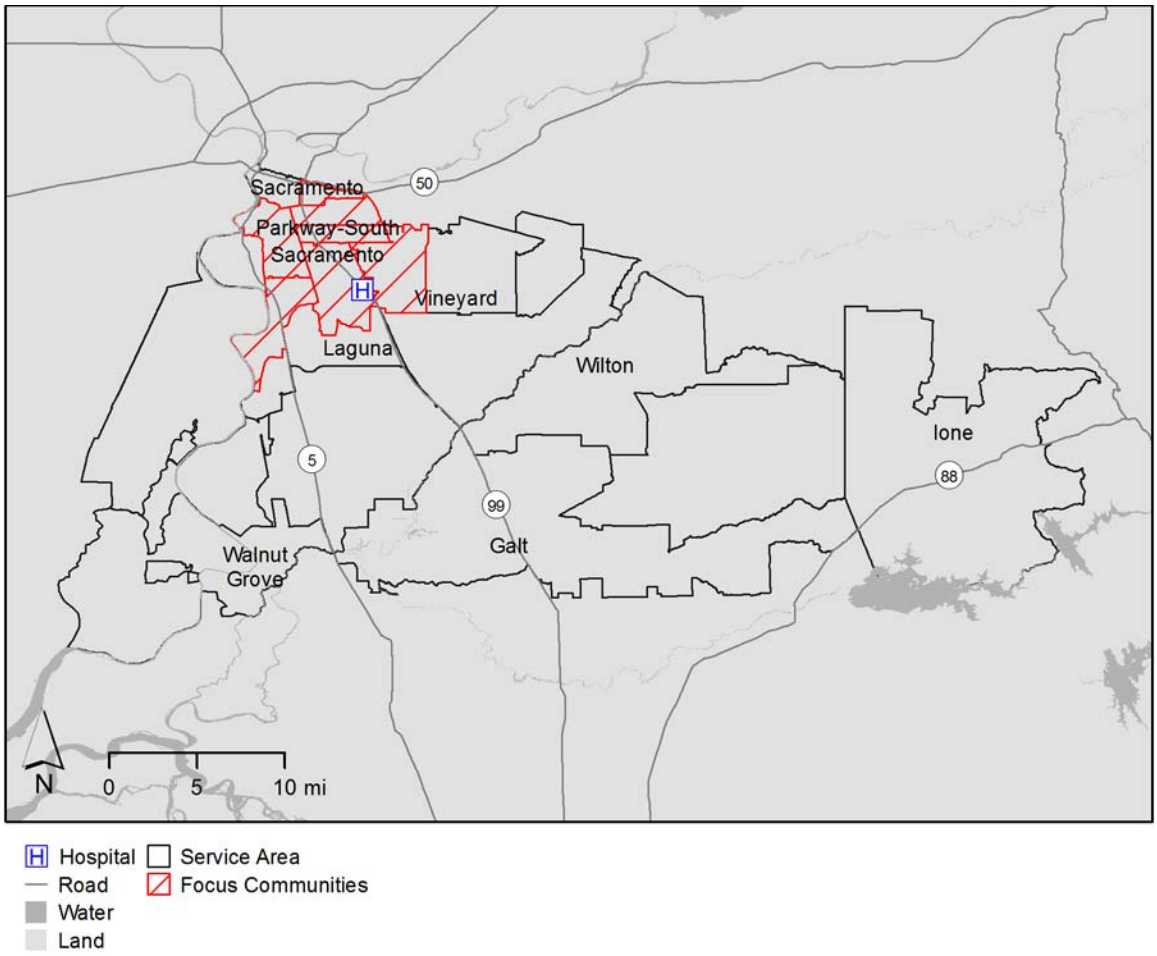


Figure 4. Map of Focus Communities

A. Secondary data

i. Sources and Dates of Secondary Data Used in the Assessment

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

ii. Methodology for Collection, Interpretation and Analysis of Secondary Data

This section serves to provide a brief overview of the secondary data collection, processing and analysis approaches used to support the CHNA. For additional information, including detailed project methodology, please refer to Appendix A. Initial social inequities data were compiled and analyzed at the census tract and ZIP code

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

Quantitative indicators used in this assessment were guided by a conceptual framework developed by the Bay Area Regional Health Inequities Initiative (BARHII) (Figure 6). 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 state, local, tribal, or other regional governmental public health departments (or equivalent department or agency) as well as leaders, representatives, or 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-South Sacramento service area. These identified Focus Communities were then used to help inform a second phase of data collection which included additional key informant interviews and Focus Groups with medically-underserved, low-income and minority populations where additional data collection was needed.

ii. Methodology of Collection and Interpretation

Key Informant Interviews

Key informant interviews were conducted with area health experts and service providers familiar with health issues and 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 to identify locations and populations that were vulnerable to poor health outcomes and additional key informants representing these locations and populations. These findings were also used along with the CHVI and indicators of social inequities to identify the Focus Communities, which directed additional primary data collection activities. A total of 25 key informant interviews were completed with a cumulative total of 28 service providers participating in these interviews, which are listed in Appendix B.

Key informant interviewees represented the following sectors: academic research (4%), community based organizations (75%), health care (14%) public health (7%), and social services (18%). Please note that some interviewees represented multiple sectors. These 28 key informants reported working with the following populations: low-income (90%), medically underserved (86%), and racial or ethnic minorities (89%). The racial and ethnic minority groups specified by interviewees included: Latino/Hispanic, African American, Southeast Asian, Asian Pacific Islander, Slavic, Russian, and refugees from the former Soviet Union. In addition, key informants specified working with the following vulnerable sub-populations: individuals experiencing homelessness, people suffering from serious mental illness or substance abuse issues, pregnant women, children ages 0-5, individuals identifying as lesbian, gay, bisexual and/or transgender, people living with HIV, and seniors.

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 and identification of Focus Communities. Recruitment consisted of referrals from designated service providers as well as direct outreach from the Valley Vision CHNA Team to acquire input for special population groups.

Within the Kaiser Permanente South Sacramento HSA, 15 focus groups were conducted with participants representing medically underserved, minority and low-income populations and/or community members living in vulnerable locations. Of the approximately 153 participants who completed demographic data cards, the median age was 39, 73% identified as female, 25% as male, and 4% as other. In addition, 30% indicated they were not high school graduates, 12% indicated they were not covered by

health insurance, and 57% received some form of public assistance. The racial breakdown of focus group participants is as follows:

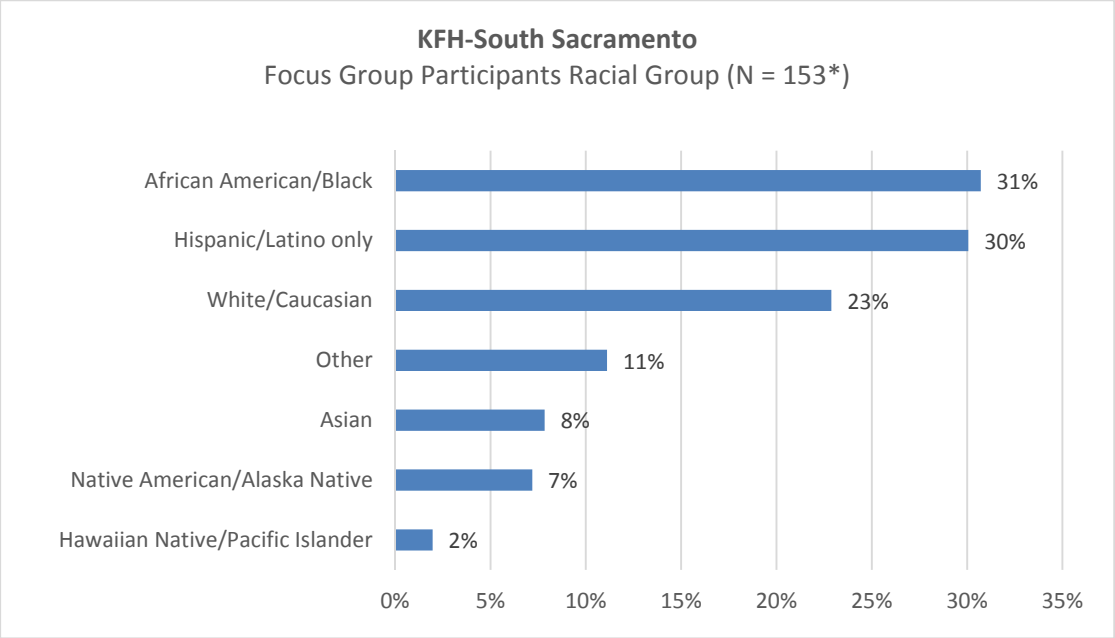


Figure 5. Participant Race/Ethnicity
*Demographic surveys were not completed by all participants

Processing Primary Data

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

Content analysis was done on the key informant and focus group transcripts utilizing NVivo 10 Qualitative Analytical Software. This analysis was completed in a two phase approach. In the first phase of analysis the qualitative data were coded based on the Bay Area Regional Health Inequities Initiative (BARHII) Framework categories and other organically arising thematic areas. Further analysis was then conducted with thematic coding to the eight potential health needs categories detailed later in this report and in Appendix D, with additional nodes for vulnerable populations and locations and resource identification. Results were aggregated to inform the determination of prioritized significant health needs as further detailed in Section 6.

C. Written Comments

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

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

D. Data Limitations and Information Gaps

The KP CHNA data platform 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- South Sacramento service area. Alternately, the secondary or quantitative data was collected for all populations within the service are. At times, this caused for there to be significant disparities between primary and secondary data for the health need. Owing to this discrepancy, significant health need categories were validated by either the quantitative or the qualitative data, rather than by both of these data sources. There were also variations between indicator percentages and rates collected from the CHNA-DP and those collected by Valley Vision owing to different years of data collected and differences in data processing methods.

VI. IDENTIFICATION AND PRIORITIZATION OF COMMUNITY'S HEALTH NEEDS

A. Identifying Community Health Needs

i. Definition of "Health Need"

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

ii. Criteria and Analytical Methods Used to Identify the Community Health Needs

Significant health needs were identified through an integration of both qualitative and quantitative data. The process began with generating a list of eight broad potential health needs (PHN categories) that could exist within the HSA as well as subcategories of these broad needs as applicable. The PHN categories and subcategories were identified through consideration of the following inputs: the health needs identified in the 2013 CHNA process; the categories in the KP CHNA data platform (CHNA-DP) - preliminary health needs identification tool; and a preliminary review of primary data. Once the PHN categories were created, quantitative and qualitative indicators associated with each category and subcategory were identified in a crosswalk table. The potential health need categories, subcategories and associated indicators were then vetted and finalized by members of the CHNA Collaborative prior to identification of the significant health needs. The PHN categories and subcategories are listed below in Table 6; 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 primary and secondary data analysis were then merged to create a final set of significant health needs. The full

result of these analyses is 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% Primary data (qualitative) 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 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%	95%	**2**	**45%**
2. HEAL	50%	95%	**2**	**45%**
3. Access to Care	50%	93%	**2**	**33%**
4. Disease Prevention	72%	85%	**2**	**30%**
5. Safe Communities	54%	93%	**2**	**18%**
6. Pollutant Free	73%	50%	**2**	**3%**
7. Basic Needs	52%	98%	**1**	**20%**
8. Transport	50%	63%	**1**	**8%**

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)

Access to Behavioral Health Services (mental health and substance abuse) is a significant health need in the Kaiser Foundation Hospital (KFH) South Sacramento Hospital Services Area (HSA). Six of 13 indicators (46%) pertaining to mental health perform poorly as compared to State of California benchmark, and nine of 12 indicators (75%) pertaining to substance abuse also compare unfavorably benchmarks. The issue of mental health is marked by high rates of emergency department utilization due to self-inflicted injuries. In addition, this HSA experiences high rates of emergency department utilization and hospitalizations due to mental health issues. Suicide rates among non-Hispanic Whites and Native Hawaiian/Pacific Islanders are high compared to other racial/ethnic groups and the overall HSA as a whole. Substance abuse issues are evidenced by high rates of emergency department utilization and hospitalizations directly related to substance abuse, high rates of excessive alcohol consumption and tobacco usage for teens and adults. Furthermore, this HSA experiences high rates of emergency department utilization and hospitalization due to Chronic Obstructive Pulmonary Disease (COPD).

Many times participants discussed these two categories together, as there seemed to be belief that the two were connected, including co-morbid physical health and mental health/substance use issues. Depression and anxiety were highlighted as significant mental health issues in this service area, while a focus on co-occurring substance use and mental health issues were frequently discussed. This included the need for additional facilities and services addressing both issues.

Challenges and concerns of accessing mental health and substance abuse services in an emergency room or hospital specific was mentioned by service providers and community members. Service providers discussed the challenges of serving individuals on 5150 holds in their emergency rooms/hospital beds. A lack of adequate resources as well as provider misunderstandings for appropriate care were often mentioned as barriers to accessing mental health and substance abuse services.

Tobacco use and ease of access to tobacco products were discussed as being significant for this HSA. Tobacco use among youth, young adults and adults was mentioned, including e-cigarette use. Also, community members expressed interest in culturally sensitive smoking cessation programs for LGBT community members.

Participants shared specific geographic areas where there are regular safety concerns directly related to substance use issues including certain neighborhoods, schools and parks within the HSA. Interviewees were most concerned about safety issues related to youth and homeless individuals. Alcohol and other drugs were discussed as being used in tandem and as contributing factors to overall health issues. Alcohol, meth, cocaine, marijuana and tobacco use was also discussed as substances commonly used among youth and

homeless, a significant concern to service providers and community members. Additionally, ease of access to the listed drugs was mentioned as being a serious issue in this HSA.

Adverse childhood experience (ACEs) were mentioned as being important issues in this service area. ACEs were discussed as being contributing factors to child neglect and early initiation in substance use by youth as a way to cope with serious mental illness and/or growing up in challenging circumstances. A lack of social engagement and support were mentioned as important factors in assisting communities in being healthier.

Daily stress was mentioned as being an important health issue by residents in this service area. Stress was mentioned as being prevalent, especially for those with substance use and mental health issues. Stigma and discrimination were highlighted as creating major barriers in individuals accessing the care that they desired for substance use and/or mental health issues. Culturally significant themes were discussed as relating to lack of support in accessing care and challenges finding culturally sensitive providers and services. Culturally sensitive care is desired in this HSA for both mental health and substance use disorders.

Alzheimer's and dementia were mentioned as a concern in the senior population. Senior neglect and isolation were mentioned generally and also for seniors experiencing Alzheimer's and/or dementia. The need for Alzheimer's care was mentioned as being unclear as it was reported that data are not collected for Alzheimer's regularly. The cost of care for seniors was highlighted as being extreme and unattainable for many families.

2. Healthy Eating and Active Living

Healthy eating and active living (HEAL) is a significant health need in the KFH-South Sacramento HSA. Sixteen of 30 indicators (53%) pertaining to healthy eating and active living perform poorly as compared to state benchmarks. Challenges associated with healthy eating and/or active living are indicated by high rates of food deserts, lack of access to recreation and fitness facilities, limited access to Women, Infants, Children (WIC) authorized food stores and high rates of mortality due to diabetes mellitus. The rate of overweight youth among Hispanic/Latino youth is higher in the HSA as compared to other racial/ethnic groups. Additionally, the rate of youth obesity is higher in the Non-Hispanic Black and Hispanic/Latino populations as compared to other racial/ethnic groups in this HSA. The Non-Hispanic Black and Hispanic/Latino youth populations also have higher rates of physical inactivity as compared other racial/ethnic populations. Related, the Non-Hispanic White and Non-Hispanic Other populations have low rates of walking/biking and skating to school as compared to other racial/ethnic groups. A higher percentage of Non-Hispanic Other youth and youth in the overall HSA have low fruit/vegetable consumption as compared to other groups and the HSA as a whole. Health disparities are present in regards to the percentage of mothers who breastfeed their infants after birth in the following populations: Non-Hispanic Blacks, Non-Hispanic Asians, Non-Hispanic Others and Non-Hispanic Multiple Races as compared to other racial/ethnic groups. Finally, the percentage of mothers who exclusively breastfeed their infants during post-partum hospital stay is lower in the HSA as compared to the State benchmark. Likewise, the following populations have a lower percentage of babies who were exclusively breastfed compared to the state benchmark: Non-Hispanic Black, Non-Hispanic Asian and in the Non-Hispanic Other populations.

Food access issues were discussed related to lack of affordable grocery stores, transportation challenges to and from grocery stores and an abundance of unhealthy food options. There was regular discussion of the challenges of living in communities considered to be food deserts. Community members and service providers suggest the addition of farmer's markets and other healthy food outlets that are affordable and culturally relevant to the area. There is common perception that healthy foods are cost prohibitive for residents living in this service area. The inherent challenges of poverty and being able to purchase healthy foods was mentioned regularly.

In addition, residents discussed the need for health education related to healthy eating and active living. It was highlighted that many individuals do not know what healthy foods are and may not be familiar with how to prepare these foods. Moreover, there was great interest in accessible food pantries and food assistance programs. Active living concerns included neighborhood safety concerns (e.g. neighborhoods not being safe enough to exercise in), lack of affordable recreation facilities such as gyms and lack of time to exercise while attempting to meet basic needs (e.g. living in poverty and unsafe neighborhoods).

3. Access to High Quality Healthcare and Services

Access to high quality healthcare and services is a significant health need in the KFH-South Sacramento HSA. Sixteen of 32 indicators (50%) pertaining to access to high quality healthcare and services, including maternal, child and infant health and oral/dental services compare unfavorably as compared to state benchmarks. More specifically, six of 13 indicators (46%) pertaining to access to care generally perform poorly as compared to state benchmarks, including five of 10 indicators (50%) pertaining to access to maternal and child health care and five of 10 indicators (50%) pertaining to access to oral health care. Challenges with access to care are evidenced by high rates of the population receiving public insurance and Medicaid compared to other benchmarks. There are especially high rates of uninsured individuals, as compared to other racial/ethnic groups, in the following populations: Native American/Alaska Native, Asian, Non-Hispanic Native Hawaiian/Pacific Islander, Hispanic/Latino, and a population that did not self-identify. As compared to other racial/ethnic groups, those classifying as Non-Hispanic Other and Hispanic/Latino experience lack of access to primary care services.

Challenges to accessing maternal and child health services are seen in lower rates of accessing prenatal care (as compared to the state benchmark), lower school enrollment for children ages 3-4 years and food insecurity. Health disparities are present in the percentage of mothers who breastfeed their infants after birth in the following populations: Non-Hispanic Blacks, Non-Hispanic Asians, Non-Hispanic Others and Non-Hispanic Multiple Races as compared to other racial/ethnic groups. Finally, the percentage of mothers who exclusively breastfeed their infants during post-partum hospital stay is lower than the HSA as a whole as compared to other benchmarks, as well as in the Non-Hispanic Black, Non-Hispanic Asian and Non-Hispanic Other populations as compared to other racial/ethnic groups.

Challenges to accessing oral health care services are evidenced by lack of access to dentists, high rates of emergency department utilization and hospitalizations due to dental/oral diseases and overall poor dental health in the HSA compared to state benchmark. Non-Hispanic Whites and Hispanic/Latino youth in KFH-South Sacramento

have low rates of recent dental exams as compared to other racial/ethnic groups and the state benchmark.

Challenges to accessing maternal and child health services are seen in lower rates of accessing prenatal care (as compared to the state benchmark), lower school enrollment for children ages 3-4 years and food insecurity. Health disparities are present in regards to the category of “any breastfeeding” in the following populations: Non-Hispanic Blacks, Non-Hispanic Asians, Non-Hispanic Others and Non-Hispanic Multiple Races as compared to other racial/ethnic groups. Finally, exclusive breastfeeding percentages are lower than the HSA as a whole as compared to benchmarks and in the Non-Hispanic Black, Non-Hispanic Asian and in the Non-Hispanic Other populations as compared to other racial/ethnic groups.

In this HSA, challenges with access to oral health care are evidenced by lack of access to dentists, high rates of emergency department utilization and hospitalizations due to dental/oral diseases and poor dental health. Non-Hispanic Whites and Hispanic/Latino youth in the KFH- South Sacramento HSA have low rates of recent dental exams as compared to other racial/ethnic groups and the state benchmark.

Thirty-seven of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to access to care as a health need. Nine of 40 sources mentioned maternal and child health as a health need and 17 of 40 mentioned dental/oral health as a health need. It was shared that health system capacity has changed in light of the Affordable Care Act. It was reported that many patients wait months before being able to see a doctor and that few providers now accept Medi-Cal. Additionally, it was discussed that many hospital emergency rooms are overwhelmed and over utilized since the newly insured population may not know how to use/access their doctor and/or are dealing with long wait times. In addition, access to care is often limited by distance and transportation barriers and challenges with the public transportation system (e.g., high cost, lack of routes and limited schedules). Service providers discussed numerous coverage gaps for both Medi-Cal and non Medi-Cal populations due to a lack of understanding in how to access care.

Community members discussed barriers to accessing dental care, including limited resources, particularly for Medi-Cal populations. It was shared that there are only a few dental providers that accept Medi-Cal and who provide comprehensive dental care services (e.g. care outside of extractions). Also, oral health for children was discussed as being particularly important but many low-income children do not receive regular check-ups.

Seniors were also mentioned as having many barriers to accessing care (e.g., transportation, income, insurance, living on restricted incomes) and the negative impact this can have on health behaviors including having to choose between food and medication. Additionally, it was shared that many times seniors with dementia and Alzheimer's often can't get the supportive services they need.

Community members expressed a desire for culturally sensitive care. The demographics of the health service area are diverse with a variety of minority groups that have distinct language and/or cultural differences. Many of these groups have historically been marginalized and are in the process of building trust in the healthcare system. Community

members spoke about the need for culturally relevant outreach and services, using innovative strategies to reach adults and youth from underserved populations (i.e. ethnic groups, people of color, refugees and recent immigrants, undocumented, LGBT, homeless, gang members). Access to primary care services is a challenge, particularly for Medi-Cal populations. Residents discussed the challenges with making an appointment with an assigned Primary Care Practitioner (PCP), including often taking months to get an appointment, often being assigned to PCPs that aren't accepting new patients and the need for use of emergency rooms for primary care health issues due to the aforementioned issues.

The lack of culturally and linguistically appropriate services was mentioned as a barrier to care for those with limited English proficiency. Interpretation and translation services were discussed as often lacking or inadequate. Residents stated that they do not always trust hospital and clinic translators. Interviewees discussed that providers need more cultural sensitive training for working with diverse populations according to race/ethnicity, immigration status, sexual and gender identity and for those in poverty. Also, navigating Medi-Cal was discussed as difficult if English second language and/or with limited literacy levels. Undocumented populations have very limited access to care and this lack of access is a huge barrier in terms of health and wellness. Primary and specialty care is especially difficult to access and ER may be their only option for care.

4. Disease Prevention, Management and Treatment

Disease prevention, management and treatment related to cancer, cardiovascular diseases (CVD), stroke, asthma and sexually transmitted infections (STIs), including HIV and AIDS are significant health needs in the KFH-South Sacramento HSA. Sixteen of 31 indicators (52%) pertaining to cancer, 16 of 30 indicators (53%) pertaining to CVD/stroke, eight of 13 indicators (62%) pertaining to asthma and five of eight indicators (63%) pertaining to HIV/AIDS/STIs compare unfavorably as compared to benchmarks. Overall, cancer mortality and cancer incidence (breast, colon, rectum, prostate and lung) rates are high in this HSA. Non-Hispanic Whites, Blacks, Non-Hispanic Pacific Islanders are at greater risk of cancer mortality. In terms of breast cancer incidence, Non-Hispanic Mixed Race individuals have higher rates, while Blacks have higher rates of colon, rectum and prostate cancers and Whites and Blacks have higher rates of lung cancer incidence.

The percentages of adults with obesity or who use tobacco are higher in this HSA as compared to state benchmark. Additionally, residents in this HSA have higher rates of hospitalization due to hypertension and emergency department utilization related to diabetes as compared to state benchmark. Related, this HSA has lack of access to recreational and fitness facilities. Non-Hispanic Whites and Hispanic/Latino youth are less physically active as compared to other youth in this HSA. Higher percentages of Hispanic/Latino youth in this HSA are considered to be overweight and Non-Hispanic Black and Hispanic/Latino youth have higher percentages of obesity as compared to the state benchmark. The prevalence of asthma and hospitalizations due to asthma are also higher in this HSA as compared to state benchmark. In addition, there is a high particulate matter score for KFH-South Sacramento that creates air quality concerns in this HSA. It is also noted that there are higher rates of Chlamydia and Gonorrhea along with increased rates of emergency department utilization due to HIV. Furthermore, Non-Hispanic Whites and Blacks experience higher rates of HIV prevalence as compared to other racial/ethnic groups.

Fifteen of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to cancer as a health need. Various types of cancer were discussed including lung, breast, colon, prostate, cervical and stomach cancers. The possible connection between pesticide exposure and cancer and the importance of cancer screening programs were discussed as well. Challenges associated with cancer were shared related to diagnosis, management and treatment.

Twenty-seven of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to cardiovascular disease (CVD) or stroke as a health need. The need for diagnosis, management, health education and affordable medication for hypertension were discussed frequently. In addition, congestive heart failure and increases in CVD incidence among youth were discussed.

Seven of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to asthma as a health need. Asthma was also discussed as a problematic health condition within the service area. It was noted by community members that many people (both youth and adults) are suffering from asthma due to the inhalation of contaminated air and smoke. Community members also expressed concern that asthma medications can be cost prohibitive. Moreover, observations were also made in relation to the number of smoke shops in low-income areas and the need for more laws to regulate second hand smoke and tobacco use.

Five of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to sexually transmitted infections as a health need. Sexually transmitted infections (STIs) are also of concern to individuals in this HSA. Stigma related to STIs and acknowledgment that STIs are not always discussed openly, especially between parents and their children were discussed. In addition, participants spoke about the fact that the gay, transgender, and substance using populations suffer a disproportional burden of HIV, syphilis, and Hepatitis C. There was a recommendation for more testing and education of how to manage and treat STIs.

5. Safe, Crime and Violence-Free Communities

Safe, crime and violence-free communities is a significant health need in KFH-South Sacramento HSA. Fifteen of 26 indicators (58%) pertaining to safe, crime and violence free communities compare unfavorably as compared to state benchmarks. Issues related to safety and violence were marked by high rates of homicide, intentional injury, assault, domestic violence, rape and robbery as compared to state benchmarks. The combined rate of all violent crimes, which includes homicide, rape, robbery and aggravated assault, was significantly higher in this HSA as compared to the state. In addition, the rate of school suspensions was higher in this HSA as compared to the state rate. Black residents in this HSA experience higher level of death by homicide as compared to other racial/ethnic groups.

Thirty-seven of 40 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. Tension with police was discussed as being a significant health concern. Residents, especially Latino and African American groups, stated that they do not feel safe in their communities and do not always feel safe accessing law enforcement services. Gang violence was discussed as creating health issues within the communities of this service

area. Residents are fearful of gang violence, retaliation and being robbed. Gun and knife violence were mentioned on multiple occasions as being prevalent in this service area. Violence by means of gunshots and stabbings have created fear in many residents. Programs such as Summer Night Lights were mentioned as being helpful in violence reduction. Domestic violence and sexual assault were highlighted as significant issues in this service area. Residents mentioned the occurrence of emotional, physical and sexual abuse. The need for assistance with restraining orders and safe shelter spaces were highlighted as important needs. In addition, child abuse and trauma were mentioned as being prevalent in communities of this service area. Substance use (including alcohol abuse) was discussed as being a health and safety issues for communities in this service area. Residents were uncomfortable with substance use by other community members and the homeless population. Additionally, there was concern about the criminalization of certain drugs and discussion surrounding the legalization of marijuana. Interviewees were concerned about youth/young adult substance use.

6. Pollution Free Living and Work Environments

Pollution free living and work environments is a significant health need in the KFH-South Sacramento HSA. Seventeen of 26 indicators (65%) pertaining to pollution free living and work environments perform poorly as compared to state benchmarks. Challenges with pollution in living and work environments were marked by high rates of tobacco usage, asthma prevalence, air particulate matter, COPD, heart disease, limited canopy cover, dense road network density and lack of transit within 0.5 miles. Additionally, mortality due to ischemic heart disease is high in this HSA.

Twenty of 40 sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to pollutant free work and school environments as a health need. Community members spoke about poor air quality and air pollution and the connection to high rates of asthma. Interviewees also spoke about poor air quality in relation to second hand smoke from cigarettes and marijuana and the need for more enforcement of anti-smoking laws and smoking cessation programs. Pesticide exposure is a concern in some communities, especially in rural parts of the service area and for the migrant worker population. Community members spoke about living close to agricultural areas where pesticides are being sprayed on crops, which contributes to allergies and eye, nose and throat problems. It was suggested that there may be a connection between pesticide exposure over time and high cancer rates. Community members spoke about the need for neighborhood beautification and clean-up programs.

7. Basic Needs (food, housing, employment and education)

Basic needs (food, housing, employment and education) are a significant health need in the KFH-South Sacramento HSA. Twelve of 25 indicators (48%) pertaining to basic needs perform poorly as compared to state benchmarks. Challenges in accessing basic needs are marked by high rates of children and adults living in poverty (below 100% and/or 200% of the Federal Poverty Level (FPL)), a high percentage of single female headed households in poverty, reading below proficiency level, food insecurity, children eligible for free/reduced price lunch, population receiving supplemental nutrition assistance program (SNAP) and low rates of individuals (five years and older) with limited English proficiency. In the overall population, Blacks, Native Americans/Alaska Natives, Hispanics/Latinos and another race

that did not self-identify experienced greater rates of poverty (below 100% FPL). Additionally, higher rates of Black, Native American/Alaska Native, Native Hawaiian/Pacific Islander and Hispanic/Latino children live in poverty (below 100% FPL) compared to other race/ethnic groups.

Thirty-nine of 40 sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to basic needs as a health need. Economic insecurity is a significant issue within this HSA. Community members discuss hunger, food insecurity, unemployment and underemployment, lack of affordable housing, lack of transportation, language barriers, lack of vocational skills and training, as issues that negatively impact their quality of life. There were concerns that assistance programs could not provide the true needs of community members, specifically regarding lack of medical access to those utilizing Medi-Cal. Undocumented residents experienced significant barriers in accessing care. Residents have desires for funded community centers providing "one-stop shops" for social services, civic engagement and safe places for children/youth to learn. Additionally, community members were very interested in the establishment of youth organized sports programs.

The need for culturally sensitive basic needs was mentioned especially for the transgender population. Additionally, the basic needs for LGBT homeless youth were highlighted as there was recently a death due to exposure within this service area. In addition, marginalized populations were discussed as needing to utilize survival sex (prostitution) as a means to meet basic needs. These non-traditional working conditions lead to violence and great risk for some community members.

The economic and infrastructure growth of the downtown Sacramento area was mentioned multiple times as taking attention away from the pockets of deep poverty within South Sacramento. There was concern by community members that revitalization efforts have been needed in lower resourced areas of this hospital service area and have been diverted to communities with less needs. Additionally, homelessness was regularly mentioned as being of major concern, specifically related to safe and legal places for homeless individuals to rest.

Disabled, impoverished residents experienced greater burden in living full and healthy lives. Childhood trauma and adverse childhood experiences were mentioned as being significant barriers to the community achieving full health. Rural areas, such a Galt, had significant challenges accessing basic needs, especially employment, transportation and education.

8. Affordable and Accessible Transportation

Affordable and accessible transportation is a significant health need in the KFH-South Sacramento HSA. Four of eight indicators (50%) pertaining to transportation compare unfavorably as compared to State benchmarks. This HSA encompasses a higher rate of individuals with disabilities, limited access to public transit (within 0.5 miles) and less individuals who commute to work through walking or biking. Non-Hispanic Whites and other Non-Hispanic individuals have lower rates of walking, biking, or skating to school as compared to other racial/ethnic groups.

Twenty-five of 40 sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to accessible and affordable transportation as a

health need. Input from service providers and community members indicated that transportation related to accessing food, healthcare and education were challenging due to limited access to private vehicles and/or public transportation limitations. Participants noted that those living in poverty have greater barriers in accessing transportation. Those interviewed suggest improvements to the public transportation system in this HSA including increased routes to avoid multiple hour trips. Those interviewed are concerned that healthy eating, active living and healthcare options are challenging to access through walking and/or public transportation. Some mentioned that public transportation is time and cost prohibitive therefore making it less desirable. In addition, there are concerns that children, disabled and seniors have limited access to safe and reliable transportation.

D. Community Resources Potentially Available to Respond to the Identified Health Needs

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

Through this process, a total of 47 resources were identified pertaining to the significant health needs for KHF-South Sacramento. The final list of health resources is available in Appendix I, and the methodology for resource identification is further detailed in Appendix D.

VII. KFH-SOUTH SACRAMENTO 2013 IMPLEMENTATION STRATEGY EVALUATION OF IMPACT

A. Purpose of 2013 Implementation Strategy evaluation of impact

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

1. Lack of Access to Primary Health Care Services
2. Healthy Eating Active Living
3. Safety as a Health Issue
4. Broader Health Care System Needs in our Communities (Workforce & Research)

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

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

B. 2013 Implementation Strategy Evaluation Of Impact Overview

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

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

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

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

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

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

    - Research: Deploying a wide range of research methods contributes to building general knowledge for improving health and health care services, including clinical research,

health care services research, and epidemiological and translational studies on health care that are generalizable and broadly shared. Conducting high-quality health research and disseminating its findings increases awareness of the changing health needs of diverse communities, addresses health disparities, and improves effective health care delivery and health outcomes

- **Grantmaking:** For 70 years, Kaiser Permanente has shown its commitment to improving Total Community Health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2014-2015, KFH South Sacramento awarded 163 grants totaling $3,235,283 in service of 2013 health needs. Additionally, KFH in Northern California has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the KFH-South Sacramento service area. During 2014-2015, a portion of money managed by this foundation was used to award 38 grants totaling $471,777 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: LACK OF ACCESS TO PRIMARY HEALTH CARE SERVICES

Long Term Goal:

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

Intermediate Goal:

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

KFH-Administered Program Highlights

KFH Program Name	KFH Program Description	Results to Date
Medicaid	Medicaid is a federal and state health coverage program for families and individuals with low incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.	• *2014: 28,890 Medi-Cal members* • *2015: 28,307 Medi-Cal members*
Medical Financial Assistance (MFA)	MFA provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.	• *2014: KFH - Dollars Awarded By Hospital - $2,415,627* • *2014: 3,027 applications approved* • *2015: KFH - Dollars Awarded By Hospital - $2,628,598* • *2015: 2,841 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: 2,865 members receiving CHC* • *2015: 2,578 members receiving CHC*

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 66 active KFH grants totaling $1,103,388 addressing Lack of Access to Primary Health Care Services in the KFH-South Sacramento service area.[1] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 19 grants totaling $307,467 that address this need. These grants are denoted by asterisks (*) in the table below.

[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.

Grantee	Grant Amount	Project Description	Results to Date
Sacramento City Unified School District (SCUSD)	$50,000 in 2015	SCUSD's Connect Center helps fill in supportive services gaps by consolidating community and district resources and providing information, service, and support to students and families. The Center helps increase access to critical health and human services by creating a single access point for the 55 SCUSD schools that do not have site-based resources.	As of December 7, SCUSD staff had provided: • direct services to 180 individuals • support services to 18 individuals • health insurance enrollment services to 10 • 8 student health and wellness trainings to 185 parents, families and district staff
CARES Community Health	$125,000 over 2 years $62,500 in 2014 & 2015 This grant impacts two KFH hospital service areas in Northern California Region.	CARES will expand clinical capacity by focusing on improving health outcomes for specific patient groups and develop processes to improve specific outcomes for all patients, with a focus on hypertension in African Americans, diabetes in Latinos, and chlamydia screening for young people.	• Completed blood pressure competency training of all staff • Created patient outreach and education strategy including a "Heart Smart" hypertension education initiative. • Completed four community outreach events where they discussed hypertension with over 400 patients and community members • % of hypertensive patients with blood pressure under control rose from a baseline of 54% to 60%
Sacramento Native American Health Centers (SNAHC)	$125,000 over 2 years $62,500 in 2014 & 2015 This grant impacts two KFH hospital service areas in Northern	Proposed project will increase QI culture and expand process improvement skills through participation in a collaborative learning environment. SNAHC will focus on improving specialty service referrals using a high-level of care coordination and a team-based approach.	• improved EHR systems to include alerts when a foot exam is due that prompts medical assistants to conduct the exam; rate of annual foot exams improved from 38% to 52% • improvement strategies increased efficacy of team huddle meetings • patients with HbA1c </ = 8, rate of controlled blood sugar improved from 39% to 59% • goal is to spread these improvements to other care teams in 2016

	California Region.		
Chapa-De Indian Health Program	$125,000 over 2 years $62,500 in 2014 & 2015 This grant impacts two KFH hospital service areas in Northern California Region.	Chapa-De plans to increase clinical capacity to care for patients with chronic illness by educating and training highly functioning teams and instituting team based care.	• develop electronic tool-registry to track diabetes patients • develop protocols for efficient phone care management and group education classes for diabetic patients • create standing orders for nurses to lead case management and reduce physician workload • hired a diabetes care manager nurse
Elica Health Centers (EHC)	$125,000 over 2 years $62,500 in 2014 & 2015 This grant impacts two KFH hospital service areas in Northern California Region.	EHC will advance its clinical capacity by sustainably integrating preventive and primary care, chronic disease management, and behavioral health services to increase process improvement skills and create a QI environment.	• updated cervical care screening guideline (based on the evidence) and reviewed changes with all physicians • improved eight processes related to improving cancer screening rates (e.g., developed checklists-algorithms to remind staff of the importance of cancer screenings and to flag patients who need screening) • substantially reduced notification time for abnormal lab results from 89 minutes to 55 minutes
WellSpace Health Centers	$125,000 over 2 years $62,500 in 2014 & 2015 This grant impacts two KFH	Project allows Sacramento FQHC Wellspace to increase quality of care and outcomes for chronic disease patients by providing regular health education and supporting behavior change to control blood pressure and diabetes, and to reduce emergency department use.	• launched group health education classes targeting Latino patients with diabetes and will spread classes to two new sites. • prepared for deployment of a sophisticated technology tool-disease registry in early 2016

	hospital service areas in Northern California Region.		
Collaboration/Partnership Highlights			
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**		**Results to Date**
Mental Health Improvement Coalition	Comprising four local health systems, Sierra Sacramento Valley Medical Society, Northern and Central California Hospital Council, Sacramento Metro Fire, area clinics, and an array of community and business stakeholders, the coalition aims to enable a coordinated response to restore and rebalance Sacramento County's system of behavioral health care.		Greater Sacramento Public Affairs Directors, Sacramento/Roseville and South Sacramento, are Coalition members. Funds were approved to expand access to the county's crisis stabilization unit; expand in-patient, outpatient, and respite care; and utilize innovative patient-centered approaches, including patient navigators and mobile crisis teams.
Sacramento City Unified School District Health Services Planning Committee	SCUSD's Health Services Planning Committee was launched to develop community-school partnerships that provide prevention and early intervention health services for district students.		The Greater Sacramento CB Manager and CB Specialist represented Kaiser Permanente at six committee meetings. At those meetings, the Committee created draft recommendations for increasing community-school partnerships.
Sierra Health Foundation/Sacramento Region Health Care Partnership/Safety Net Learning Institute	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.		The 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.
In-Kind Resources Highlights			
Recipient	**Description of Contribution and Purpose/Goals**		

Health Professions High School	• Five employees from KFH-South Sacramento Radiology, and two faculty and two students from the Kaiser Permanente School of Allied Health Sciences participated in Radiology Day, a half-day symposium for health career-focused students. • Three postdoctoral psychology fellows participated in the scoring of senior project presentations.
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 Goals:

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

Intermediate Goals:

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

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 34 active KFH grants totaling $1,333,146 addressing Healthy Eating, Active Living in the KFH-South Sacramento service area.[2] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 7 grants totaling $39,881 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
California Food Literacy Center	$20,000 over 2 years $10,000 in 2014 & 2015	The Center targets low-income children who are most at risk for obesity due to lack of access to healthy food. In targeted schools, 90% to 100% of students participate in free/ reduced price lunch programs. Food literacy education for pre-K through 6th grade at six elementary afterschool programs includes weekly 45-minute classes on cooking, nutrition, and where food comes from.	During 2014/2015 1120 children were reached with nutrition lessons, cooking, and "produce of the day," to expand kids' taste and exposure to fruits and vegetables. Activities improved knowledge and attitude about cooking and eating healthy meals and snacks, as well as portion size and making healthy versions of popular favorites.
Elk Grove Food Bank Services (EGFBS)	$26,421 in 2014	EGFBS' Nutritionally Enhanced Food Closet Program provides healthy nutrition education and more fresh produce/nutritional supplements for seniors, people who are medically at-	The Food Closet programs served 19,955 individuals. Nutrition education was provided to 79 low-income people and EGFBS expanded its services to include the typically underserved Florin area.

[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.

		risk, and low income Elk Grove residents.	
Health Education Council (HEC)	$1,000,000 $500,000 in 2014 & 2015	HEC supports the South Sacramento HEAL Zone in its collective work to increase access to healthy food and opportunities for physical activity in the Valley Hi community. The project expands on three previous years of engagement in the area and the grant supports implementation of coordinated, high reach, high impact strategies focused on policy, systems, the built environment, and program changes.	Expected reach is 13,394. Outcomes to date include the following: • installed hydration stations in regional transit stations • expanded Walk with Friends Club at Valley Hi and Mesa Grande parks • Collaborated with local apartment managers on HEAL policies • increased physical activity programming at churches • integrated farmers market nutrition education and parent cooking classes at HEAL Zone elementary schools • partnered with Elk Grove USD to grow parent engagement in Safe Routes to School • through internships at Mack Road farmers market, connected Valley High School Health Academy youth to public health practices • solidified collaboration between the business sector, housing complexes, elected officials and other non-traditional partners, which led to broader neighborhood revitalization
ReIMAGINE Mack Road Foundation	$20,000 in 2015	In conjunction with the Sacramento Summer Night Lights program, the Mack Road-Valley Hi farmer's market is held at Valley Hi Community Center, which serves a low-income, at-risk population. The market offers CalFresh and other shopper incentives.	• market provided fresh fruits and vegetables for 18 weeks, serving 2,086 • 15 vendors were on contract for the season with an average of seven vendors per market • rates for incentive programs, including Cal-Fresh redemption, increased from $1,409 in 2014 to $2,386 in 2015

			• Market Match participation increased by nearly 400%, with $2,579 in matching funds
Collaboration/Partnership Highlights			
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**	**Results to Date**	
Sierra Health Foundation/Healthy Sacramento Coalition	Healthy Sacramento Coalition envisions a county that is healthy, safe, and thriving. Its priority areas include reducing death and disability due to chronic disease; reducing health disparities; building a safe and healthy physical environment; and improving the social and emotional well-being of county residents.	The coalition has been focused on identifying alternate funding sources and revising strategies due to cessation of the CDC's Community Transformation Grant, which had funded the coalition's activities since 2012.	
Elk Grove Unified School District (EGUSD)/Wellness Advisory Committee	EGUSD's Wellness Advisory Committee is an integrated, school-affiliated program designed to enhance the health of students and staff through health education and services; nutrition services; physical education; psychological, counseling, and social services; staff health promotion; healthy school environments; and family and community involvement.	The CB Specialist represents Kaiser Permanente at the quarterly Wellness Advisory Committee meetings, which include discussions on pertinent health topics and identifying recommendations to make to the EGUSD school board.	
In-Kind Resources Highlights			
Recipient	**Description of Contribution and Purpose/Goals**		
Sacramento Food Film Fest	A KFH physician spoke at the 2014 festival screening of the "Cafeteria Man" documentary for 150 school food advocates, employees from Elk Grove and Sacramento City unified school districts, and community members.		
Impact of Regional Initiatives			
HEAL Zones: Kaiser Permanente's HEAL (Healthy Eating, Active Living) Zone initiative is a place-based approach that aims to lower the prevalence and risks of diseases associated with obesity in communities that have disproportionate rates of heart disease, type 2 diabetes, high blood pressure, stroke, depression, and some cancers. HEAL Zones focus on increasing access to fresh fruit, vegetables, and healthy beverages, as well as increasing safe places to be play and be physically active. HEAL Zones deploy robust coalitions of local public agencies, schools and school districts, community-based organizations, employers, local			

businesses, faith-based organizations, and health care providers, including Kaiser Permanente, to affect broad population-level behavior change that will ultimately lead to better health outcomes.

PRIORITY HEALTH NEED III: SAFETY AS A HEALTH ISSUE

Long Term Goal:

- Reduce violence in neighborhoods, schools, and homes, with a focus on communities of concern in the KFH-South Sacramento service area.

Intermediate Goals:

- Empower the community to reduce area violence and foster a safe community environment
- Engage at-risk youth and support families to increase individual and family resilience and reduce unhealthy behaviors
- Strengthen and coordinate trauma-informed health care and community services with a focus on communities of concern

Grant Highlights

Summary of Impact: During 2014 and 2015, there were 46 active KFH grants totaling $589,007 addressing Safety as a Health Issue in the KFH-South Sacramento service area.[3] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 5 grants totaling $55,981 that address this need. These grants are denoted by asterisks (*) in the table below.

Grantee	Grant Amount	Project Description	Results to Date
Always Knocking, Inc.	$20,000 in 2015	Always Knocking's youth and gang violence prevention program identifies and redirects misguided youth by inspiring positive change through reflection of one's choices and the introduction of positive social sessions. Its basketball development program provides youth 8 to 12 with positive life skills and conflict resolution techniques. And Building Blocks of a Leader gives young girls 6 to 12 the resources, educational tools, and experience to make a positive life	• Always Knocking outreached to 191 at-risk youth • 58 individuals registered in the youth and gang violence program • 16 youth completed the intervention and prevention program • 47 youth completed the basketball development program • 22 youth completed Building Blocks of a Leader

[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.

		changes.	
My Sister's House	$25,000 in 2014	The Asian/Pacific Islander (API) Violence Prevention Project is part of My Sister's House's continued efforts to educate college students about intimate partner violence and to work with local law enforcement to respond to victims in a culturally competent way.	My Sister's House provided legal assistance to 122 survivors of sexual assault, and worked closely with 12 API survivors. Staff presence in the Sacramento Police Department has helped improve law enforcement response and connection to sexual assault supports and services available from My Sister's House. Funding has also enabled outreach to 280 students on local college campuses.
Community Against Sexual Harm (CASH)	$50,000 over 2 years $25,000 in 2014 & 2015	CASH's safety and wellness program aims to implement agency-wide trauma-informed practices and increase safe practices for victims of commercial sexual exploitation. Objectives include creating a trauma-informed culture; increasing street outreach to engage women and increase safety; and providing focused education, community linkages, and peer-support to reduce violence in the lives of women they serve.	CASH staff and volunteers were trained on trauma-informed-care principles and provided services to 105 women. Through the Wellness Program, hours at the drop in center increased, making urgent services more accessible to women. 78 women took documented harm reduction steps to increase their personal safety and mental and physical well-being. CASH also made its physical environment more welcoming and reorganized it to maximize the space available for confidential discussions
WEAVE, Inc.	$35,000 in 2015	Weave's domestic violence assistance (DVA) project is designed to ensure access to an array of critical crisis intervention services for DV victims. DVA provides 7,600 unduplicated DV victims with access to 24/7 crisis intervention triage, safe shelter, case management, group support and counseling, and referrals.	From July through October/November, WEAVE: • provided 4,822 total bed nights of safe shelter for 83 women and 107 children • provided case management for 106 adults • answered 3,163 calls to its 24-hour support line and 4,292 duplicated referrals • provided 207 crisis intervention triage and walk-in services • 91% of clients surveyed showed an improved ability to plan for their safety

			as a result of the services and an increased knowledge about other supportive services in the community • Group counseling sessions were provided to 305 adult DV victims
Collaboration/Partnership Highlights			
Organization/ Collaborative Name	**Collaborative/ Partnership Goal**		**Results to Date**
City of Sacramento/Community Safety Partnership	Formally known as the Gang Prevention Partnership, the Community Safety Partnership has reformed and is actively designing initiatives for Sacramento.		The Greater Sacramento Public Affairs Director and Trauma Outreach Coordinator represent Kaiser Permanente on the collaborative.
Health Education Council/Sacramento Minority Youth Violence Prevention Initiative (SMYVP)	SMYVP's goals are to • form a multisector collaborative to increase local coordination of services/resources to reduce crime/violence among youth of color • incorporate community policing practices and the hospital-based SVIP (Sacramento violence intervention program) into the Male Leadership Academy (MLA) to address the emotional/social/physical needs of young men of color via a school-based curriculum • integrate MLA into Sacramento Summer Night Lights to build community, create safe opportunities for youth to be active and engaged during the summer, and reduce violence in South Sacramento		The Greater Sacramento's Trauma Outreach Coordinator; CB Specialist; and former CB Manager have been engaged with the coalition and attend meetings. SMYVP is supported by a three-year joint grant from the Office of Minority Health and Department of Justice Office of Community-Oriented Policing Services that began in October 2014.
Sacramento ACEs Connection	A countywide collaborative (school districts, juvenile justice, UC Davis, Sutter, Sacramento Police, Public Health and the Health Education Council) to educate the community about ACEs		The Greater Sacramento Trauma Outreach Coordinator represents Kaiser Permanente at the collaborative's monthly meetings, and also spoke at a two-day workshop attended by more than 200 people and a screening of the "Paper Tigers" documentary.

	(adverse childhood experiences) and the effects of toxic stress. The goal is that everyone in Sacramento County integrates trauma-informed and resilience-building practices into their work, family, community, and individual lives.	
Sacramento Violence Intervention Program (SVIP)	SVIP engages youth 15 to 24 admitted to the KFH-South Sacramento Trauma Center with severe violence-related injuries. It aims to reduce re-injury, retaliation, and arrest by promoting positive life choices and violence alternatives and linking youth to community-based resources. Starting at the hospital bedside and continuing for up to six months post-recovery, intervention specialists from WellSpace Health, a local FQHC, work with youth and their families.	KFH-South Sacramento staffs the program with a Trauma Outreach Coordinator, who identifies youth and connects them with WellSpace intervention specialists. Since June 2010, KFH-South Sacramento has referred 215 youth to SVIP. Of the 164 who consented to be in the program, outcomes include: • 99% no new hospitalization • 91% no new arrests • 37% employed • 40% enrolled in educational program
California Department of Education, Student Mental Health Policy Workgroup (SMHPW)	In 2011, with California Mental Health Services Authority funding, State Superintendent of Public Instruction Tom Torlakson convened the SMHPW. The group includes teachers, school staff (social workers, counselors, nurses, psychologists, and administrators), state and county mental health professionals, and other interested stakeholders. The group is assessing the current mental health needs of California students and gathering evidence to support its policy recommendations to Torlakson and the California Legislature.	To date, the SMHPW has made four policy recommendations: **1.** include mental health into the teacher and administrative credentialing standards set by the California Commission on Teacher Credentialing **2.** address student mental health, including suicide prevention, in the Comprehensive School Safety Plans **3.** plan and evaluate districts' policies and strategies for suicide prevention, intervention, and postvention procedures **4.** encourage school staff to participate in professional development related to student mental health, including youth mental health first aid (YMHFA) A Child Psychiatrist at KFH-South Sacramento, has represented Kaiser Permanente, bringing a medical/health perspective to the dialogue.

Center for Youth Wellness, Policy Working Group	The group contributes to the content/design of statewide convenings on reducing and preventing adverse childhood experiences (ACEs) in California, and makes recommendations for state policy changes that will enable different sectors to converge and create systemic changes for families and communities.	• contributed to 2015 statewide convening and to plans for 2016 convening • prepared draft policy recommendations document • The Greater Sacramento trauma injury prevention coordinator, KFH-South Sacramento, represents Kaiser Permanente and brings a medical/health perspective to the dialogue.

In-Kind Resources Highlights	
Recipient	**Description of Contribution and Purpose/Goals**
Elk Grove Unified School District Wellness Advisory Committee	The Greater Sacramento Trauma Outreach Coordinator presented on trauma-informed care to the committee. She was joined by an intervention specialist with SVIP, a collaboration between KFH-South Sacramento Trauma department and WellSpace Health (and funded by Kaiser Permanente Regional CB).
ReImagine Mack Road Foundation	On April 26, 2014 more than 4,000 community volunteers volunteered at 16 project sites in the Valley Hi neighborhood. They rehabbed a community center, spruced up landscaping along Mack Road, painted fences, and installed a "Welcome to Mack Road" sign. Among the volunteers were more than 70 Kaiser Permanente employees and physicians who rehabbed 1 of 10 Valley Hi homes comprising Rebuilding Together's annual spring build day. In 2015 Kaiser Permanente Educational Theater's Community Troupe provided an obstacle course for youth at Sacramento Summer Night Lights (SSNL), an evidence-based violence prevention strategy begun in Los Angeles and piloted in South Sacramento's Valley Hi neighborhood. It brings people out to socialize, eat, play sports, and enjoy entertainment on Thursday, Friday, and Saturday evenings. SSNL also provides jobs for area youth during Elk Grove USD's 14-week summer break. In total, 14,122 people attended, with an average of 200 meals served each night.

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 17 Workforce Development grants totaling $209,742 that served the KFH-South Sacramento service area.[4] In addition, a portion of money managed by a donor advised fund at East Bay Community Foundation was used to award 5 grants totaling $37,106 that address this need. In addition, KFH South Sacramento provided trainings and education for 161 residents in their Graduate Medical Education program in 2014 and 147 residents in 2015, 36 nurse practitioners or other nursing beneficiaries in 2014 and 41 in 2015, and 39 other health (non-MD) beneficiaries as well as internships for 27 high school and college students (Summer Youth, INROADS, etc) for 2014-2015.

Grant Highlights

Grantee	Grant Amount	Project Description	Results to Date
Valley High School	$19,000 in 2014	Through the Cultural Awareness Community Healthy Education (CACHE) program, Health TECH Academy students meet with Kaiser Permanente physician mentors every three weeks and get tools that better prepare them for health careers. Students are grouped based on ethnicity. Each group surveys its own community to identify a top health concern. With guidance from the physician mentors, the students create and deliver a public health presentation that addresses a critical public health issue specific to their cultural community.	Health TECH Academy students have presented their research at health fairs and community events, and through a local Hmong radio program to roughly 5,000 people in the Sacramento Region. Beginning in 2014, Health TECH Academy launched a community health worker training and certification program to allow students who meet certain requirements to be certified as community health workers during the twelfth grade. The academy is also developing pre-academy curriculum for Samuel Jackman Middle School to prepare pre-academy students for the rigors of the CACHE program.
City Year	$300,000 in 2014	Grant will support a City Year Whole School Whole Child (WSWC) team of AmeriCorps members at Fern Bacon Middle School to address vulnerable students with at least three risk factors (dropping out, poor attendance, behavior issues, and/or poor coursework) for three years.	Goals are to retain 95% whole school attendance; reduce referrals and suspensions by 30%; provide English Language Arts (ELA) and math support to more than 700 Fern Bacon students throughout the year; and help at least 70% of focus-list students improve scores on end-of-year ELA and math assessment.

[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.

*Public Health Institute (PHI)	$149,889 in 2015 This grant impacts four KFH hospital service areas in Northern California Region.	PHI's FACES for the Future Coalition is a program that works with at-risk, underrepresented high-school students to increase their presence in the health professions through academic support, internships in hospitals and community clinics, youth leadership development, and wellness training that includes psychosocial intervention as needed.	Anticipated outcomes include: • FACES is implemented in San Francisco Unified School District • FACES tracks students' individual progress through changes in GPA, attendance and cause of absence, internship supervisor feedback, case management documentation, and pre/post surveys and testing that measure learning outcomes • Plan for and pilot FACES at South Sacramento's Health Professions and Hiram Johnson high schools • to further expand the program, FACES electronically disseminates a newly developed replication toolkit to a wide number of interested groups
*Physicians Medical Forum (PMF)	$150,000 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 Region.	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 effectiveness of health services delivery models. In addition, funding allowed CHIS to support enhancements for AskCHIS Neighborhood Edition (NE). New AskCHIS NE visualization and mapping tools will be used to demonstrate the geographic differences in health and health-related outcomes across multiple local geographic levels, allowing users to visualize the data at a sub-county level.	CHIS 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 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.*	**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

	6. *Over half of U.S. infants sleep in potentially hazardous bedding.*	**4.** Elizabeth Scruth, et al. **5.** Van et al. **6.** Deborah McBride, KFH-Oakland

VIII. APPENDICIES

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 8.

Table 7. CHNA Data Platform Indicators

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

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

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

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

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

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

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

Variable	Year	Definition	Reporting Unit	Data Source
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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

Variable	Year	Definition	Reporting Unit	Data Source
Poverty - Population Below 200% FPL	2009-2013	Percent Population with Income at or Below 200% FPL	Tract	US Census Bureau, American Community Survey
Preventable Hospital Service Days	2011	Age-Adjusted Discharge, Rate per 10,000 Population	County	California Office of Statewide Health Planning and Development, OSHPD Patient Discharge Data. Additional data analysis by CARES
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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
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

Variable	Year	Definition	Reporting Unit	Data Source
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.

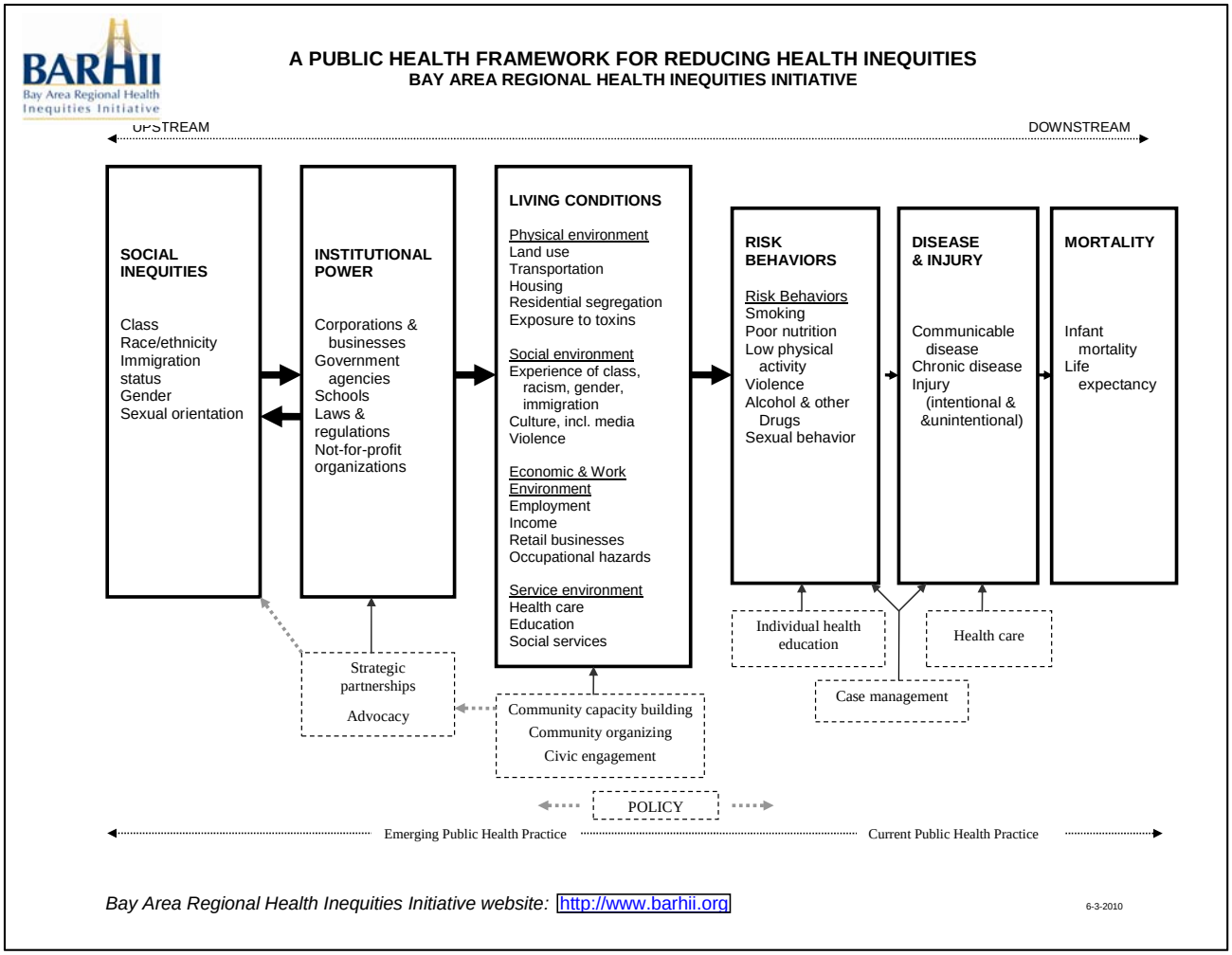


Figure 6. BARHII Framework

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-

Derived Indicator Name	Source Indicator Names	Source
		year Estimate Table DP05
Percent Asian (Not Hispanic)	Total Population: Not Hispanic or Latino (Asian lone)	2013 American Community Survey 5-year Estimate Table DP05
Percent Black (Not Hispanic)	Total Population: Not Hispanic or Latino (Black or African American lone)	2013 American Community Survey 5-year Estimate Table DP05
Percent Hispanic (Any Race)	Total Population: Hispanic or Latino (of any race)	2013 American Community Survey 5-year Estimate Table DP05
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

Derived Indicator Name	Source Indicator Names	Source
Percent Single Female-Headed Households	Female householder, No Husband Present, Family Household	2013 American Community Survey 5-year Estimate Table S1101
Percent 25 or Older Without a High School Diploma	100 - Percent High School Graduate or Higher	2013 American Community Survey 5-year Estimate Table S1501
Percent Families with Children in Poverty	All families: Percent Below Poverty Level; Estimate; With Related Children Under 18 Years	2013 American Community Survey 5-year Estimate Table S1702
Percent Single Female-Headed Households in Poverty	Female householder, No Husband Present: Percent Below Poverty Level; Estimate; With Related Children Under 18 Years	2013 American Community Survey 5-year Estimate Table S1702
Percent Unemployed	Unemployment Rate; Estimate; Population 16 Years and Over	2013 American Community Survey 5-year Estimate Table S2301
Percent Uninsured	Percent Uninsured; Estimate; Total Civilian Noninstitutionalized Population	2013 American Community Survey 5-year Estimate Table S2701

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

Derived Variable Name	Source Variable Names	Source
Total Population	Total Population	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014) 2010 Decennial Census Summary File 1
Female	Female	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Male	Male	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age Under 1	DP05: Under 5 years PCT12: Male and Female, ages under 1, 1, 2, 3, and 4	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014); 2010 Decennial Census Summary File 1 Table PCT12
Age 1 to 4	DP05: Under 5 years PCT12: Male and Female, ages under 1, 1, 2, 3, and 4	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014); 2010 Decennial Census Summary File 1 Table PCT12

[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 5 to 14	5 to 9 years; 10 to 14 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 15 to 24	15 to 19 years; 20 to 24 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 25 to 34	25 to 34 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 35 to 44	35 to 44 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 45 to 54	45 to 54 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 55 to 64	55 to 59 years; 60 to 64 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 65 to 74	65 to 74 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 75 to 84	75 to 84 years	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Age 85 and over	85 years and over	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
White	HISPANIC OR LATINO AND RACE - Total population - Not Hispanic or Latino - White alone	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Black	HISPANIC OR LATINO AND RACE - Total population - Not Hispanic or Latino - Black or African American alone	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
Hispanic	HISPANIC OR LATINO AND RACE - Total population - Hispanic or Latino (of any race)	American Community Survey 5-year Estimate Table DP05 (2011, 2012, 2013, 2014)
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

[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

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.

Table 11. CDPH Birth and Mortality Data by ZIP Code

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

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

Table 12. Remaining Secondary Variables

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

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

ZIP Code Definitions

All morbidity and mortality variables collected in this analysis are reported by patient mailing ZIP codes. ZIP codes are defined by the US Postal Service as a single location (such as a PO Box), or a set of roads along which addresses are located. The roads that comprise such a ZIP code may not form contiguous areas, and do not match the approach of the US Census Bureau, which is the main source of population and demographic information in the US. Instead of measuring the population along a collection of roads, the Census reports population figures for distinct, contiguous areas. In an attempt to support the analysis of ZIP code data, the Census Bureau created ZIP Code Tabulation Areas (ZCTAs). ZCTAs are created by identifying the dominant ZIP code for addresses in a given Census block (the smallest unit of Census data available), and then grouping blocks with the same dominant ZIP code into a corresponding ZCTA. The creation of ZCTAs allows us to identify population figures that, in combination the morbidity and mortality data reported at the ZIP code level, allow us to calculate rates for each ZCTA. But the difference in the definition between mailing ZIP codes and ZCTAs has two important implications for analyses of ZIP level data.

First, it should be understood that ZCTAs are approximate representations of ZIP codes, rather than exact matches. While this is not ideal, it is nevertheless the nature of the data being analyzed. Secondly, not all ZIP codes have corresponding ZCTAs. Some PO Box ZIP codes or other unique ZIP codes (such as a ZIP code assigned to a single facility) may not have enough addressees residing in a given census block to ever result in the creation of a ZCTA. But residents whose mailing addresses correspond to these ZIP codes will still show up in reported morbidity and mortality data. This means that rates cannot be calculated for these ZIP codes individually because there are no matching ZCTA population figures.

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

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

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

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

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

General Processing Steps

Rate Smoothing

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

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

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

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

match the state norm. While this may not entirely resolve the small number problem in all cases, it does make the comparison of the resulting rates more appropriate. Because the rate for each ZCTA is adjusted to some degree by the EBR process, it also has a secondary benefit of better preserving the privacy of patients within the ZCTAs.

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

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

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

Age Adjustment

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

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

[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.

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 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

[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

- 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 GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
1	Key Informant Interview	Public Health Officer	Sacramento County Public Health Dept.	1	Public Health Department Representative	Leader	05/19/15
2	Group Key Informant Interview	ED Director	Methodist Hospital of Sacramento	1	Hospital representative	Representative	06/11/15
3	Group Key Informant Interview	Regional Director, Social Work	Methodist Hospital of Sacramento	1	Hospital representative	Representative	06/11/15
4	Group Key Informant Interview	Social Work Manager	Kaiser Permanente South Sacramento Medical Center	1	Hospital representative	Representative	06/11/15
5	Key Informant Interview	Executive Director	La Familia Counseling Center Inc.	1	Minority, Medically Underserved, Low-Income	Representative	06/18/15
6	Key Informant Interview	Executive Director	Center for Community Health and Well-Being	1	Minority, Medically Underserved, Low-Income	Representative	06/22/15
7	Key Informant Interview	Chief Executive Officer	Peach Tree Health	1	Minority, Medically Underserved, Low-Income	Representative	06/22/15
8	Key Informant Interview	Chief Executive Officer	Sacramento Native American Health Center	1	Minority, Medically Underserved,	Representative	06/23/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
					Low-Income		
9	Key Informant Interview	Director	Sacramento City Unified School District- Student Support and Health Services	1	Minority, Medically Underserved, Low-Income	Representative	06/25/15
10	Key Informant Interview	Director of Residential & Crisis Response Services	WEAVE	1	Minority, Medically Underserved, Low-Income	Representative	06/26/15
11	Key Informant Interview	Director	Department of Human Assistance	1	Minority, Medically Underserved, Low-Income	Representative	07/02/15
12	Key Informant Interview	Executive Director	Health Education Council	1	Minority, Medically Underserved, Low-Income	Representative	07/07/15
13	Key Informant Interview	Chief Executive Officer	Saint John's Program for Real Change	1	Minority, Medically Underserved, Low-Income	Representative	07/08/15
14	Key Informant Interview	Development Director	TLCS Inc.	1	Minority, Medically Underserved, Low-Income	Representative	07/16/15
15	Key Informant Interview	Executive Director	Sacramento Steps Forward	1	Minority, Medically Underserved, Low-Income	Representative	07/16/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
16	Key Informant Interview	Director	Slavic Assistance Center-Sacramento	1	Minority, Medically Underserved, Low-Income	Representative	07/20/15
17	Key Informant Interview	Chief Executive Officer	WellSpace Health	1	Minority, Medically Underserved, Low-Income	Representative	07/22/15
18	Key Informant Interview	Executive Director	Sheriff's Community Impact Program	1	Minority, Medically Underserved, Low-Income	Representative	07/22/15
19	Key Informant Interview	Managing Attorney	Legal Services for Northern California- Health	1	Minority, Medically Underserved, Low-Income	Representative	07/22/15
20	Key Informant Interview	Executive Director	Sacramento Covered	1	Minority, Medically Underserved, Low-Income	Representative	07/23/15
21	Key Informant Interview	Program Manager	Sacramento Covered	1	Minority, Medically Underserved, Low-Income	Representative	07/23/15
22	Key Informant Interview	Executive Director	Sacramento LGBT Center	1	Minority, Medically Underserved, Low-Income	Representative	07/23/15
23	Key Informant Interview	Executive Director	Hmong Women's Heritage	1	Minority, Medically Underserved,	Representative	07/23/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
					Low-Income		
24	Key Informant Interview	Executive Director	Mercy Housing	1	Minority, Medically Underserved, Low-Income	Representative	07/29/15
25	Key Informant Interview	Executive Director	Wind Youth Services	1	Minority, Medically Underserved, Low-Income	Representative	08/04/15
26	Key Informant Interview	Executive Director	El Hogar	1	Minority, Medically Underserved, Low-Income	Representative	08/06/15
27	Key Informant Interview	Executive Director	Eskaton	1	Minority, Medically Underserved, Low-Income	Representative	08/07/15
28	Key Informant Interview	Associate Director	Child Abuse Prevention Center	1	Minority, Medically Underserved, Low-Income	Representative	08/10/15
29	Key Informant Interview	Co-executive Director & Clinical Director	Strategies for Change	1	Minority, Medically Underserved, Low-Income	Representative	08/14/15
30	Key Informant Interview	Executive Director	Turning Point	1	Minority, Medically Underserved, Low-Income	Representative	08/19/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
31	Key Informant Interview	Executive Director	Southeast Asian Assistance Center	1	Minority, Medically Underserved, Low-Income	Representative	08/19/15
32	Key Informant Interview	Executive Director	North Franklin District Business Association	1	Minority, Medically Underserved, Low-Income	Representative	08/20/15
33	Focus Group	LGBTQ Focus Group	Gender Health Center	8	Minority, Medically Underserved, Low-Income	Member	08/21/15
34	Focus Group	Service Provider Focus Group	Sacramento Covered	6	Minority, Medically Underserved, Low-Income	Representatives	09/04/15
35	Focus Group	Service Provider FG	La Familia Counseling Center	13	Minority, Medically Underserved, Low-Income	Representatives	09/22/15
36	Focus Group	Slavic/Ukrainian/Russian Community Member Focus Group	Slavic Assistance Center	10	Minority, Medically Underserved, Low-Income	Member	09/28/15
37	Focus Group	Valley Hi Families Focus Group	Valley Hi Family Resource Center	8	Minority, Medically Underserved, Low-Income	Member	10/01/15
38	Focus Group	Food Bank Clients Focus Groups	Sacramento Food Bank and Family Services	6	Minority, Medically Underserved,	Member	10/02/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
					Low-Income		
39	Focus Group	Community Member Focus Group	City Church of Sacramento	19	Minority, Medically Underserved, Low-Income	Member	10/10/15
40	Focus Group	Service Provider Focus Group	Sierra Health Foundation- Respite Care Partnership	5	Minority, Medically Underserved, Low-Income	Representatives; members	10/12/15
41	Focus Group	Peer Advocates and Community Member Focus Group	WellSpace SVIP	8	Minority, Medically Underserved, Low-Income	Representatives; members	10/14/15
42	Focus Group	Community Member Focus Group	Mercy Housing- Alder Grove/ Marina Vista	6	Minority, Medically Underserved, Low-Income	Member	10/15/15
43	Focus Group	Youth Focus group	Oak Park B.E.S.T. Program	15	Minority, Medically Underserved, Low-Income	Member	10/17/15
44	Focus Group	Community in Recovery Focus Group	Strategies for Change- South Sacramento	14	Minority, Medically Underserved, Low-Income	Member	10/22/15
45	Focus Group	Community Member Focus Group	All Nations Church of God in Christ	8	Minority, Medically Underserved, Low-Income	Member	10/22/15

	DATA COLLECTION METHOD	TITLE/NAME	ORGANIZATION	NUMBER	TARGET GROUP(S) REPRESENTED	ROLE IN TARGET GROUP	DATE INPUT WAS GATHERED
46	Focus Group	Charles E. Mack Elementary Families Focus Group	Charles E. Mack Elementary Family Resource Center	16	Minority, Medically Underserved, Low-Income	Member	10/27/15
47	Focus Group	Health TECH Academy Students Focus Group	Valley High School Health TECH Academy	7	Minority, Medically Underserved, Low-Income	Member	10/29/15

APPENDIX C: Health Need Profiles

KFH-South Sacramento Service Area Health Needs (in order of priority)	Health Need Criteria
1. Access to Behavioral Health Services (Mental Health and Substance Abuse) 2. Healthy Eating and Active Living 3. Access to High Quality Health Care and Services 4. Disease Prevention, Management and Treatment 5. Safe, Crime and Violence-Free Communities 6. Pollution Free Living and Work Environments 7. Basic Needs (Food, Housing, Employment, Education) 8. Access to Affordable and Accessible Transportation	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 Solano County and California benchmarks are not necessarily statistically significant. Red color coding is used to highlight indicators that have a higher rate or percentage that is an undesirable difference from the KFH-South Sacramento 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 & Substance Abuse)		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS**	**Contributing Factors RELATED INDICATORS**
Behavioral Health o **Mental Health -** Mental health and well-being is essential to living a meaningful and productive life. The burden of mental illness in the United States is among the highest of all diseases, and people with untreated mental health disorders are at high risk for many unhealthy and unsafe behaviors, including substance abuse and suicide. People with severe mental disorders on average tend to die earlier (10-25 years) as compared to the general population. Mental health disorders are also associated with chronic	**Mortality – Suicide** • HSA 10.70% // CA 9.80% (health disparities) **Mental Health – Needing Mental Health Care** • HSA 16.20% // CA 15.90% (health disparities)	• Chronic liver disease and cirrhosis - MORT • Chronic Lower Respiratory Disease - MORT • COPD (ED)** • COPD (H)**

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. *Source:* http://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health http://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse http://www.healthypeople.gov/2020/topics-objectives/topic/tobacco-use	**Health Professional Shortage Area – Mental Health** • HSA 1.00 // CA N/A **Self-Inflicted Injuries (ED) (per 100,000)** • HSA 12.85** // CA 8.18 **Self-Inflicted Injuries (H) (per 100,000)** • HSA 3.63 // CA 4.40 **Mental Health (ED) (per 100,000)** • HSA 259.21** // CA 149.93 **Mental Health (H) (per 100,000)** • HSA 213.59** // CA 186.92	

http://www.who.int/mental_health/management/info_sheet.pdf		

Primary Data:

Thirty-one of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to mental health as a health need and 32 of 30 (80%) mentioned substance abuse as a health need. Themes related to this health need are as follows:

- Tobacco use and access were discussed as being significant for this area. Tobacco use among youth, young adults and adults was discussed, including e-cigarette use. A significant theme related to tobacco use was ease of accessibility of tobacco products in this service area. Also, there is an interest in culturally sensitive smoking cessation programs for LGBT community members.
- Participants discussed specific geographic safety concerns mainly related to substance use issues. Locations mentioned include safety concerns at neighborhoods, schools and parks. The main populations of concern were predominately youth and homeless individuals.
- Physical and mental health/substance use were discussed often as being significant health needs. Physical health issues included diabetes, liver issues, heart disease and other serious physical health issues. Mental health and/or substance use disorders were discussed as having contributed to the overall poor health of residents.
- Alcohol and other drugs were discussed generally as being used in tandem and as contributing factors to overall health issues in this service area. Alcohol, meth, cocaine, marijuana and tobacco use was discussed. Youth use of the aforementioned substances was discussed as being a significant concern. Additionally, easy access to these drugs was mentioned as a serious issue.
- Social engagement and support were mentioned as important factors in assisting communities in being healthier. The lack of engagement between residents and amongst residents and local elected official was discussed. Also, the neglect of children/youth and elderly individuals was highlighted as an important consideration.
- Adverse childhood experience (ACEs) were mentioned as being important issues in this service area. ACEs were discussed as being contributing factors to child neglect and early initiation in substance use by youth as a way to cope with serious mental illness and/or growing up in challenging circumstances.
- Daily stress was mentioned as being an important health issue by residents in this service area. Residents were concerned about meeting their basic needs, such as food, housing and transportation. Stress was mentioned as being prevalent, especially for those with substance use and mental health issues.
- Stigma and discrimination were highlighted as creating major barriers in individuals accessing the care that they desired for substance use and/or mental health issues. Culturally significant themes were discussed as relating to lack of support in accessing care and challenges finding culturally sensitive providers and services.
- Culturally sensitive care is desired in this hospital service area for both mental health and substance use disorders.
- Co-occurring substance use and mental health issues were frequently discussed. Also, the need for facilities/services addressing both issues are desired by residents and service providers who were interviewed.

- Homelessness was mentioned as being connected to mental health and substance use issues especially in parks and public places.
- Emergency room and hospital specific care was mentioned as being challenging for residents with mental health and/or substance use issues. Lack of adequate resources was highlighted as a main issue along with provider misunderstandings of appropriate care. Additionally, providers discussed the challenges of serving individuals on 5150 holds in their emergency rooms/hospital beds.
- Alzheimer's and dementia were mentioned as being of concern in the senior population of this service area. Senior neglect and isolation were mentioned generally and also for seniors experiencing Alzheimer's and/or dementia. The need for Alzheimer's care was mentioned as being unclear as it was reported that data are not collected for Alzheimer's regularly. The cost of care for seniors was highlighted as being extreme and unattainable for many families.
- Depression and anxiety were highlighted as significant mental health issues in this service area.
- Co-morbid physical health and mental health/substance use issues were discussed. Residents connected the two issues as being prevalent in this hospital service area.
- Mental health and substance use disorders were both mentioned as significant issues for this service area. Often, participants discussed these two categories together and there seemed to be belief that the two were connected.

Geographic Impact:

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

	Zip Code	ED	Hospitalization
MENTAL HEALTH	95639	305.88	251.13
	95817*	276.31	384.89
	95820*	313.49	306.08
	95822*	313.09	283.16
	95823*	426.88	296.63
	95828*	299.86	226.89
	KFH-South Sacramento	259.21	213.59
	SACRAMENTO	271.38	227.04
	YOLO	195.58	143.92
	CALIFORNIA	149.93	186.92

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

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

	Zip Code	ED	Hospitalization
SUBSTANCE ABUSE	95640	662.91	204.08
	95817*	599.43	346.59
	95820*	593.27	308.28
	95822*	529.72	247.57
	95823*	739.11	266.14
	95824*	550.25	273.11
	95832*	581.99	212.09
	KFH-South Sacramento	409.88	177.38
	SACRAMENTO	438.58	196.37
	YOLO	360.54	121.75
	CALIFORNIA	253.80	145.00

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

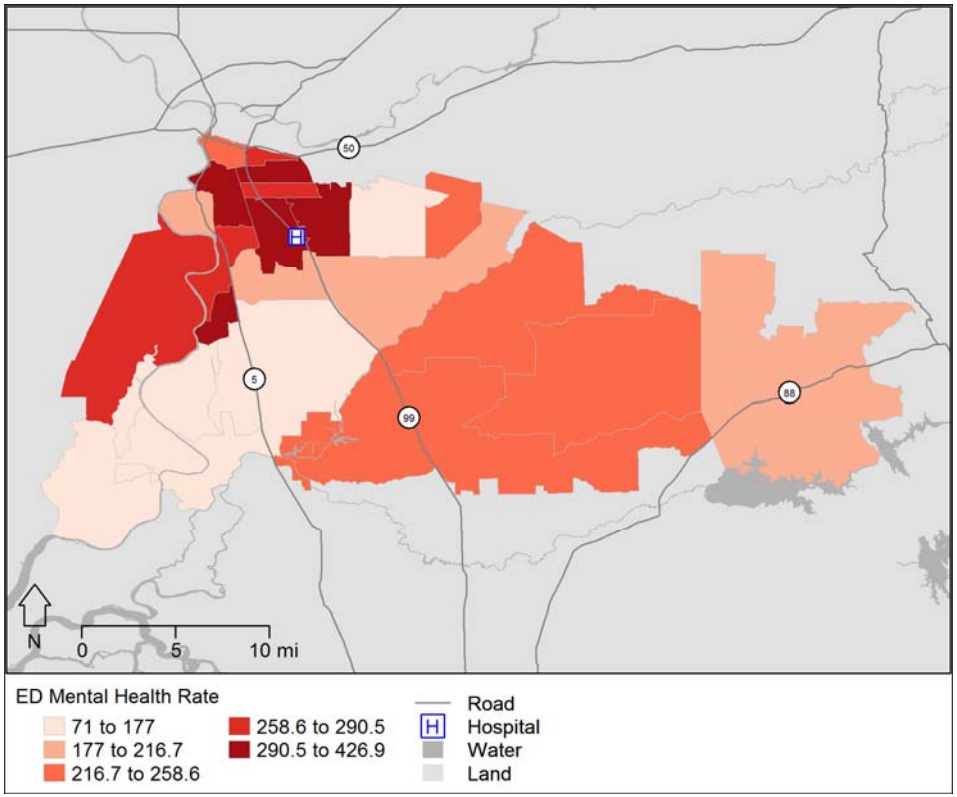


Figure 7. Mental Health (ED)

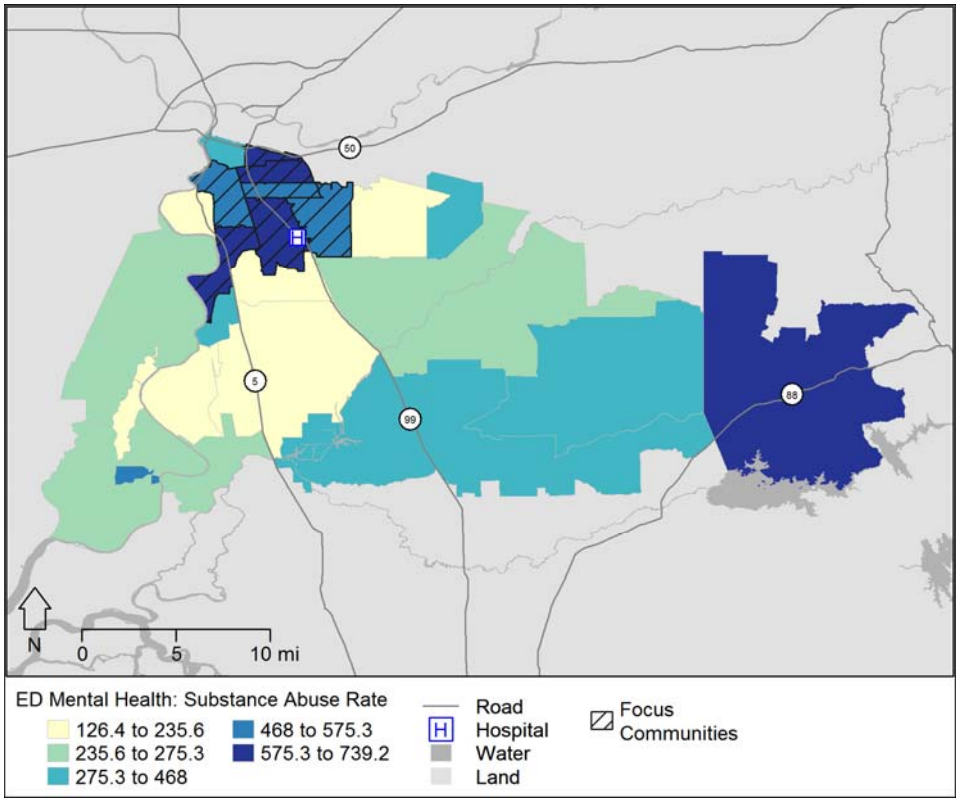


Figure 8. Substance Abuse (ED)

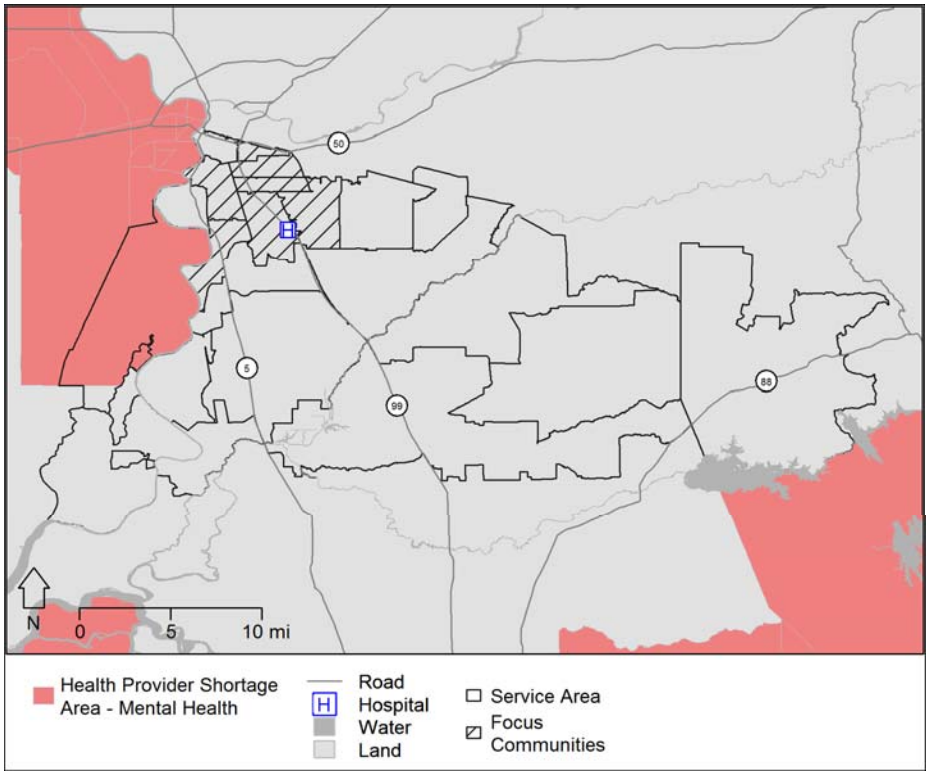


Figure 9. Health Professions Shortage Area (Mental Health)

<table>
<tr><th colspan="3">Healthy Eating and Active Living</th></tr>
<tr><th>Rationale</th><th>Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS</th><th>Contributing Factors RELATED INDICATORS</th></tr>
<tr>
<td><u>Active Living and Healthy Eating</u>
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.

Source:
http://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status

http://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity</td>
<td>Overweight (youth)
HSA 18.89% // CA 19.30% (health disparities)
Obesity (youth)
HSA 17.66% // CA 18.99% (health disparities)
Diabetes Mellitus – Mortality (per 100,000)
HSA 2.14 // CA 2.11</td>
<td>Low Fruit/ Vegetable Consumption (youth)* (health disparities)
Physical Inactivity (youth) (health disparities)
Breastfeeding (Any)* (health disparities)
Breastfeeding (Exclusive) (health disparities)
Walking/Biking/Skating to School (health disparities)
Food Environment – Grocery Stores*
Food Environment – WIC Authorized Food Stores**
Recreation and Fitness Facility Access**
Commute to Work – Walking/Biking*
Diabetes Management (A1C Test)*
Food Security – Food Desert Population**
Osteoporosis**</td>
</tr>
<tr><td colspan="3">Primary Data:
Thirty-eight of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to healthy eating and active living as a health need. Themes related to this health need are as follows:
Interviewees discussed great density of unhealthy food options in their communities and schools. The desire for healthy and affordable food in South Sacramento communities was discussed often.</td></tr>
</table>

- Culturally specific food and customs were discussed as being of great importance in this service area. The Hmong, Hispanic and Ukrainian communities were discussed specifically. Challenges highlighted were lack of healthy culturally specific food, differences from home communities and American food customs and changes in how food is prepared and consumed.
- Residents were concerned about the time intensity needed to shop for healthy foods, plan meals and to prepare meals for themselves and their families.
- Food access issues were discussed related to lack of affordable grocery stores, transportation challenges to and from grocery stores and an abundance of unhealthy food options. There was regular discussion of the challenges of living in communities considered to be food deserts. Interviewees suggest an increase in farmer's markets and other healthy food outlets that are affordable and culturally relevant to the area.
- Residents discussed the need for health education related to healthy eating and active living. It was highlighted that many individuals do not know what healthy foods are and may not be familiar with how to prepare these foods.
- The inherent challenges of poverty and being able to purchase healthy foods was mentioned regularly. Additionally, there was great interest in accessible food pantries and food assistance programs. There is common perception that healthy foods are cost prohibitive for residents living in this service area.
- Active living concerns included neighborhood safety concerns (e.g. neighborhoods not being safe enough to exercise in), lack of affordable recreation facilities such as gyms and lack of time to exercise while attempting to meet basic needs (e.g. living in poverty and unsafe neighborhoods).

Access to High Quality Health Care and Services		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS**	**Contributing Factors RELATED INDICATORS**
<u>Access to Care</u> Access to high quality, affordable health care and health services that provide a coordinated system of community care is essential to the prevention and treatment of morbidity and increases the quality of life, especially for the most vulnerable. Essential components of access to care include health insurance coverage, access to a primary care physician and clinical preventive services, timely access to and administration of health services, and a robust health care workforce. Culturally and linguistically appropriate health services are necessary to decrease disparities for diverse populations, including racial and ethnic minorities, LBGTQ populations and older adults. Health education/literacy and patient navigation services are also increasingly important following the passage of the Affordable Care Act of 2010, as the newly insured gain entry to the health care system. 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	**Lack of Consistent Source of Primary Care (per 100,000)** • HSA 13.70 // CA 14.30 **Prenatal Care (per 100,000)** • HSA 78.99** // CA 83.60 **Dental Care-No Recent Exam (Youth) (per 100,000)** • HSA 24.90** // CA 18.50 **Access to Dentists (per 100,000)** • HSA 72.10** // CA 77.50 **Dental/Oral Diseases (ED) (per 10,000)** • HSA 69.71** // CA 41.34 **Poor Dental Health (per 100,000)** • HSA 13.10** // CA 11.30 **Dental/Oral Diseases (H) (per 10,000)** • HSA 9.11* // CA 7.81	• Insurance-Uninsured Population • Population with Public Insurance** • Insurance - Population Receiving Medicaid** • Cancer Screening - Pap Test** • Preventable Hospital Events** • Breastfeeding (Any)* • Breastfeeding (Exclusive) • Education - School Enrollment Ages 3-4** • Food Security - Food Insecurity Rate**

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. *Source:* http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health http://www.healthypeople.gov/2020/topics-objectives/topic/oral-health http://www.gao.gov/new.items/d081121.pdf		
Primary Data: Thirty-seven of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to access to care as a health need. Nine of 40 (23%) sources mentioned maternal and child health as a health need and 17 of 40 (43%) mentioned dental/oral health as a health need. Themes related to this health need are as follows:		

- Seniors are in high need of services and have many barriers in accessing care (transportation, income, insurance, living on restricted incomes) and this can have a negative impact on health behaviors (e.g. having to choose between food and medication). Additionally, seniors with dementia and Alzheimer's often can't get the supportive services they need.
- Community members expressed a desire for culturally sensitive care. The demographics of the health service area are diverse with a variety of minority groups that have distinct language and/or cultural differences. Many of these groups have historically been marginalized and are in the process of building trust in the healthcare system. Community members spoke about the need for culturally relevant outreach and services, using innovative strategies to reach adults and youth from underserved populations (i.e. ethnic groups, people of color, refugees and recent immigrants, undocumented, LGBT, homeless, gang members, etc.) Access to primary care services is a challenge, particularly for Medi-Cal populations. Residents discussed the challenges with getting an appointment with an assigned PCP (can take months), patients often being assigned to PCPs that aren't accepting new patients and the need for use of emergency rooms for primary care health issues due to the aforementioned issues.
- Health system capacity has been highly impacted by the Affordable Care Act. It was reported that many patients wait months before being able to see a doctor and that few providers accept Medi-Cal. Additionally, many hospital ERs are overwhelmed and over utilized since the newly insured may not know how to use/access their doctor and/or wait times are so long.
- The lack of culturally and linguistically appropriate services is a barrier to care for those with limited English proficiency. Interpretation and translation services are often lacking or inadequate. Residents stated that they do not always trust hospital and clinic translators. Interviewees discussed that providers need more cultural sensitive training for working with diverse populations according to race/ethnicity, immigration status, sexual and gender identity and for those in poverty. Also, navigating Medi-Cal is particularly difficult if English is a second language and/or with limited literacy levels.
- Access to care is often limited by distance and transportation barriers and challenges with the public transportation system (high cost, lack of routes and limited schedules).
- Undocumented populations have very limited access to care and this lack of access is a huge barrier in terms of health and wellness. Primary and specialty care is especially difficult to access and ER may be their only option for care.
- There are numerous coverage gaps for both Medi-Cal and non Medi-Cal populations due to a lack of understanding in how to access care.
- Access to dental care is limited, particularly for Medi-Cal populations. There are few dental providers that accept Medi-Cal and who provide comprehensive dental care (e.g. care outside of extractions). Also, oral health for children is particularly important but many low-income children do not receive regular check-ups.

Geographic Impact:	

Table 15: Zip codes with the worst rates for ED visit and Hospitalization 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	95817*	136.27	14.35
	95820*	115.55	12.55
	95822*	81.35	9.67
	95823*	132.13	11.80
	95824*	104.78	12.76
	95832*	89.34	8.39
	KFH-South Sacramento	69.71	9.11
	SACRAMENTO	72.66	9.77
	YOLO	47.18	6.89
	CALIFORNIA	41.34	7.81

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

Table 16. ZIP codes with the worst rates for prenatal care compared to hospital service area, county and state benchmarks

PRENTAL CARE	95817*	75.77
	95822*	75.76
	95823*	73.96
	95824*	71.65
	95832*	75.50
	KFH-South Sacramento	78.99
	SACRAMENTO	81.40
	YOLO	82.70
	CALIFORNIA	83.60

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

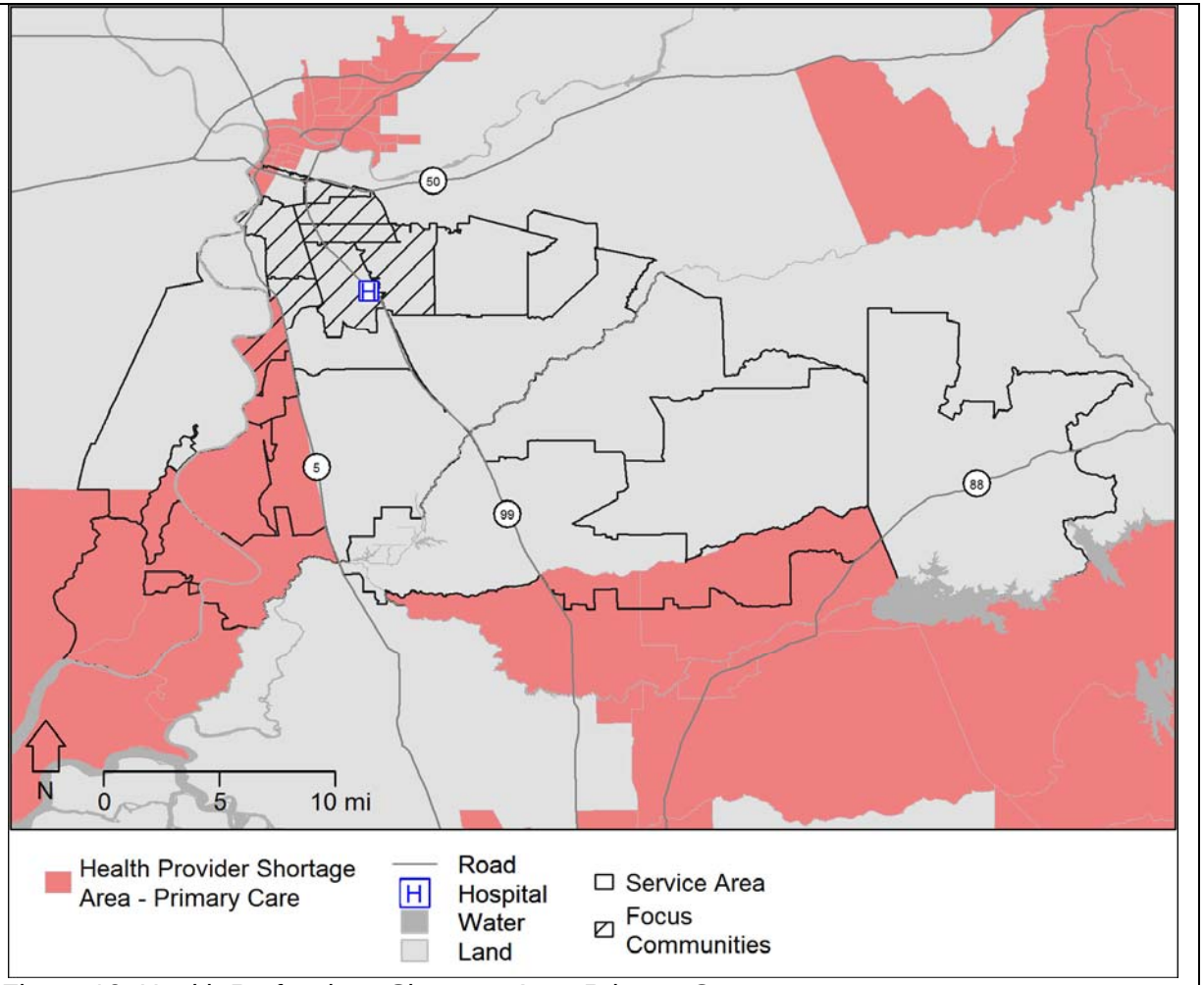


Figure 10. Health Professions Shortage Area-Primary Care:

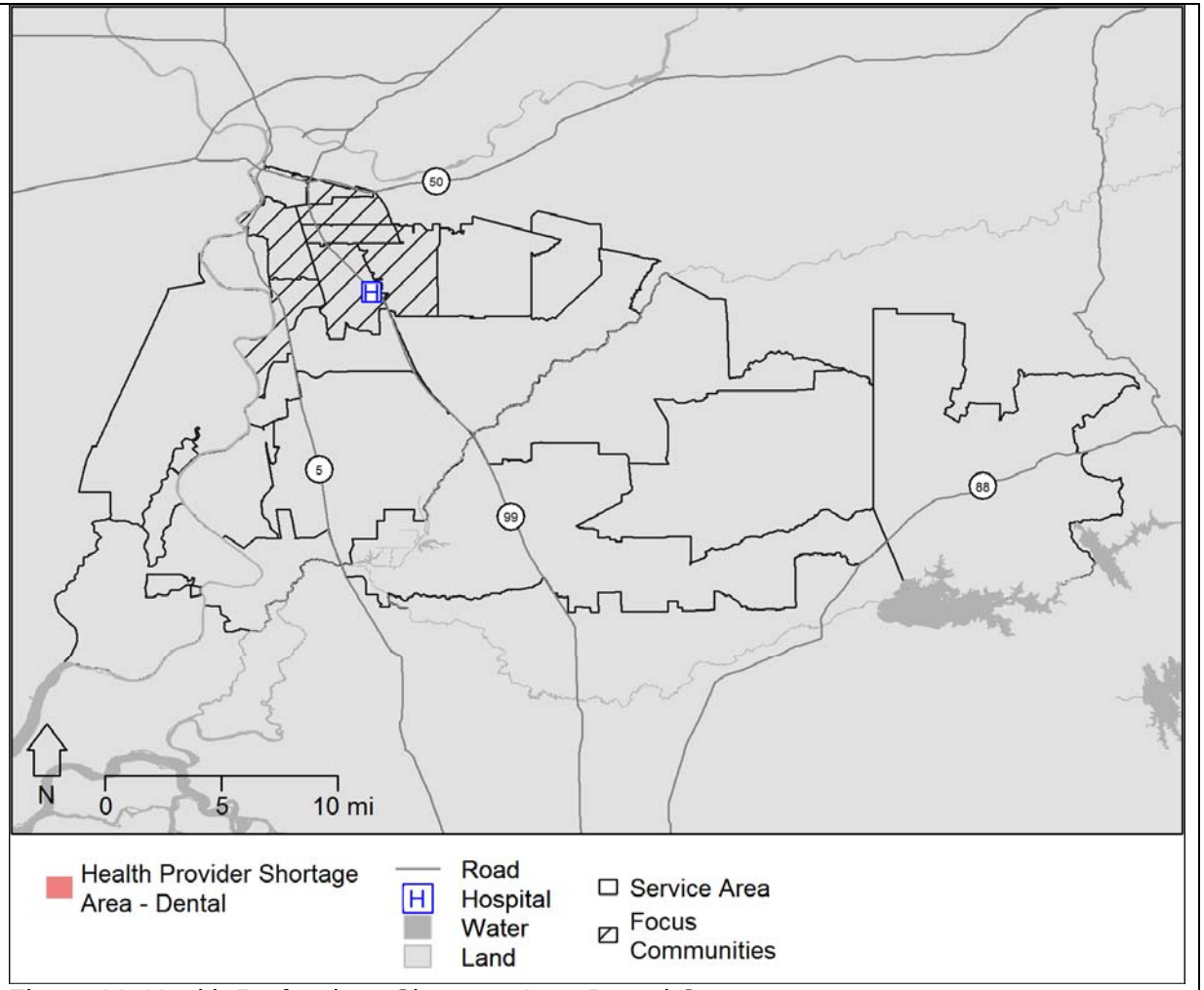


Figure 11. Health Professions Shortage Area-Dental Care:

Disease Prevention and Management		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] 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. *Source:* http://www.cdc.gov/Features/PreventionStrategy **Asthma** Prevention, early-detection, treatment and management of asthma improves quality of life and productivity. Reducing exposures to triggers and risk factors such as tobacco smoke and poor air quality can decrease the burden of asthma and promote better health. *Source:* http://www.healthypeople.gov/2020/topics-objectives/topic/respiratory-diseases **Cancer**	**CANCER:** **Cancer Incidence-Breast (per 100,000)** • HSA 131.10** // CA 122.10 (Health Disparities) **Mortality-Cancer (per 100,000)** • HSA 181.40** // CA 157.10 (Health Disparities) **Cancer Incidence-Colon and Rectum (per 100,000)** • HSA 43.20** // CA 40.00 (Health Disparities) **Cancer Incidence-Prostate (per 100,000)** • HSA 131.40** // CA 126.90 (Health Disparities) **Cancer Incidence-Lung (per 100,000)** • HSA 58.60** // CA 48.00 (Health Disparities) **Colorectal Cancer (ED) (per 100,000)** • HSA 2.12 // CA 1.85 **Colorectal Cancer (H) (per 100,000)** • HSA 5.89 // CA 6.43 **Lung Cancer (H) (per 100,000)** • HSA 7.45 // CA 7.95 **Prostate Cancer (ED) (per 100,000)** • HSA 6.02 // CA 5.79 **CVD/STROKE:** **Mortality-Ischemic Heart Disease (per 100,000)**	**CANCER:** • Alcohol - Excessive Consumption* • Obesity (Adult)** • Food Security - Food Desert Population** • Tobacco Usage** • Cancer Screening - Pap Test** • Air Quality - Particulate Matter 2.5** • Pollution Burden Score • Tobacco Usage (adults and teens)** **CVD/STROKE:** • Obesity (Adult)** • Diabetes Management (A1C Test)* • Recreation and Fitness Facility Access**

Screening and early detection can help to reduce the illness, disability and death caused by cancer. Many cancers are preventable by reducing risk factors such as tobacco use, physical inactivity, poor nutrition and obesity and promoting preventative behaviors such as vaccination against human papillomavirus and hepatitis B. *Source:* http://www.healthypeople.gov/2020/topics-objectives/topic/cancer **CVD/Stroke** Cardiovascular disease is the leading cause of death and strokes are the third leading cause of death in the United States. Heart disease and stroke can result in serious illness and disability, a decreased quality of life and a significant financial burden on society. These diseases can be prevented and managed through behaviors such as engaging in regular physical activity, eating healthy foods and not smoking. *Source:* http://www.healthypeople.gov/2020/topics-objectives/topic/heart-disease-and-stroke **HIV/AIDS/STIs** Preventing or reducing the transmission of HIV/AIDS and STIs leads to healthier, longer lives. There are approximately 19 million STI infections each year, almost half among the millennial population. HIV/AIDS/STIs are costly to treat and have long term health	• HSA 171.12** // CA 163.18 (Health Disparities) **Mortality-Stroke (per 100,000)** • HSA 41.87** // CA 37.38 (Health Disparities) **Heart Disease (ED) (per 100,000)** • HSA 183.34** // CA 112.64 **Heart Disease (H) (per 100,000)** • HSA 249.00** // CA 222.00 **Stroke (ED) (per 100,000)** • HSA 31.95** // CA 18.55 **Stroke (H) (per 100,000)** • HSA 63.98** // CA 52.23 **ASTHMA:** **Asthma-Prevalence** • HSA 18.50%** // CA 14.20% **Asthma-Hospitalizations** • HSA 10.00* // CA 8.90 **HIV/AIDS/STIs:** **STI-HIV Prevalence (per 100,000)** • HSA 268.30 // CA 363.00 (Health Disparities) **STI-Chlamydia (per 100,000)** • HSA 559.10** // CA 444.90 **STIs (ED) (per 100,000)** • HSA 6.34** // CA 3.20 **STIs (Gonorrhea - Incidence) (per 100,000)** • HSA 15.22** // CA 11.68 **HIV (ED) (per 100,000)** • HSA 2.72 // CA 1.95	• Alcohol - Excessive Consumption* • Tobacco Usage** • Physical Inactivity (Youth)-(Health Disparities)** • Overweight (Youth)-(Health Disparities) • Obesity (Youth)-(Health Disparities) • Tobacco Usage (adults and teens)* • Hypertension (H)** • Diabetes (ED)** **ASTHMA:** • Obesity (Youth)-(Health Disparities) • Obesity (Adult)** • Overweight (Youth)-(Health Disparities) • Tobacco Usage** • Air Quality - Particulate Matter 2.5** • Tobacco Usage (adults and teens) • Pollution Burden Score **HIV/AIDS/STIs:** • Not applicable.

consequences, especially on reproductive health. *Source:* http://www.healthypeople.gov/2020/topics-objectives/topic/hiv http://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases		

Primary Data:

Fifteen of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to cancer as a health need. Themes related to this health need are as follows:

- Cancer was discussed as being of concern, specifically pediatric cancer, leukemia, cervical, prostate, breast and colon/rectal. Additionally, participants discussed lasting impacts of Chernobyl and pesticide exposure on populations who now live in South Sacramento. In addition, residents were aware of the treatment possibilities for cancer, but noted that treatment was not always accessible in their communities.

Twenty-seven of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to cardiovascular disease/stroke as a health need. Themes related to this health need are as follows:

- Cardiovascular disease and stroke were regularly discussed as significant health issues. Participants spoke frequently about hypertension, especially the need for diagnosis and management of hypertension with education and affordable medication. They also spoke about stroke and congestive heart failure as being significant concerns.

Seven of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to asthma as a health need. Themes related to this health need are as follows:

- Asthma and respiratory issues were noted as significant and problematic health conditions within this service area. Asthma was considered to be connected to marijuana and tobacco use along with environmental concerns with allergens, dust, asbestos, mold and pesticides. Multiple residents were interested in living in smoke-free housing. Additionally, residents were concerned about tobacco use during pregnancy, especially for African American women. Observations were also made in relation to the number of smoke shops in low-income areas and the need for more laws to regulate second hand smoke and tobacco use.

Five of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to sexually transmitted infections as a health need. Themes related to this health need are as follows:

- Residents discussed “hotspots” of sexually transmitted diseases and infections and were concerned about the lack of prevention/education/screening/treatment for youth and young adults. There is concern that the rates of HIV/AIDS/STIs are

high within Sacramento County and that there are specific disease burdens with men who have sex with men and transitional aged youth. The need for reproductive health education, prevention and treatment was mentioned in numerous interviews.

Geographic Impact:

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	95823*	390.32	140.64
	95832*	328.69	116.00
	95822*	273.72	124.18
	95824*	265.52	124.36
	95820*	259.82	138.11
	95817*	243.61	135.59
	KFH- South Sacramento	222.17	103.61
	Sacramento	235.95	101.20
	Yolo	153.89	65.31
	California	148.86	70.55

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

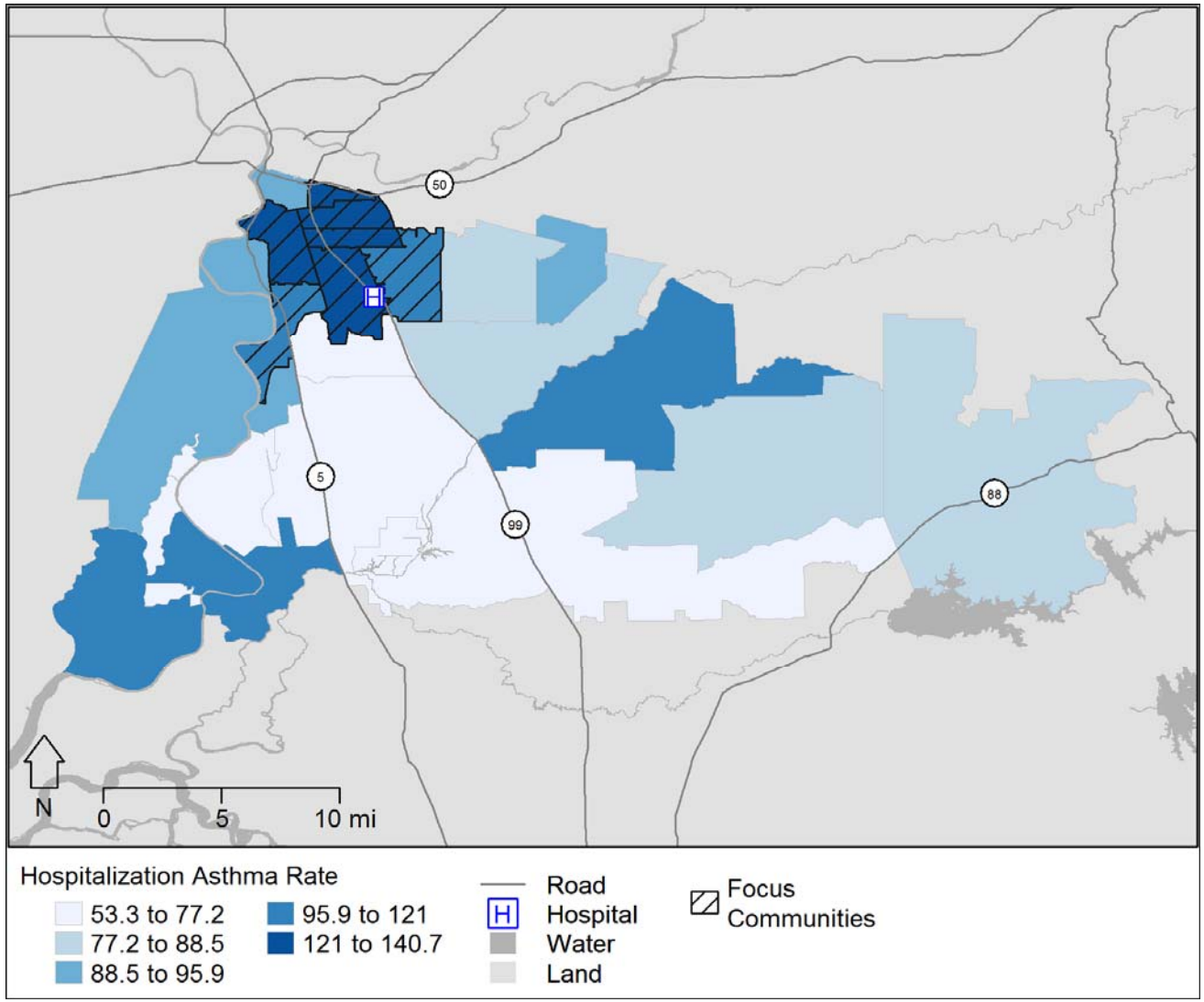


Figure 12. Asthma Hospitalization Rate

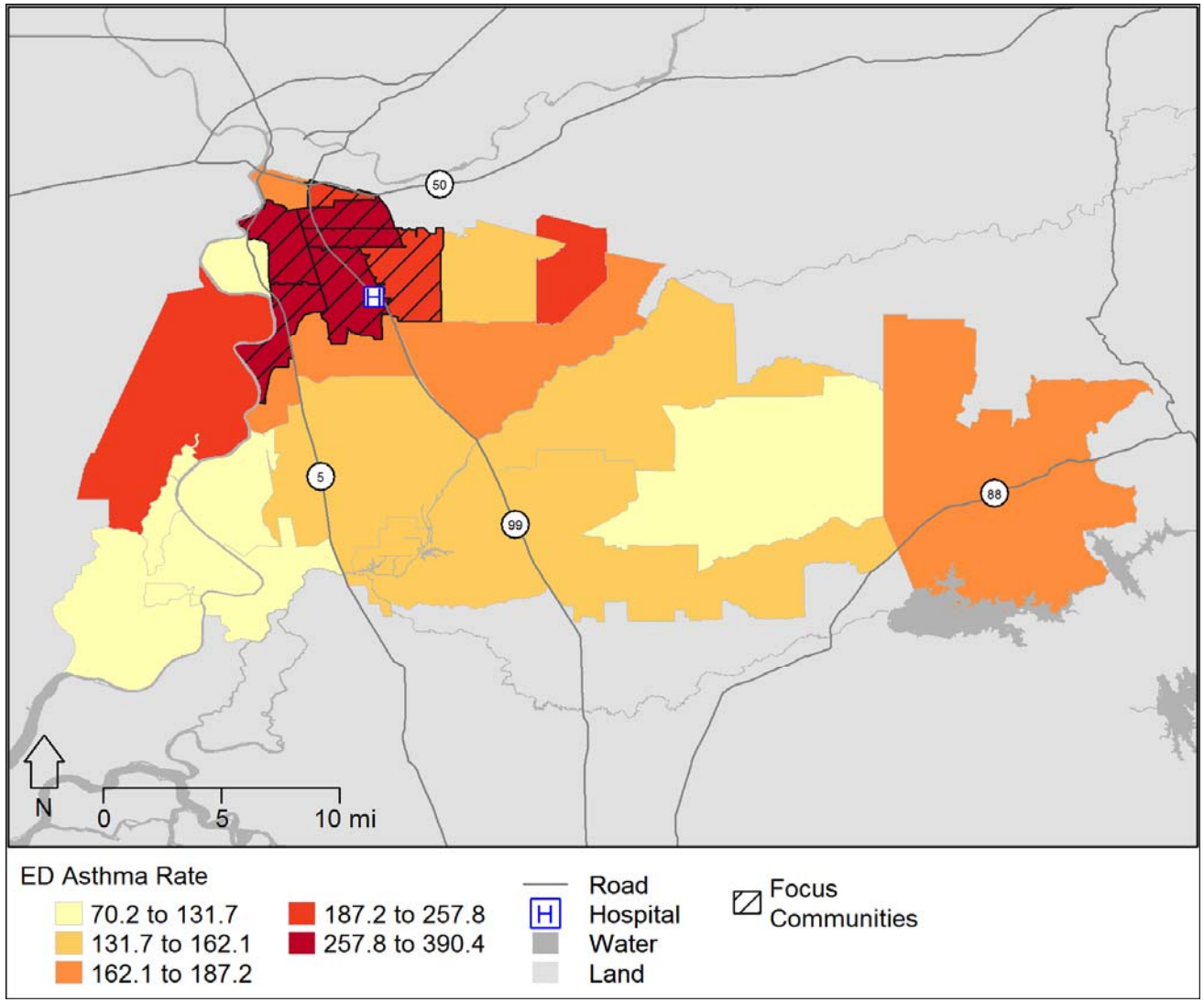


Figure 13. Asthma Emergency Department Rate

Table 18. Cancer mortality compared to hospital service area, county and state benchmarks (rates per 10,000 population)		
Cancer Mortality Rate	95822*	24.48
	95831	22.43
	95820*	20.97
	95693	17.53
	95638	17.48
	KFH-South Sacramento	16.57
	SACRAMENTO	17.24
	YOLO	13.98
	CALIFORNIA	15.41

Sources: CDPH Mortality rates, 2012
* Indicates Focus Community

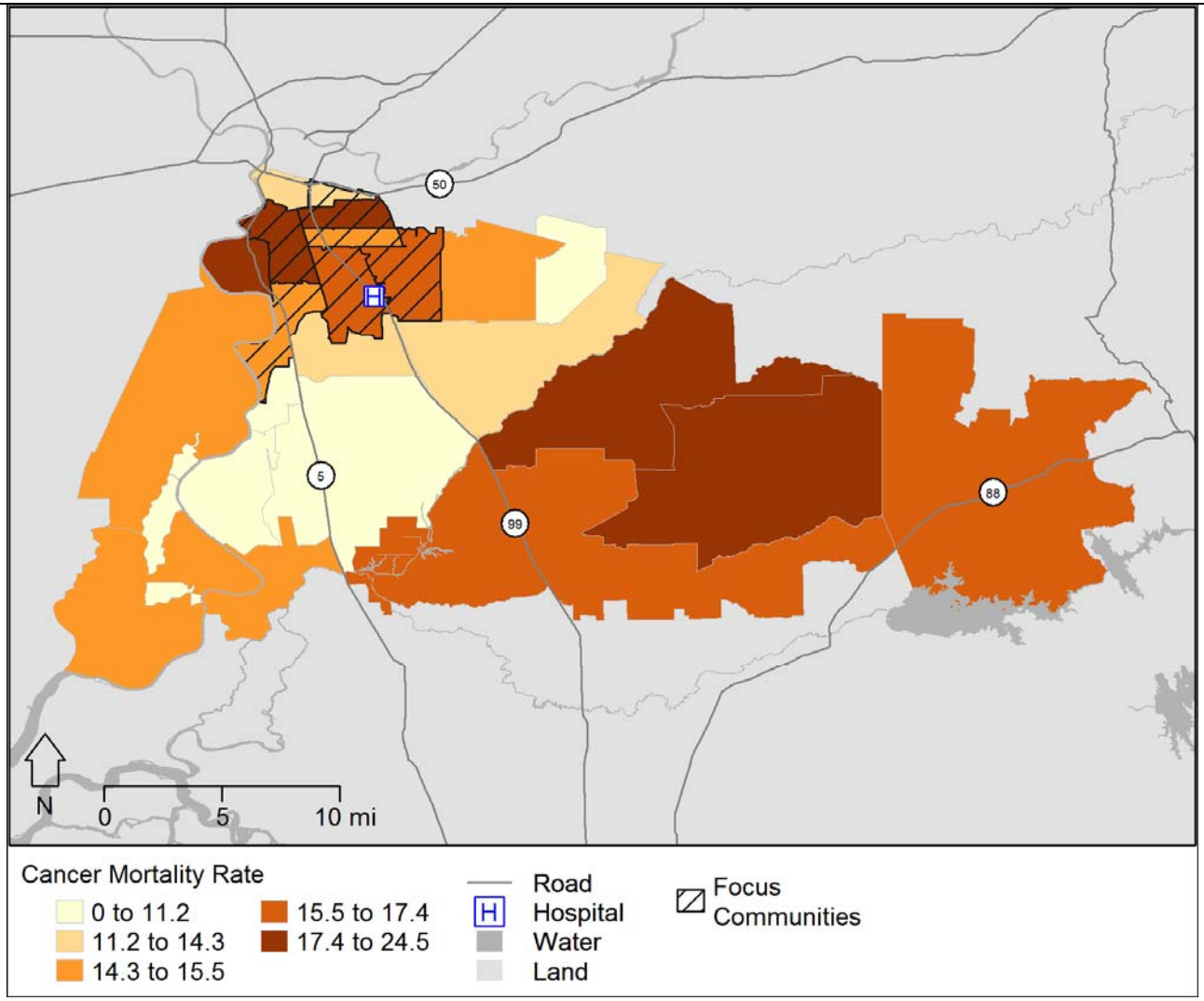


Figure 14. Cancer Mortality

Table 19. ED visit and Hospitalization rates for sexually transmitted infections compared to hospital service area, county and state benchmarks (rates per 10,000 population)

	Zip Code	ED	Hospitalization
Sexually Transmitted Infections (STIs)	95823*	12.60	6.40
	95817*	11.47	11.76
	95615	10.45	15.90
	95832*	9.93	6.09
	95820*	9.90	6.96
	95824*	9.50	6.54
	KFH- South Sacramento	6.34	3.93
	Sacramento	5.53	3.95
	Yolo	1.51	1.68
	California	3.20	4.58

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

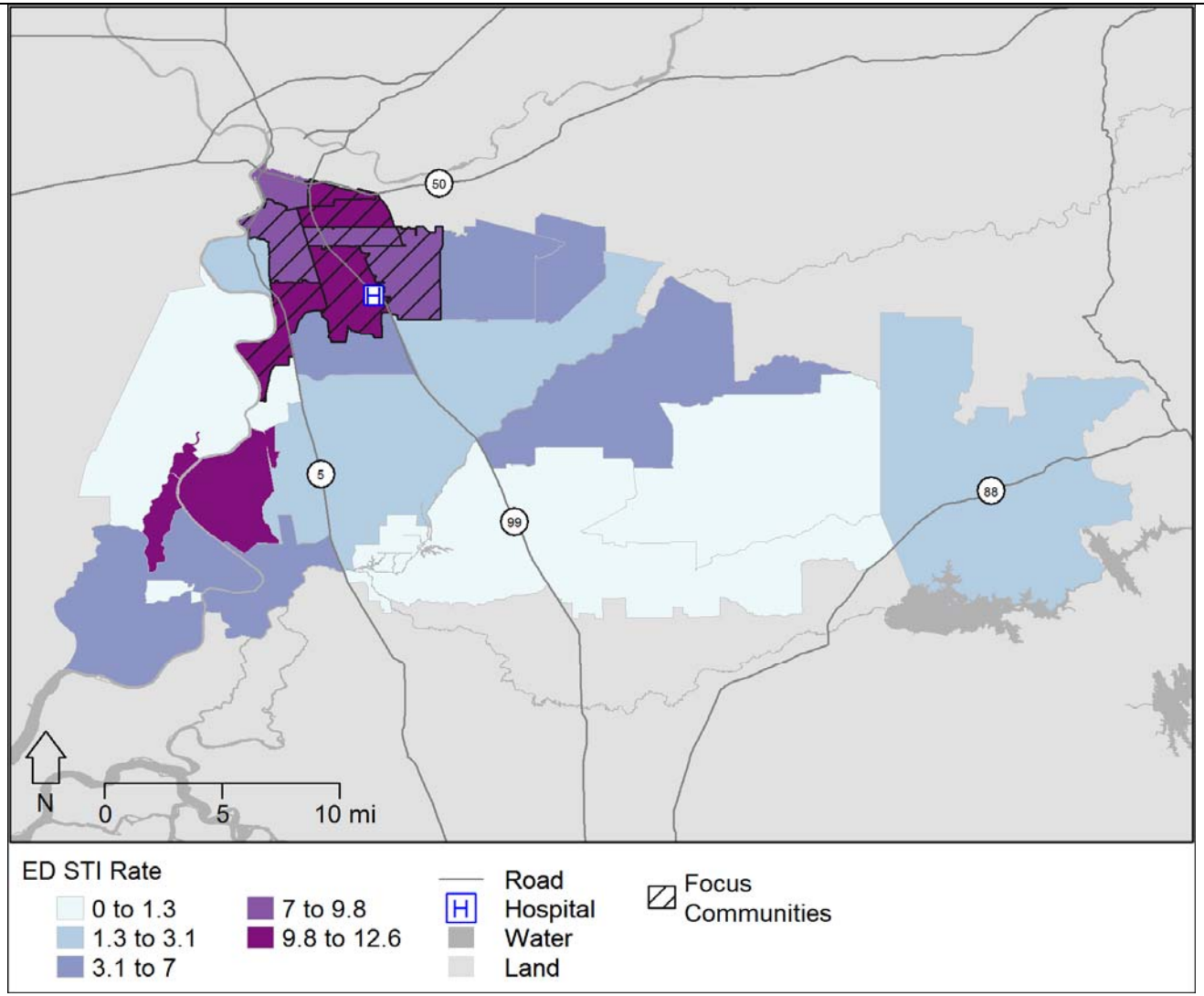


Figure 15. STI Rates (ED)

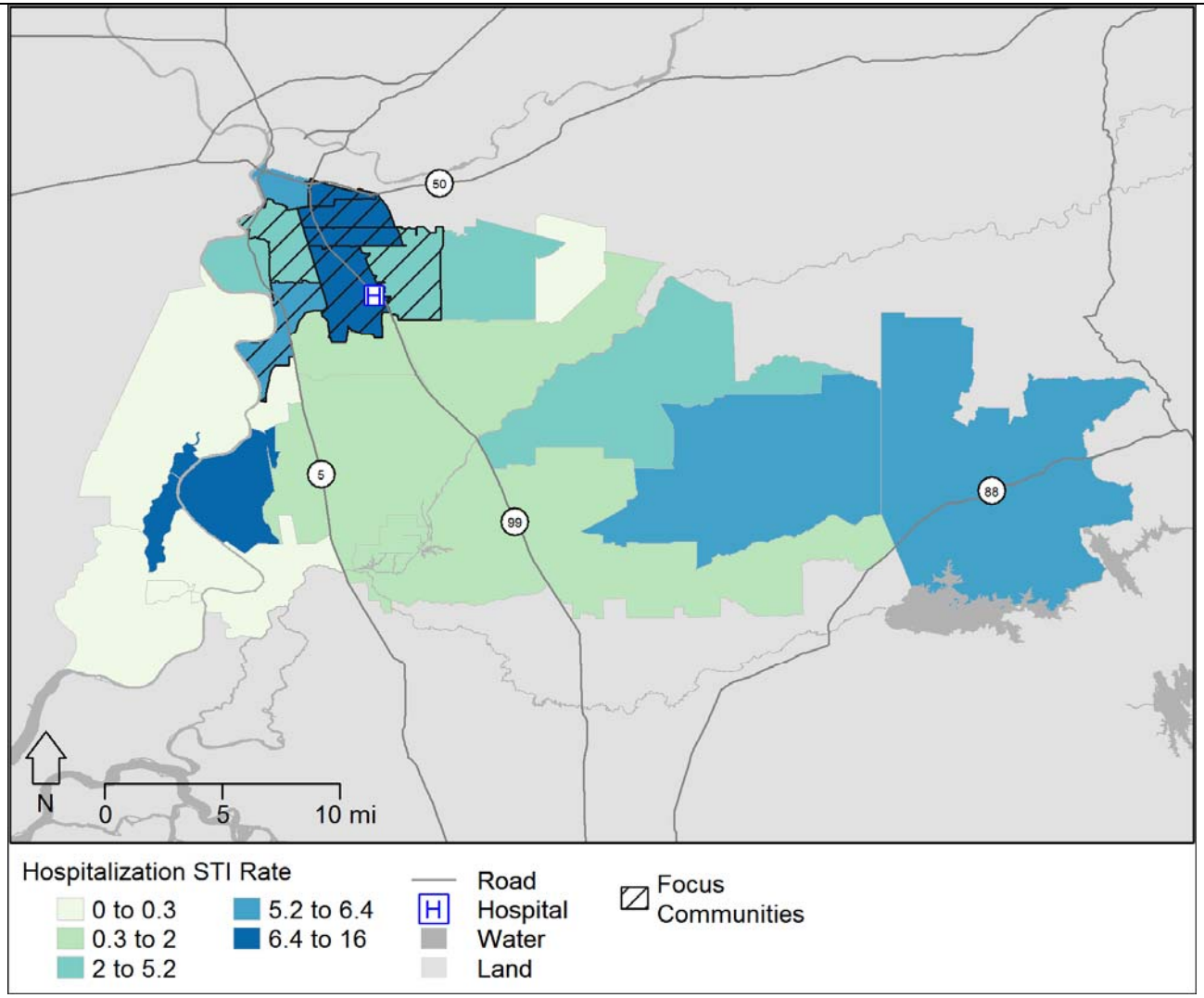


Figure 16. STI Rates (H)

Table 20. Heart Disease mortality rate compared to hospital service area, county and state benchmarks (rates per 10,000 population)

Heart Disease Mortality Rate	95822*	22.66
	95693	21.42
	95818	20.34
	95690	19.07
	95615	18.80
	KFH-South Sacramento	14.94
	SACRAMENTO	16.75
	YOLO	19.79
	CALIFORNIA	15.82

Sources: CDPH Mortality rates, 2012
* Indicates Focus Community

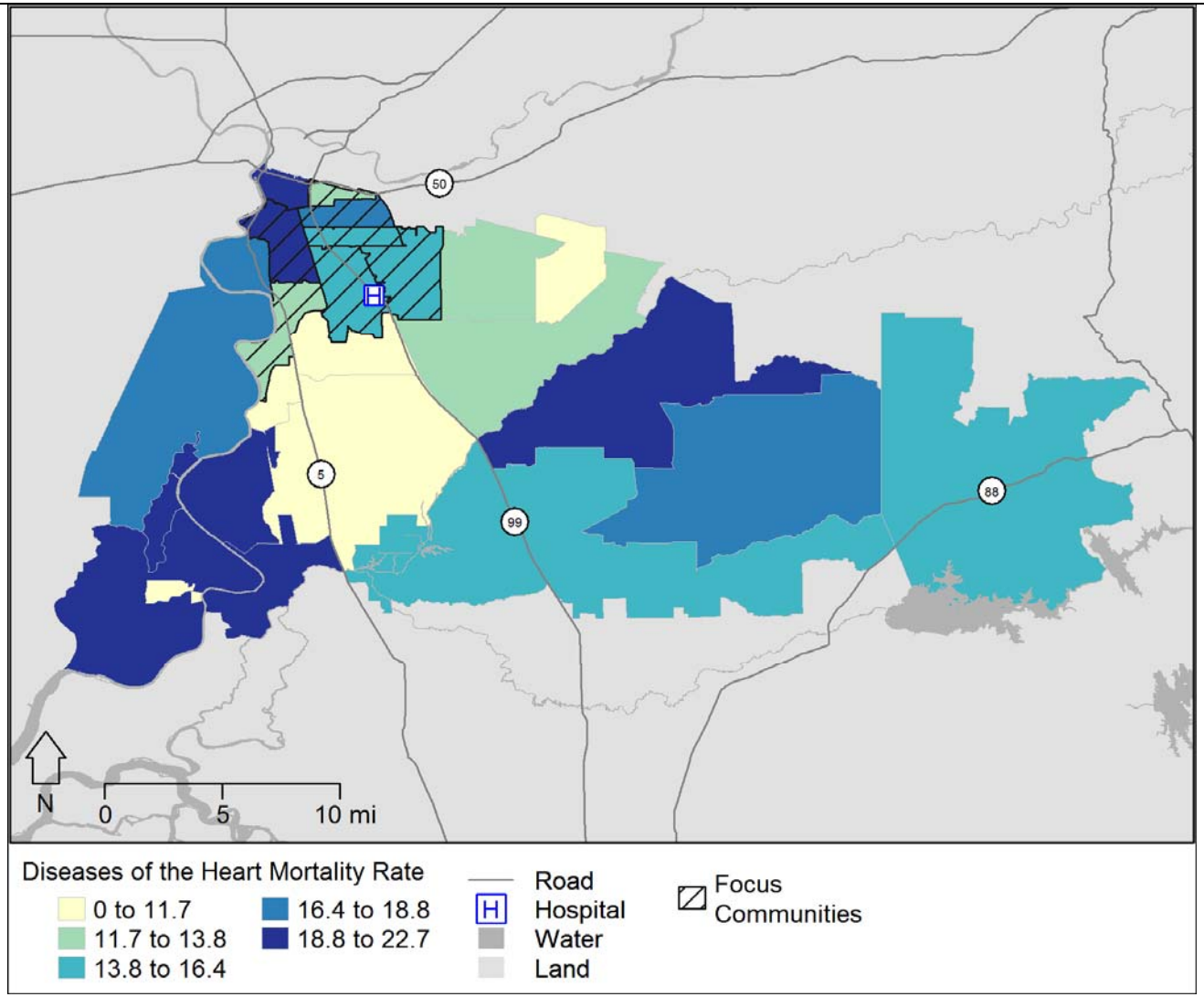


Figure 17. Diseases of the Heart Mortality Rate

Safe, Crime and Violence-Free Communities		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS**	**Contributing Factors RELATED INDICATORS**
<u>Safe, Violence Free Communities</u> Safe communities contribute to overall health and well-being. Injuries and violence contribute to premature death, disability, poor mental health, high medical costs and loss of productivity. Individual behaviors such as substance use and aspects of the social environment such as peer group associations can affect the risk of injury and violence. The physical environment may also affect the rate of injuries related to falls, motor vehicle accidents and violent crime. Safe communities promote community cohesion and economic development, provide more opportunities to be active and improve mental health while reducing untimely deaths and serious injuries. *Source:* http://www.healthypeople.gov/2020/topics-objectives/topic/injury-and-violence-prevention	**Mortality – Homicide (per 100,000)** • HSA 6.49* // CA 5.15 (health disparities) **Major Crimes (per 100,000)** • HSA 460.40** // CA 312.65 **Violence – Youth Intentional Injury (per 100,000)** • HSA 998.40** // 738.70 **Violence – Assault (Injury) (per 100,000)** • HSA 375.10** // CA 290.30 **Violence – Domestic Violence (per 100,000)** • HSA 11.80** // CA 9.50 **Violence - Assault (Crime) (per 100,000)** • HSA 335.10** // CA 249.40 **Violence - Robbery (Crime) (per 100,000)** • HSA 187.20** // CA 149.50 **Violence - All Violent Crimes (per 100,000)** • HSA 553.80** // CA 425.00 **Rate of LE Calls for DV/IPV (per 100,000)** • HSA 39.95 // CA 40.18 **Violence - Rape (Crime) (per 100,000)** • HSA 25.90** // CA 21.00	• Violence - School Suspensions** • Alcohol - Excessive Consumption* • Substance Abuse (ED)** • Substance Abuse (H)**

Primary Data:
Thirty-seven of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to safe, crime and violence free communities as a health need. Themes related to this health need are as follows:

- Tension with police was discussed as being a significant health concern. Residents, especially Latino and African American groups, stated that they do not feel safe in their communities and do not always feel safe accessing law enforcement services.
- Substance use (including alcohol abuse) was discussed as being a health and safety issues for communities in this service area. Residents were uncomfortable with substance use by other community members and the homeless population. Additionally, there was concern about the criminalization of certain drugs and discussion surrounding the legalization of marijuana. Interviewees were concerned about youth/young adult substance use.
- Gun and knife violence were mentioned on multiple occasions as being prevalent in this service area. Violence by means of gunshots and stabbings have created fear in many residents. Programs such as Summer Night Lights were mentioned as being helpful in violence reduction.
- Gang violence was discussed as creating health issues within the communities of this service area. Residents are fearful of gang violence, retaliation and being robbed.
- Domestic violence and sexual assault were highlighted as significant issues in this service area. Residents mentioned the occurrence of emotional, physical and sexual abuse. The need for assistance with restraining orders and safe shelter spaces were highlighted as important needs.
- Child abuse and trauma were mentioned as being prevalent in communities of this service area.

Geographic Impact:

Table 21. Zip codes with the worst rates for ED visit and Hospitalization rates for assault compared to hospital service area, county and state benchmarks (rates per 10,000 population)

	Zip Code	ED	Hospitalization
ASSAULT	95817*	69.43	14.87
	95820*	63.79	11.78
	95822*	49.16	7.67
	95823*	72.24	7.59
	95824*	58.62	11.01
	95832*	54.86	8.00
	KFH-South Sacramento	38.90	5.27
	SACRAMENTO	39.09	5.78
	YOLO	24.21	3.02
	CALIFORNIA	30.36	3.88

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

Table 22. Zip codes with the worst rates for ED visit and Hospitalization rates for unintentional injury compared to hospital service area, county and state benchmarks (rates per 10,000 population)

	Zip Code	ED	Hospitalization
UNINTENTIONAL INJURY	95640	879.76	167.31
	95680	1009.64	164.19
	95690	634.11	215.10
	95817*	953.80	214.32
	95820*	974.54	222.01
	95822*	861.74	218.37
	95823*	1053.90	178.91
	95830	778.10	211.39
	KFH-South Sacramento	742.62	160.24
	SACRAMENTO	761.56	176.40
	YOLO	645.28	121.09
	CALIFORNIA	666.38	154.85

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

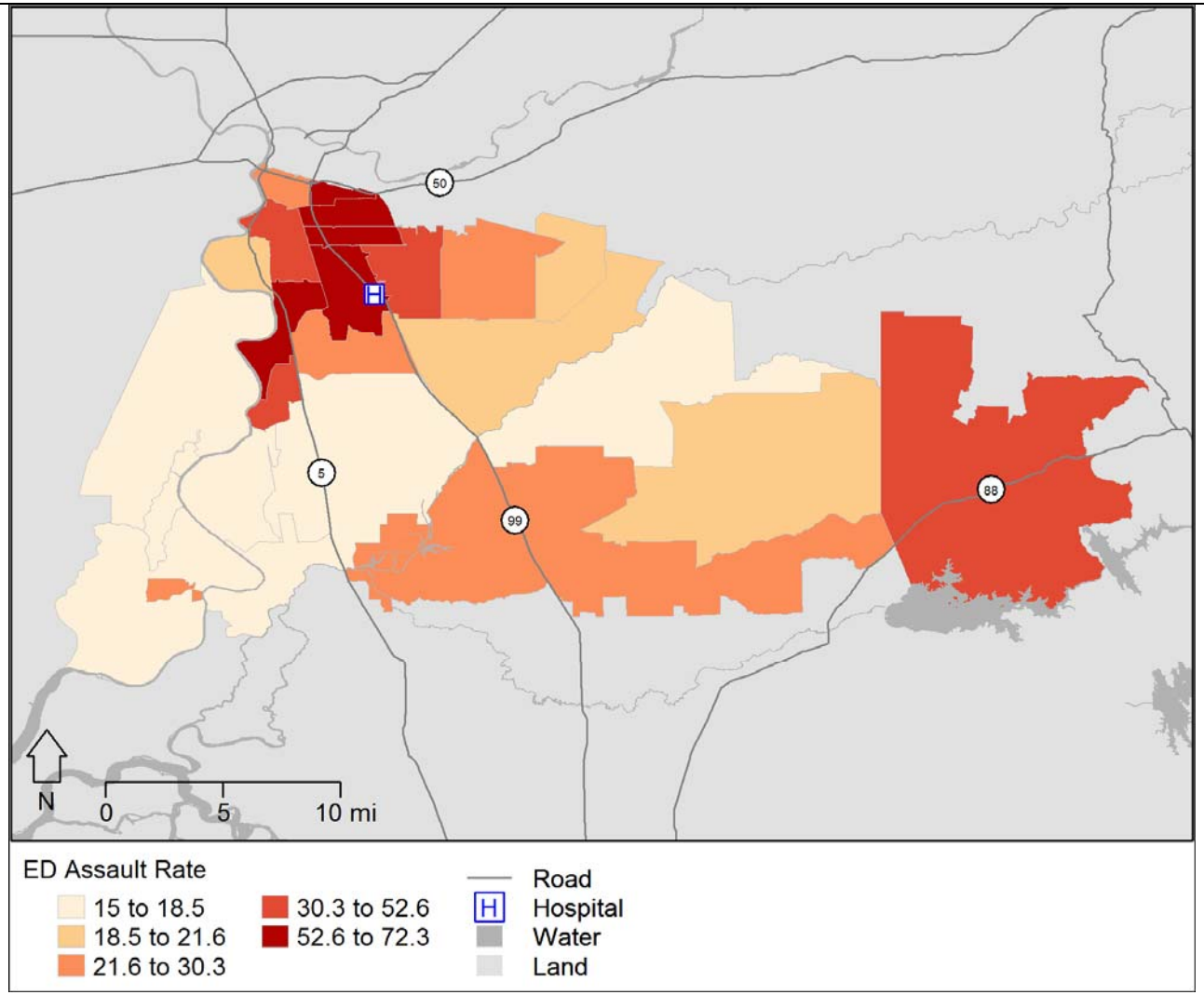


Figure 18. Assault Rate (ED)

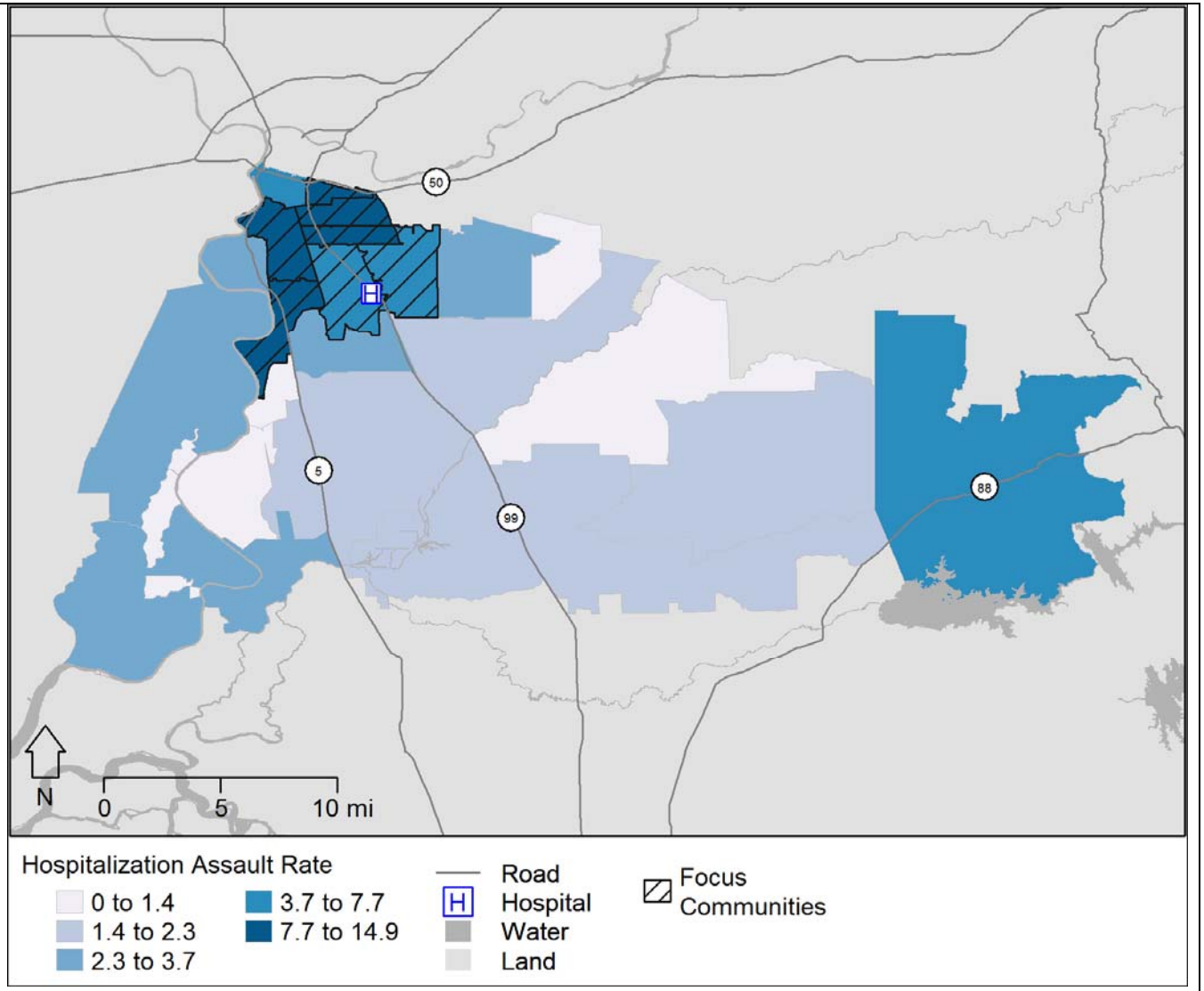


Figure 19. Assault (H)

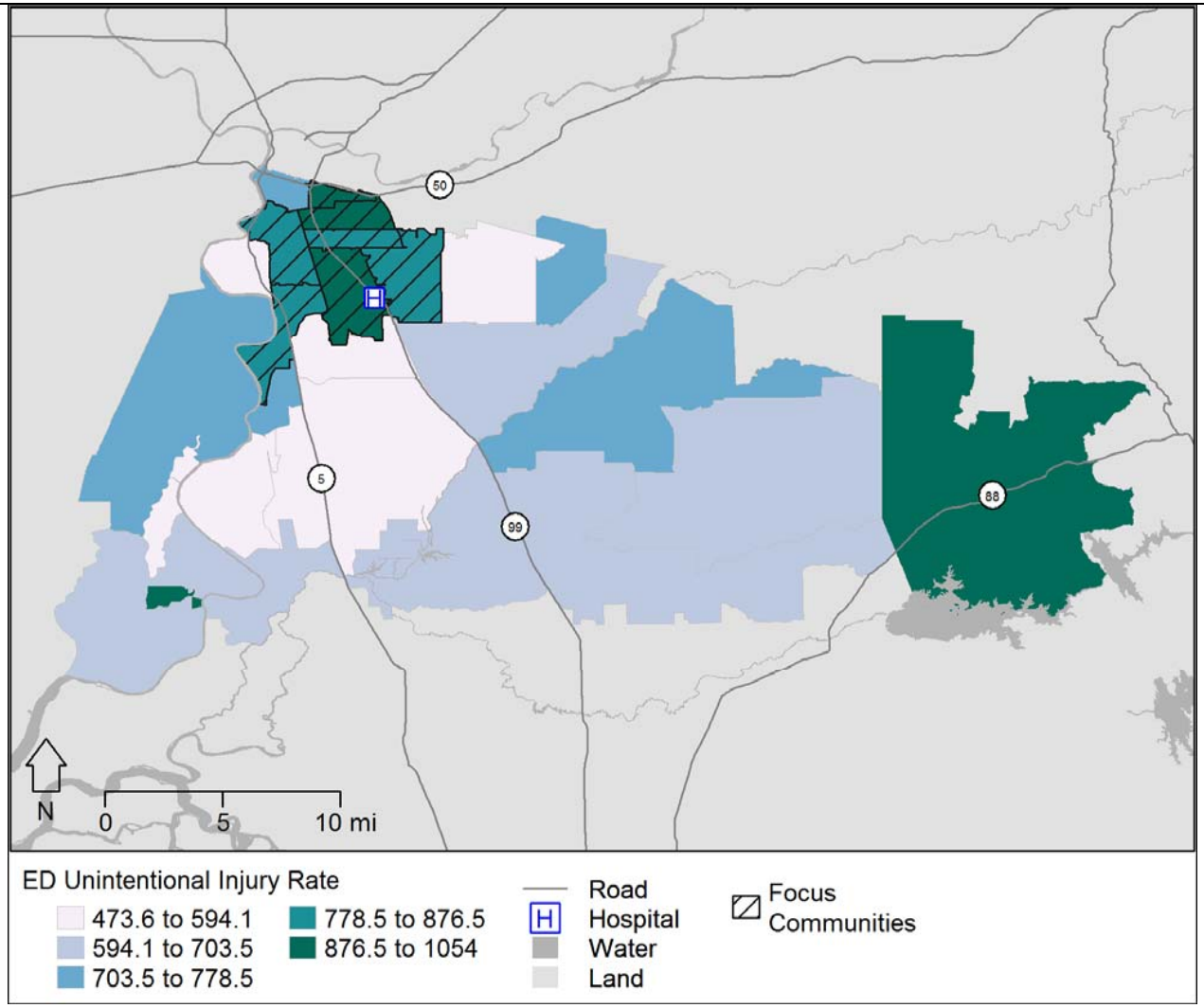


Figure 20. Unintentional Injury (ED)

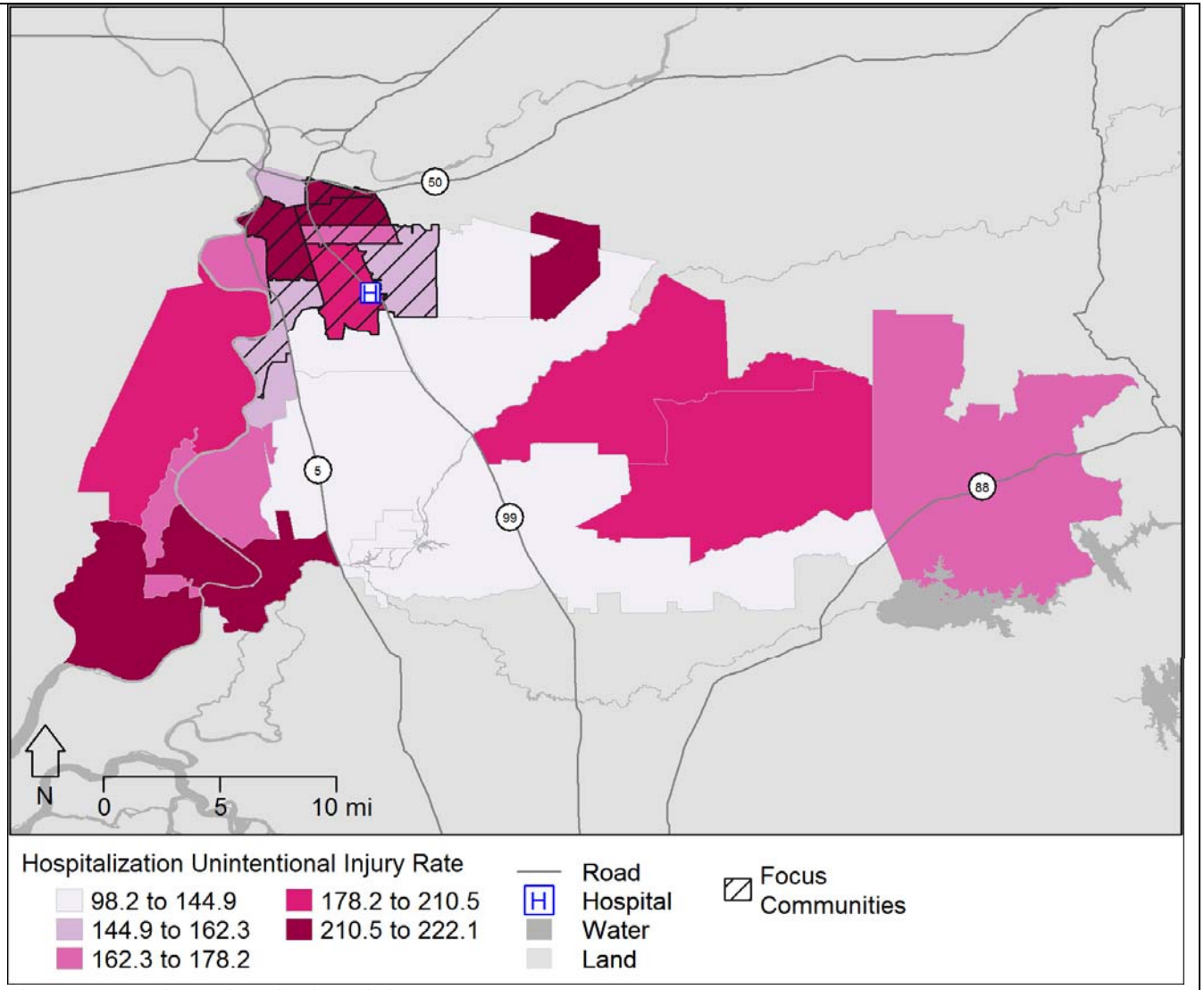
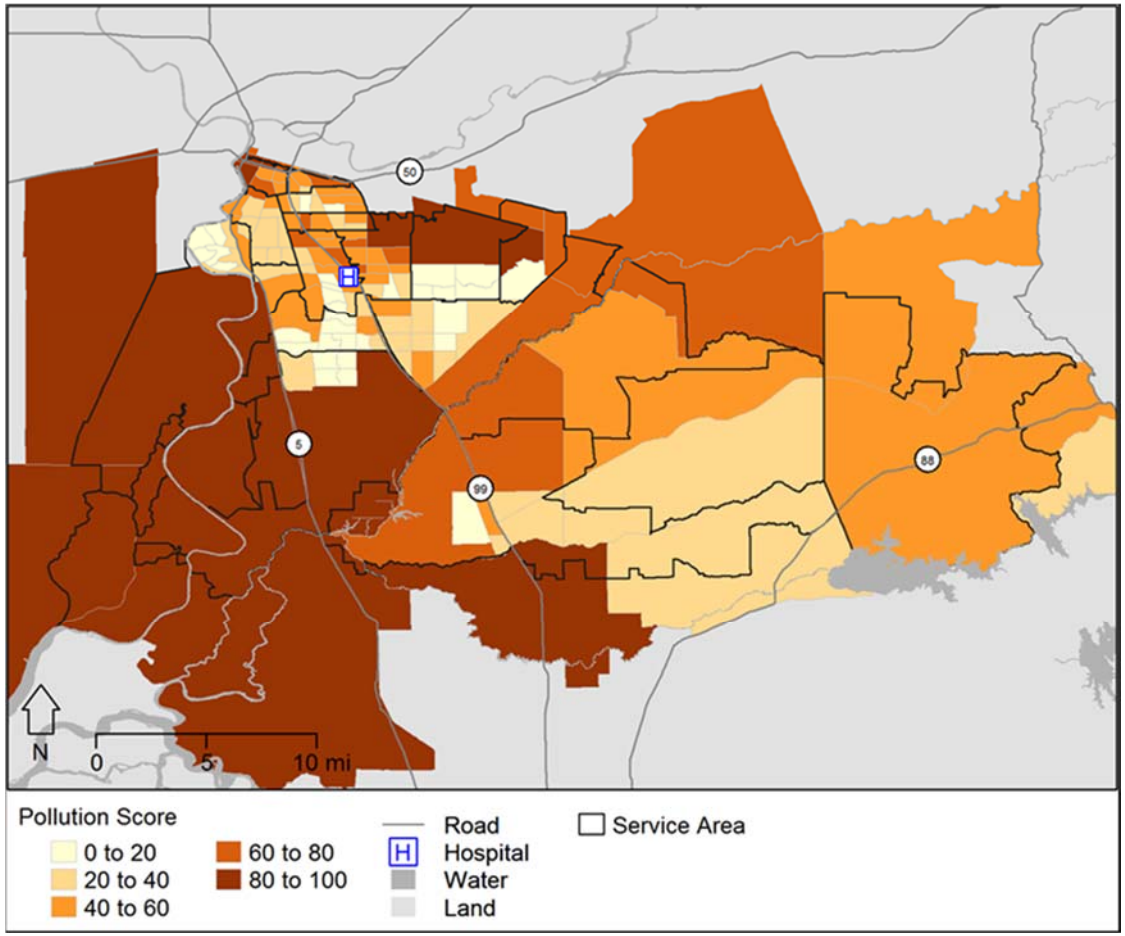


Figure 21. Unintentional Injury (H)

Pollution -Free Living and Work Environments		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] 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. *Source:* http://www.healthypeople.gov/2020/topics-objectives/topic/environmental-health http://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Environmental-Quality	**Tobacco Usage (per 100,000)** • HSA 14.80** // CA 12.80 **Pollution Burden Score** • HSA 0.78 // CA (see map below) **Asthma – Prevalence (per 100,000)** • HSA 18.50** // CA 14.20 **Assault (ED) (per 100,000)** • HSA 38.90** // CA 30.36 **Assault (H) (per 100,000)** • HSA 5.27* // CA 3.88 **Unintentional Injury (ED) (per 100,000)** • HSA 64.66 // CA 63.48 **Air Quality - Particulate Matter 2.5** • HSA 13.80**// CA 4.17	• Asthma (ED)** • Asthma (H)** • Chronic Lower Respiratory Disease - MORT • COPD (ED)** • COPD (H)** • Heart Disease (ED)** • Heart Disease (H)** • Tobacco Usage (adults and teens)** • Mortality - Ischemic Heart Disease • Obesity (Adult)** • Transit - Road Network Density* • Transit - Public Transit within 0.5 miles* • Climate & Health - Canopy Cover*

Primary Data:
Twenty of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to pollutant free work and school environments as a health need. Themes related to this health need are as follows:

- Poor air quality is an issue within the health service area. Community members spoke about air pollution and the connection to high rates of asthma. Interviewees also spoke about poor air quality in relation to second hand smoke from cigarettes and marijuana and the need for more enforcement of anti-smoking laws and smoking cessation programs.
- Residents discussed the connection of environmental hazards such as cockroaches within housing units as being of significant concern. There is thought that cockroaches are connected to asthma and other respiratory health issues.
- Community members believed that poverty exacerbated respiratory health issues, specifically through unsafe living environments, second hand smoke, pests, allergens and pollutants from industrial equipment. Main respiratory diseases mentioned were asthma and COPD.

Geographic Impact:	 Figure 22. Pollution Burden Score

Basic Needs		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] CORE INDICATORS**	**Contributing Factors RELATED INDICATORS**
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. *Source:* 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 15.94% ** // CA 19.19% (Health Disparities) **Poverty- Children Below 100% FPL** • HSA 27.04% ** // CA 22.15% (Health Disparities) **Poverty - Population Below 200% FPL** • HSA 39.90% ** // CA 35.91% **Percent Single Female Headed Households in Poverty** • HSA 17.2% // CA 13.49%	• Education-Reading Below Proficiency* • Food Security - Food Insecurity Rate** • Education - School Enrollment Ages 3-4** • Insurance - Population Receiving Medicaid** • Food Security - Population Receiving SNAP** • Children Eligible for Free/Reduced Price Lunch* • Population 5 Years of Older who Speak Limited English** • Life Expectancy at Birth

Primary Data: Thirty-nine 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to basic needs as a health need. Themes related to this health need are as follows: • Economic security is a significant issue within this hospital service area. Community members discussed hunger, food insecurity, unemployment and underemployment, lack of affordable housing, lack of transportation, language barriers, lack of vocational skills and training, as issues that negatively impact their quality of life. There were concerns that assistance programs could not provide the true needs of community members, specifically regarding lack of medical access to those utilizing Medi-Cal. Undocumented residents experienced significant barriers in accessing care. • The need for culturally sensitive basic needs was mentioned especially for the transgender population. Additionally, the basic needs for LGBT homeless youth were highlighted as there was recently a death due to exposure within this service area. In addition, marginalized populations were discussed as needing to utilize survival sex (prostitution) as a means to meet basic needs. These non-traditional working conditions lead to violence and great risk for some community members. • The economic and infrastructure growth of the downtown Sacramento area was mentioned multiple times as taking attention away from the pockets of deep poverty within South Sacramento. There was concern by community members that revitalization efforts have been needed in lower resourced areas of this hospital service area and have been diverted to communities with less needs. • Homelessness was regularly mentioned as being of major concern, specifically related to safe and legal places for homeless individuals to rest. • Residents have desires for funded community centers providing “one-stop shops” for social services, civic engagement and safe places for children/youth to learn. Additionally, community members were very interested in the establishment of youth organized sports programs. • Neighborhood safety and distrust of law enforcement were mentioned as making it difficult for residents to feel connected to their communities and neighbors. • Disabled, impoverished residents experienced greater burden in living full and healthy lives. In addition, elderly residents experienced many barriers in accessing basic needs, especially those with Alzheimer’s and/or dementia. Elderly residents reported feeling isolated and depressed. • Childhood trauma and adverse childhood experiences were mentioned as being significant barriers to the community achieving full health. • Rural areas, such a Galt, had significant challenges accessing basic needs, especially employment, transportation and education.		

Geographic Impact:

Table 23. Percent with income less than the federal poverty level compared to county and state benchmarks (100% FPL)

Percent with Income less than Federal Poverty Level	95680	38.77
	95824*	36.66
	95817*	36.18
	95832*	30.67
	95823*	30.12
	KFH-South Sacramento	19.32
	YOLO	21.59
	SACRAMENTO	17.59
	CALIFORNIA	15.94

Sources: 2013 American Community Survey, Five Year Estimate
* Indicates Focus Community

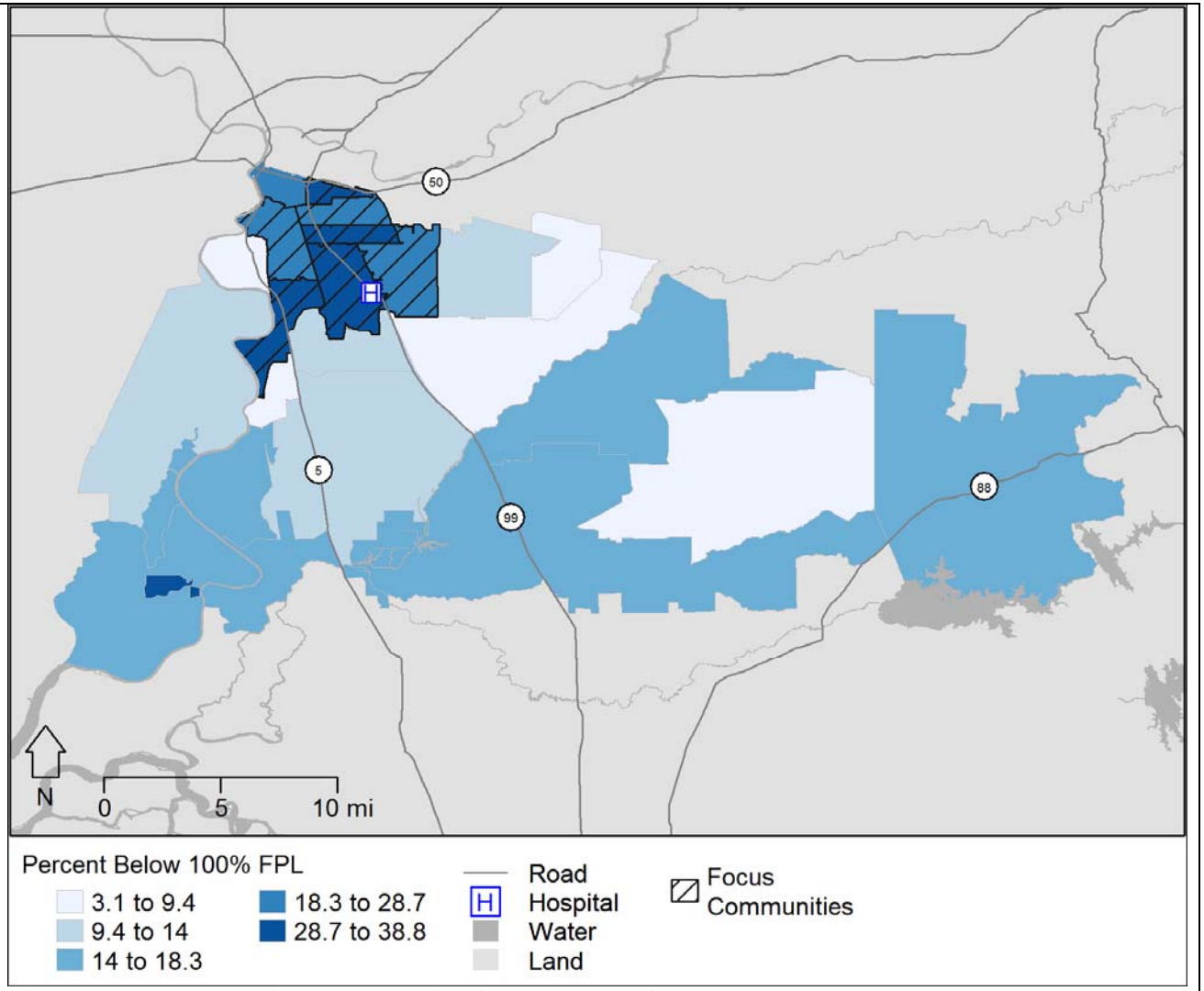


Figure 23. Percent Below 100% Federal Poverty Level:

Table 24. Life Expectancy at Birth (in years) compared to hospital service area, county and state benchmarks		
Life Expectancy at Birth	95820*	76.85
	95817*	77.17
	95828*	77.54
	95824*	77.95
	KFH-South Sacramento	79.24
	SACRAMENTO	78.74
	YOLO	76.47
	CALIFORNIA	

Sources: CDPH Mortality rates, 2012
* Indicates Focus Community

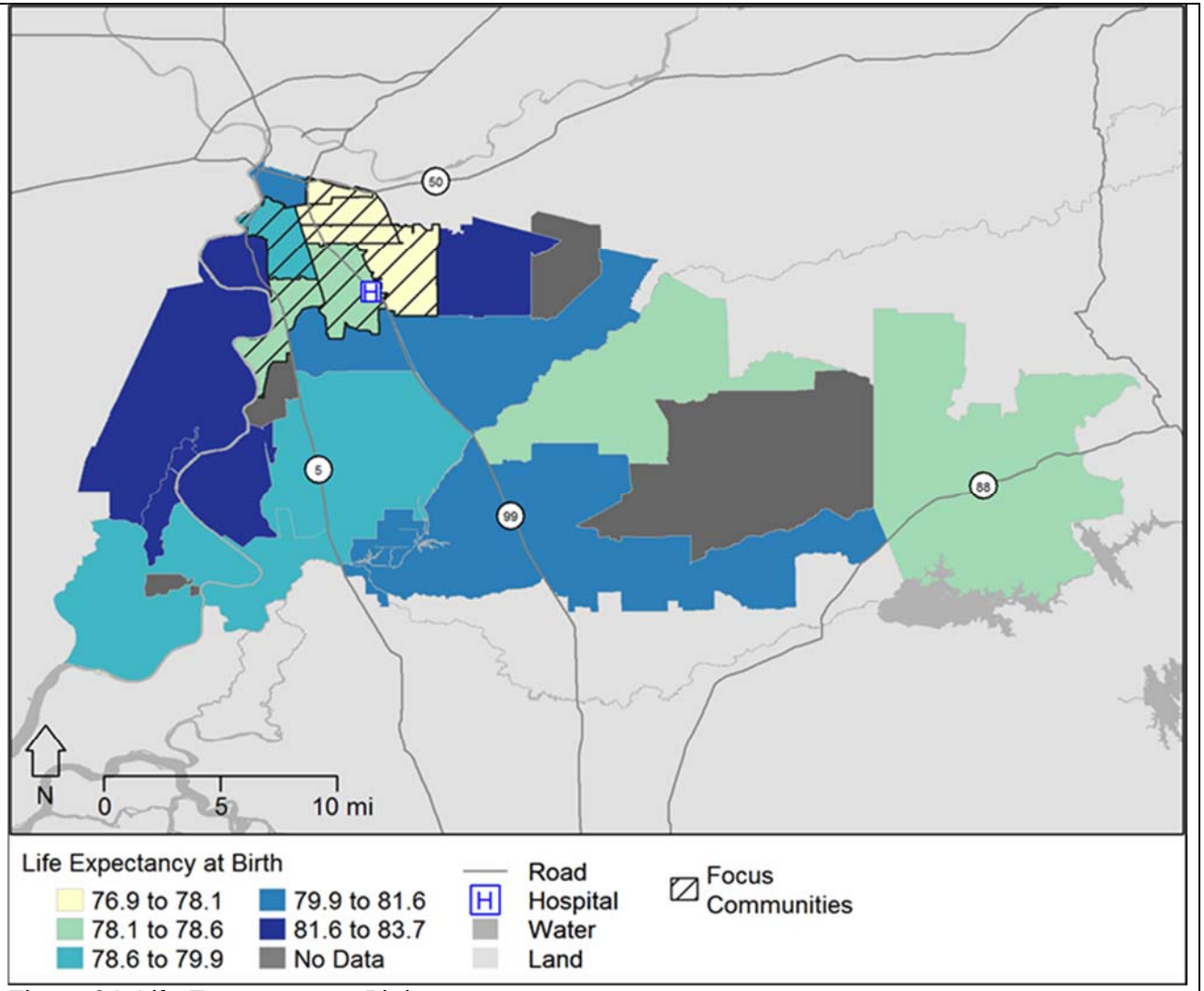


Figure 24. Life Expectancy at Birth:

Affordable and Accessible Transportation		
Rationale	**Health Outcomes Indicators [Report Area // Benchmark] 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. *Source:* http://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf	**Transit - Public Transit within 0.5 miles (EPA 2011)** • HSA 14.26% // CA 15.53%	• Walking/Biking/Skating to School (Health Disparities) • Population with Any Disability • Commute to Work - Walking/Biking

Primary Data:

Twenty-five of 40 of sources (key informant interviews and community member focus groups) mentioned health issues or drivers related to accessible and affordable transportation as a health need. Themes related to this health need are as follows:

- Participants noted that those living in poverty have greater barriers in accessing transportation. Those interviewed suggest improvements to the public transportation system in this HSA including increased routes to avoid multiple hour trips.
- Those interviewed are concerned that healthy eating, active living and healthcare options are challenging to access through walking and/or public transportation.
- Some mentioned that public transportation is time and cost prohibitive therefore making it less desirable. In addition, there are concerns that children, disabled and seniors have limited access to safe and reliable transportation.

Geographic Impact:

Table 25. ZIP codes with the highest percent of civilian noninstitutionalized population with a disability compared to hospital service area, county and state benchmarks

DISABILITY	95615	21.6
	95820*	19.5
	95817*	18.7
	95832*	18.5
	95638	18.2
	SACRAMENTO	12.7
	YOLO	10.3
	CALIFORNIA	10.1

Sources: 2013 American Community Survey 5-year Estimate
* Indicates Focus Community

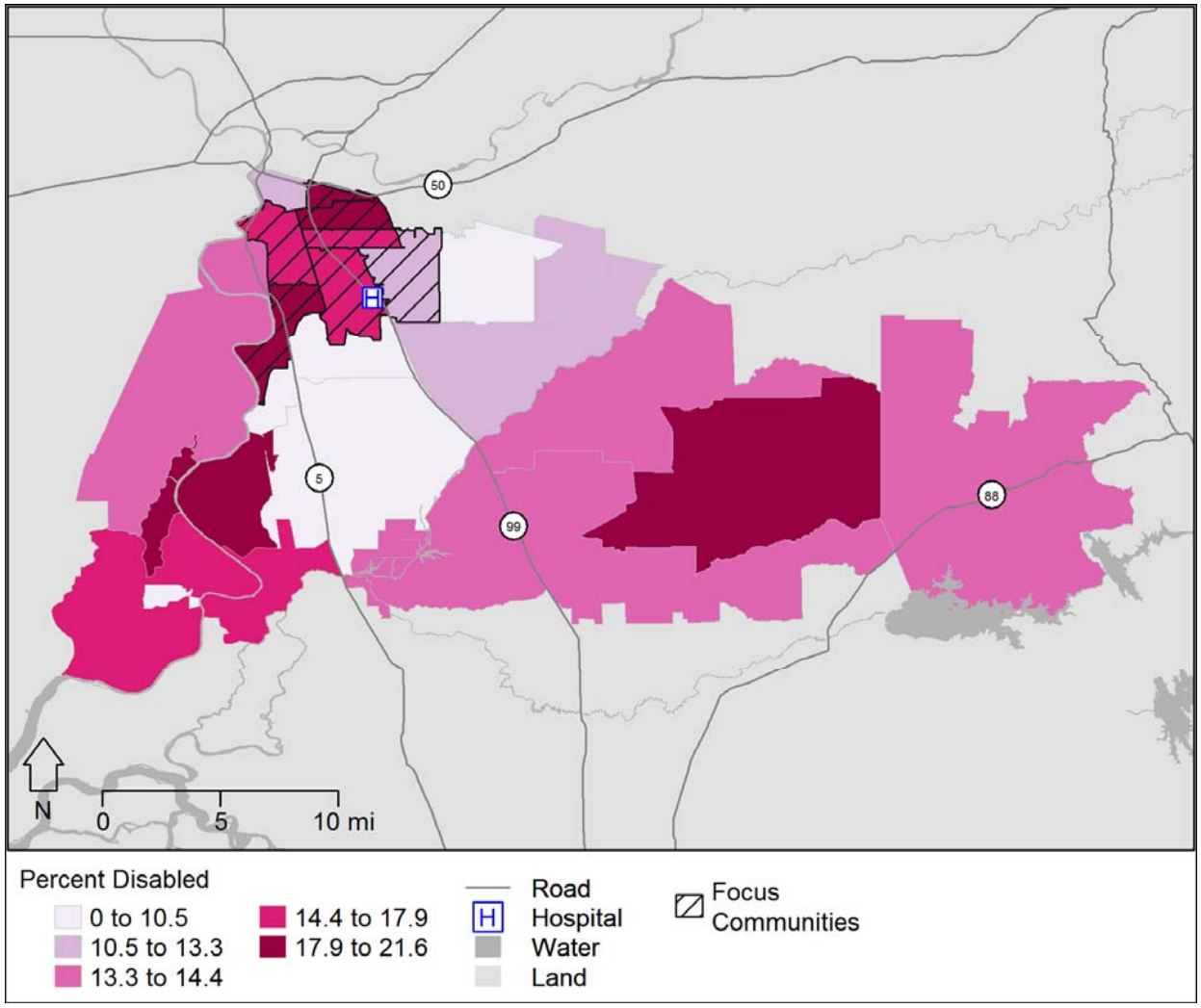


Figure 25. Population with Disability Map

Appendix D: Detailed Methodology Process for Identifying Significant Health Needs

BARHII Framework

Quantitative indicators used in this assessment was guided by a conceptual framework developed by the Bay Area Regional Health Inequities Initiative (BARHII) (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 26.

Table 26. 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 27. Indicators were sourced from the CHNA-DP and as outlined in Appendix A.

Table 27. 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
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)	• Maternal infant health • Medi-Cal access • Pain management • Patient navigation/referral • Prevention services/preventative care • Primary care • Senior care services • Specialty care
VV sourced indicators • Prenatal Care in First Trimester	
Oral Health • Absence of Dental Insurance Coverage • Dental Care - Lack of Affordability (Youth) • Dental Care - No Recent Exam (Adult/Youth) • Drinking Water Safety • Health Professional Shortage Area - Dental • Poor Dental Health • Soft Drink Expenditures	
VV sourced indicators • Dental/Oral Diseases (ED/H)	
Access to Behavioral Health Services	
Quantitative Indicators	Qualitative Indicators
Mental Health • Access to Mental Health Providers • Lack of Social or Emotional Support • Mental Health - Depression Among Medicare Beneficiaries • Mental Health - Needing Mental Health Care • Mental Health - Poor Mental Health Days • Mortality – Suicide	• Comorbidity • Depression-anxiety • Desire for alternative treatment • Elderly-Alzheimer's-dementia • ER/ Hospital • Homelessness • Limited services-lack of capacity • Mental health/substance abuse • Need for culturally sensitive care • Serious mental Illness • Stigma/discrimination • Stress • Suicide • Trauma and/or ACEs
VV sourced indicators • Alzheimer's Disease • Health Professional Shortage Area - Mental Health • Life expectancy at birth • Mental Health (ED/H) • Self-Inflicted Injuries (ED/H)	

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

• Children Eligible for Free/Reduced Price Lunch • Economic Security - Commute Over 60 Minutes • Economic Security - Households with No Vehicle • Economic Security - Unemployment Rate • Education - Head Start Program Facilities • Education - High School Graduation Rate • Education - Less than High School Diploma (or Equivalent) • Education - Reading Below Proficiency • Education - School Enrollment Age 3-4 • Food Security - Food Insecurity Rate • Food Security - Population Receiving SNAP • Food Security - School Breakfast Program • Housing - Assisted Housing • Housing - Cost Burdened Households • Housing - Substandard Housing • Housing - Vacant Housing • Insurance - Population Receiving Medicaid • Insurance - Uninsured Population • Median Income • Percent Households 65 years or Older In Poverty • Percent with social support (SNAP, public cash assistance, etc.) • Poverty - Children Below 100% FPL • Poverty - Population Below 100% FPL • Poverty - Population Below 200% FPL	Housing • Gentrification/displacement • Housing discrimination • Homelessness/shelter crisis • Lack of affordable housing • Role of public housing agencies • Seniors/aging in place • Substandard housing Food Security • 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 Economic Security • Loss of safety net benefits • Need for job training resources • Safety net benefits (TANF, CalFresh, WIC) • Stigma/shame of poverty • Unemployment/lack of jobs Education • 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	
Disease Prevention, Management and Treatment	
Quantitative Indicators	Qualitative Indicators

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

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

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

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

Significant Health Needs

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

For the secondary (quantitative) data, indicators were flagged that compared unfavorably to state benchmarks or had evident racial/ethnic group disparities. Indicators from the CHNA-DP were flagged if: (a) the HSA value performed poorly (>2% or 2 percentage point difference) or moderately (between 1-2% or 1-2 percentage point difference) compared to the state benchmark; or (b) a given indicator had one or more racial/ethnic group disparities where a given racial/ethnic group performed poorly (>2% or 2 percentage point difference) compared to the value for the HSA. Indicators sourced by Valley Vision were flagged if they compared unfavorably to benchmark by any amount, as presented in Table 28 below.

Table 28. Measures for PHN Identification and Benchmark Comparisons

Indicator	HSA Value	Indicator Flag Criteria
Alzheimer's Disease	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Assault (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Assault (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Asthma (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Breast Cancer (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Breast Cancer (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Chronic liver disease and cirrhosis – MORT	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Chronic Lower Respiratory Disease - MORT	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Colorectal Cancer (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Colorectal Cancer (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
COPD (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
COPD (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Dental/Oral Diseases (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Dental/Oral Diseases (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Diabetes (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Diabetes Mellitus – MORT	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Domestic Violence/Intimate Partner Violence	Maximum Rate for Associated Agencies	Exceeds State Benchmark
Essential Hypertension & Hypertensive Renal Disease – MORT	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark

Gonorrhea – Incidence	Maximum Rate for Associated County	Exceeds State Benchmark
Health Professional Shortage Area - Mental Health	HSA Intersects Mental Health Shortage Area	HSA intersects HPSA
Heart Disease (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Heart Disease (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
HIV/AIDS (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Hypertension (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Hypertension (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Life Expectancy at Birth	Calculated HSA Rate from ZCTA rates	Below State Benchmark
Lung Cancer (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Lung Cancer (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Major Crimes	Maximum Rate for Associated Agencies	Exceeds State Benchmark
Mental Health (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Mental Health (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Modified Retail Food Environment Index (MRFEI)	Calculated HSA Rate from ZCTA rates	Below State Benchmark
Osteoporosis (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Osteoporosis (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Percent Single Female Headed Households in Poverty	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Pollution Burden Score	Percent of HSA ZCTAs that intersect census tract within the top 20% of pollution burden scores in the state	Exceeds 25% of ZCTAs in the HSA
Population 5 Years or Older who speak Limited English	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Population with Any Disability	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Population with Public Insurance	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Prenatal Care	Calculated HSA Rate from ZCTA rates	Below State Benchmark
Prostate Cancer (ED)	Calculated HSA Rate from	Exceeds State

	ZCTA rates	Benchmark
Prostate Cancer (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Self-Inflicted Injuries (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Self-Inflicted Injuries (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
STIs (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
STIs (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Stroke (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Stroke (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Substance Abuse (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Substance Abuse (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Tobacco Usage (adults and teens)	Maximum Rate for Associated County	Exceeds State Benchmark
Unintentional Injury (ED)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark
Unintentional Injury (H)	Calculated HSA Rate from ZCTA rates	Exceeds State Benchmark

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

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

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

Health needs that met or exceeded the thresholds for both the primary and secondary data categories were given a score of two (2 points); health needs that met or exceeded the thresholds for only one of the categories were given a score of one (1 point). The health needs were then ranked so that those with two points were put into a higher tier for prioritization than those with one point. Finally, the percentage of importance was used as a way to prioritize the significant health needs. The prioritized significant health needs are displayed in Table 29.

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

Table 30. Demographics of KFH-South Sacramento Focus Communities

Name	ZIP	TPOP	MINO	LENG	NDIP	UEMP	PVFC	PVEL	PVSF	RENT	UINS
North Oak Park	95817	14377	58.9	5.57	17.5	17.3	39.7	5.28	55.1	63.7	16.8
Tahoe Park	95820	33967	69.0	10.47	26.1	18	30.3	2.58	30.9	45.9	18.2
Executive Airport/ Meadowview	95822	43024	71.5	11.59	22.6	15.9	31.7	2.74	42	42.4	15.4
Fruitridge/ Mack Road	95823	74154	84.2	14.69	25.5	19	37.2	2.7	51	52.4	18.9
Parkway	95824	29344	81.7	21.73	39.1	19.5	40.1	3.75	40.4	57.6	24.7
Florin	95828	60993	80.2	14.43	28.3	17.7	23.7	2.42	33.4	40	19.6
Freeport/ Meadowview	95832	12051	85.6	14.81	36.1	20.8	34.8	1.99	60.4	49.6	23.6
SACRAMENTO		1435207	52.1	7.12	14.1	13.7	20.1	1.92	37.6	43.3	14.6
YOLO		202288	50.6	7.89	15.7	10.4	14.7	2.09	28.8	47.1	13.2
CALIFORNIA		37659181	60.3	10.78	18.8	11.5	17.8	2.26	36.8	44.7	17.8

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

Source: 2013 American Community Survey 5-year Estimate
* Indicates Focus Community

APPENDIX F: Informed Consent

Informed Consent

Gathering Information for a Community Health Assessment

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

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

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

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

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

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

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

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

VALLEY VISION

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

VALLEY VISION

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

VALLEY VISION

Key Informant Questionnaire

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

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

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

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

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

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

_____

_____

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

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

Thank you for your participation!

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Self-Report Demographic Data Card

Gathering Information for a Community Health Assessment

Please share…
Tell us a little about you….

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

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

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

   _____

2. **What is your ethnicity?**

   ☐Hispanic/Latino ☐Not Hispanic/Latino

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

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

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

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

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

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

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

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

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

   ☐Yes ☐No

Thank you for your participation!

Tarjeta de Datos Demográficos

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

Cuéntanos un poco acerca de usted…

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

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

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

_____

2. ¿Cuál es tu raza?

☐ Latino/Hispano ☐ No Latino/ Hispano

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

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

4. ¿En qué año naciste? _____

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

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

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

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

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

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

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

☐Si ☐No

¡Gracias por participar!

APPENDIX H: Interview Guides

Key Informant Interview Guide - Questions

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

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

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

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

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

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

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

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

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

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

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

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

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Focus Group Guide- Questions

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

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

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

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

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

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

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

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

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

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

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

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Focus Group Guide- Youth

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

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

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

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

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

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

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

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

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Guía de Grupo de Enfoque

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX I: Project Summary Sheet

Key Informant Project Summary Sheet

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

Project Management:

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

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

Organization Information:

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

Project Overview:

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

Key Deliverables:

Each CHNA report will:

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

Strategic Partners:

Lead project consultation:

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

Data collection, analysis and GIS mapping:

Dr. Mathew C. Schmidtlein
Assistant Professor
Dept of Geography
CSU Sacramento

Transcription and translation services:

Cherie Yure
Southern California Transcription Services

Project Orientation:

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

Project Sponsors:

VALLEY VISION
Connect. Partner. Impact.

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 · UCDAVIS HEALTH SYSTEM

Community Project Summary Sheet - Spanish

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

Focus Group Outreach Flyer

You're invited to a group conversation!

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

Date:
Time:
Location:

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

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

Questions? Contact (PM) at Valley Vision, 916.325.1630

Focus Group Outreach Flyer - Spanish

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

¿Cuando?
¿A Qué hora?
¿Donde?

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

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

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

ame	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
Area 4	Arden-Arcade	Yes	x	x	x	x			x	x
of	Oak Park	Yes		x						
ation	North Sacramento	Yes			x					x
other	South Sacramento	Yes			x					x
eling	Tahoe Park	Yes			x					
c.	Oak Park, South Sacramento, Citrus Heights	Yes		x						x
	South Sacramento, North Sacramento	Yes	x	x	x					
ps of o	South Sacramento	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
Breathe California of Sacramento- Emigrant Trails	Downtown Sacramento	Yes	x			x		x		
Building Healthy Communities	South Sacramento	Yes					x		x	
Center for AIDS Research, Education and Services- CARES Community Health	Midtown Sacramento	Yes	x		x		x			
Child Abuse Prevention Center	North Highlands	Yes							x	
Child and Family Institute (CFI)	South Sacramento	Yes			x					
Children's Receiving Home of Sacramento	Arden-Arcade	Yes	x	x	x		x			
Clara's House	Midtown Sacramento	Yes	x							
Community Against Sexual Harm (CASH)	Oak Park	Yes			x				x	
Community Link	Rosemont	Yes			x					
Crisis Nursery Program- Sacramento Children's Home	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
Department of Human Assistance	Arden-Arcade	Yes		x						
DHHS Primary Health Services	Tahoe Park	Yes	x							
Dignity Health	Carmichael, Folsom, Rancho Cordova, South Sacramento, East Sacramento	Yes	x			x	x			x
Drug Diversion (PC-1000) Program	South Sacramento	Yes			x					
Elk Grove Unified School District	Elk Grove	Yes	x	x	x		x		x	
Eskaton	Carmichael	Yes	x	x	x					x
First 5 Sacramento Commission	North Sacramento	Yes	x	x	x	x	x		x	
Gender Health Center	Oak Park	Yes	x	x	x					
Golden Rule Services	South Sacramento	Yes	x			x				

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities	Transportation
Goodwill- Sacramento Valley & Northern Nevada	Rosemont	Yes		x						
Harm Reduction Services (HRS)	Oak Park	Yes	x		x	x				
Health and Life Organization (HALO Cares)- Sacramento Community Clinic	South Sacramento	Yes	x		x					
Health Education Council	West Sacramento	Yes					x		x	
Health For All Community Clinics	Downtown Sacramento, North Sacramento, South Sacramento	Yes	x	x						
Health Tech Academy- Valley High School	Elk Grove	Yes		x						
Hmong Women's Heritage Association	South Sacramento	Yes			x					
Human Services Coordinating Council (HSCC)	South Sacramento	Yes		x						

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities	Transportation
Imani Clinic	Oak Park	Yes	x		x					
Kaiser Permanente South Sacramento Medical Center	South Sacramento	Yes	x		x	x	x			x
La Familia Counseling Center, Inc.	South Sacramento	Yes	x	x	x		x		x	
Legal Services of Northern California-Health Rights	Downtown Sacramento	Yes		x						
Lilliput Children's Services	South Sacramento	Yes		x						
MAAP (Mexican American Alcoholism Program)	South Sacramento	Yes			x					
Mack Road Partnership	South Sacramento	Yes		x			x		x	
Mack Road Partnership Community Center	South Sacramento	Yes	x	x			x			
Meadowview Family Resource Center	South Sacramento	Yes			x					
Meals on Wheels Sacramento	Rocklin	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
Mercy Housing	South Sacramento	Yes		x						
Methodist Hospital of Sacramento	South Sacramento	Yes	x			x	x			x
Mexican Consulate General in Sacramento	Natomas	Yes		x					x	
Molina Healthcare	South Sacramento	Yes	x							x
My Sister's House	South Sacramento	Yes	x	x	x				x	
New Beginnings Health & Wellness Center-Center for Community Health & Well Being	South Sacramento	Yes	x							
Next Move	Oak Park	Yes	x	x					x	
North Franklin District Business Association	South Sacramento	Yes							x	
Oak Park Community Center	Oak Park	Yes					x			
Oak Park Neighborhood Association	Oak Park	Yes							x	
Oak Park Sol Community Garden	Oak Park	Yes	x							

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities	Transportation
Paratransit, Inc.	South Sacramento	Yes								
Planned Parenthood Fruitridge Health Center	South Sacramento	Yes	x			x				
PRIDE Industries	Auburn, Fair Oaks, Grass Valley, North Sacramento, North Highlands, Placerville, South Sacramento, Woodland	Yes		x						
River Oak Family Resource Center	Oak Park	Yes			x		x			
Roberts Family Development Center	North Sacramento	Yes		x			x			
Sacramento Area Congregations Together (Sacramento ACT)	Rosemont	Yes		x	x					
Sacramento Children's Home	South Sacramento	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
Sacramento City Church	Upper Land Park	Yes		x						
Sacramento City College- Dental Health Clinic	South Sacramento	Yes	x							
Sacramento City Unified School District	South Sacramento	Yes	x	x	x					
Sacramento County Department of Health and Human Services	South Sacramento	Yes	x		x	x	x	x	x	
Sacramento County Department of Health and Human Services- Primary Health Services	South Sacramento	Yes	x		x					
Sacramento County Department of Health and Human Services- Public Health Division	South Sacramento	Yes	x			x	x	x		
Sacramento Covered	Rosemont	Yes	x							
Sacramento Employment and Training Agency (SETA)	North Sacramento	Yes		x						
Sacramento Food Bank and Family Services	Oak Park	Yes		x			x			

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 Housing and Redevelopment Agency (SHRA)	Downtown Sacramento	Yes		x						
Sacramento Junior Giants	South Sacramento	Yes					x			
Sacramento LGBT Community Center	Midtown Sacramento	Yes		x					x	
Sacramento Native American Health Center, Inc.	Midtown Sacramento	Yes	x		x	x	x		x	
Sacramento Steps Forward	North Sacramento	Yes		x						
Sacramento Tree Foundation	Arden-Arcade	Yes						x		
Sacramento Violence Intervention Program (SVIP)- WellSapce Health	South Sacramento	Yes							x	
Sacramento Works Job Center	Galt, South Sacramento	Yes		x						
Saint John's Program for Real Change	South Sacramento	Yes		x	x					
Sam & Bonnie Pannell Community Center	Galt	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
SeniorCare PACE	South Sacramento, Downtown Sacramento	Yes	x			x	x			
SETA Head Start	North Sacramento	Yes		x			x			
Sherriff Community Impact Program	Arden-Arcade	Yes			x		x		x	
Shiloh Baptist Church	Oak Park	Yes		x						
Shingle Springs Tribal TANF Program	El Dorado, Sacramento, Shingle Springs	Yes		x						
Shriner's Hospital for Children	Oak Park	Yes	x							
Sierra Health Foundation	North Sacramento	Yes	x		x	x	x		x	
Slavic Assistance Center	Arden-Arcade	Yes		x						
South Sacramento Interfaith Partnership (SSIP) Food Closet	South Sacramento	Yes		x						
Southeast Asian Assistance Center	South Sacramento	Yes			x					

Resource Provider Name	Service Site Locations	Serves Focus Community or Focus Population (Y/N)	Access to Care	Basic Needs	Behavioral Health	Disease Prevention	HEAL	Pollution-Free Communities	Safe Communities	Transportation
St. Paul Missionary Baptist Church	South Sacramento	Yes					x			
St. Vincent de Paul Sacramento Council	Broderick	Yes		x						
Strategies for Change	South Sacramento	Yes		x	x				x	
Summer Night Lights Sacramento- Mack Road Partnership	South Sacramento	Yes					x		x	
Sutter Center for Psychiatry	Rosemont	Yes			x					
Terra Nova Counseling	Midtown Sacramento	Yes			x					
The Gardens- A Family Care Community Center	South Sacramento	Yes		x	x	x				
The Keaton Raphael Memorial	Roseville	Yes				x				
The Mental Health Association in California	Midtown Sacramento	Yes			x					
The Salvation Army	Oak Park	Yes	x	x						
TLCS (Transitional Living and Community Support)	Arden-Arcade	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
Turning Point Community Programs	Rancho Cordova	Yes		x	x					
UC Davis Medical Center	Oak Park	Yes	x		x	x				
United lu Mein Community Inc.	South Sacramento	Yes	x		x				x	
Valley Hi Family Resource Center	South Sacramento	Yes			x					
Visions Unlimited	South Sacramento	Yes			x					
Volunteers of America-Northern California & Norther Nevada	Arden-Arcade	Yes		x						
WarmLine Family Resource Center	Downtown Sacramento	Yes								
WEAVE	Midtown Sacramento, South Sacramento	Yes		x	x				x	
Wellness and Recovery Center- Consumer Self Help	South Sacramento	Yes			x					
WellSpace Health	Oak Park, South Sacramento	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
Wellspring Women's Center	Oak Park	Yes			x		x			
WIC Sacramento	South Sacramento	Yes	x			x	x			
Wind Youth Services	Midtown Sacramento	Yes		x	x					
Women's Empowerment	Midtown Sacramento	Yes		x	x					
YMCA of Superior California	Downtown Sacramento	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
	People's Guide to Health, Welfare and Other Services: Sacramento County (2014-2015) http://www.sachousingalliance.org/wp-content/uploads/2012/10/Peoples-Guide-FINAL-Draft-7-21-14.pdf
	SACPROS Mental Health Resources http://www.sacpros.org/Pages/default.aspx
	Sacramento Steps Forward: Resource Guide for People Experiencing Homelessness http://sacramentostepsforward.org/wp-content/uploads/2013/08/Resource-Guide_1.pdf

Additional Assets	Community Assets *Reported in Key Informant Interviews and Focus Groups*
	211
	Adult Day Programs
	Churches and Faith-Based Organizations
	Colleges/Universities
	Donations (Including Food)
	Farmer's markets
	Gyms
	Parks

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.