



SUTTER ROSEVILLE MEDICAL CENTER

2022 Community Health Needs Assessment

Mission

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

Vision

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

Community Health Needs Assessment

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

2022 Community Health Needs Assessment

Conducted on behalf of

Sutter Roseville Medical Center
One Medical Plaza Drive
Roseville, CA 95661

Conducted by



May 2022

Acknowledgments

We are deeply grateful to all those who contributed to the community health needs assessment conducted on behalf of Sutter Roseville Medical Center. Many dedicated community health experts and members of various social service organizations serving the most vulnerable members of the community gave their time and expertise as key informants to help guide and inform the findings of the assessment. Many community residents also participated and volunteered their time to tell us what it is like to live in the community and shared the challenges they face trying to achieve better health. We also appreciate the collaborative spirit of Kaiser Permanente (and Harder and Company) and their willingness to share the data they gathered while conducting a similar health assessment in Sacramento and Placer Counties. To everyone who supported this important work, we extend our heartfelt gratitude.

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

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Report Summary

Purpose

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

Community Definition

The definition of the community served included the primary service area of the hospital, Sutter Roseville Medical Center. The hospital service area which consists of 21 ZIP codes across Placer, Sacramento, and Sutter Counties. The main area used for this assessment were the ZIP codes and county rates for Sacramento and Placer counties.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.¹ This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 33 community health experts, social service providers, and medical personnel. Furthermore, 59 community residents or community service provider organizations participated in 4 focus groups across the service area. Finally, 69 community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization.

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

At the time that this CHNA was conducted, the COVID-19 pandemic was still impacting communities across the United States, including SRMC's service area. The process for conducting the CHNA remained fundamentally the same. However, there were some adjustments made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were

¹ Robert Wood Johnson Foundation, and University of Wisconsin, 2021. County Health Rankings Model. Retrieved 31 Jan 2022 from <http://www.countyhealthrankings.org/>.

incorporated into the quantitative data analysis and COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs. This began by identifying 12 potential health needs (PHNs). These PHNs were identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the service area. These PHNs were selected as significant health needs. These significant health needs were prioritized based on rankings provided by primary data sources. Data were also analyzed to detect emerging health needs beyond those 12 PHNs identified in previous CHNAs.

List of Prioritized Significant Health Needs

The following significant health needs identified for Sutter Roseville Medical Center are listed below in prioritized order.

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. Access to Functional Needs
5. Injury and Disease Prevention and Management
6. Active Living and Healthy Eating
7. Increased Community Connections
8. Safe and Violence-Free Environment
9. Healthy Physical Environment
10. Access to Specialty and Extended Care
11. Access to Dental Care and Preventive Services

Resources Potentially Available to Meet the Significant Health Needs

In all, 361 resources were identified in the service area that were potentially available to meet the identified significant health needs. The identification method included starting with the list of resources from the 2019 CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report.

Conclusion

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

Introduction and Purpose

Both state and federal laws require that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years to identify and prioritize the significant health needs of the communities they serve. The results of the CHNA guide the development of implementation plans aimed at addressing identified health needs. Federal regulations define a health need accordingly: “Health needs include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities)” (p. 78963).²

This report documents the processes, methods, and findings of a CHNA conducted on behalf of Sutter Roseville Medical Center (SRMC), located at One Medical Plaza Drive, Roseville, CA 95661. SRMC’s primary service area includes 21 ZIP codes across three counties Sacramento and Placer (with one ZIP code crossing over to Sutter County). The total population of the service area was 725,725.

SRMC is an affiliate of Sutter Health a nonprofit healthcare system. The CHNA was conducted over a period of four months, beginning in February 2022, and concluding May 2022. This CHNA report meets requirements of the Patient Protection and Affordable Care Act and California Senate Bill 697 that nonprofit hospitals conduct a community health needs assessment at least once every three years.

Community Health Insights (www.communityhealthinsights.com) conducted the CHNA on the behalf of SRMC. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. Community Health Insights has conducted dozens of CHNAs and CHAs for multiple health systems and local health departments over the previous decade.

Findings

Prioritized Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the SRMC service area. In all, 11 significant health needs were identified. Primary data were then used to prioritize these significant health needs.

Prioritization was based on three measures of community input. The first two measures came from the key informant interview and focus group results. These included the percentage of sources that identified a health need as existing in the community, and the percentage of times the sources identified a health need as a top priority. The last measure was the percentage of community provider survey respondents that identified a health need as a top priority. Table 1 shows the value of these measures for each significant health need.

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

Table 1: Health need prioritization inputs for SRMC service area.

| Prioritized Health Needs | Percentage of Key Informants and Focus Groups Identifying Health Need | Percentage of Times Key Informants and Focus Groups Identified Health Need as a Top Priority | Percentage of Provider Survey Respondents that Identified Health Need as a Top Priority |
|---|---|--|---|
| Access to Basic Needs Such as Housing, Jobs, and Food | 95% | 20% | 75% |
| Access to Mental/Behavioral Health and Substance Use Services | 100% | 16% | 68% |
| Access to Quality Primary Care Health Services | 86% | 18% | 28% |
| Access to Functional Needs | 67% | 16% | 4% |
| Injury and Disease Prevention and Management | 90% | 9% | 2% |
| Active Living and Healthy Eating | 71% | 7% | 6% |
| Increased Community Connections | 76% | 4% | 9% |
| Safe and Violence-Free Environment | 38% | 4% | 23% |
| Healthy Physical Environment | 48% | 1% | 13% |
| Access to Specialty and Extended Care | 29% | 2% | 25% |
| Access to Dental Care and Preventive Services | 38% | 2% | 8% |

~ Health need not mentioned

These measures were then combined to create a health need prioritization index. The highest priority was given to health needs that were more frequently mentioned and were more frequently identified among the top priority needs.³ The prioritization index values are shown in Figure 1, where health needs are ordered from highest priority at the top of the figure to lowest priority at the bottom.

³ Further details regarding the creation of the prioritization index can be found in the technical report.

Sutter Roseville Medical Center 2022 Prioritized Health Needs

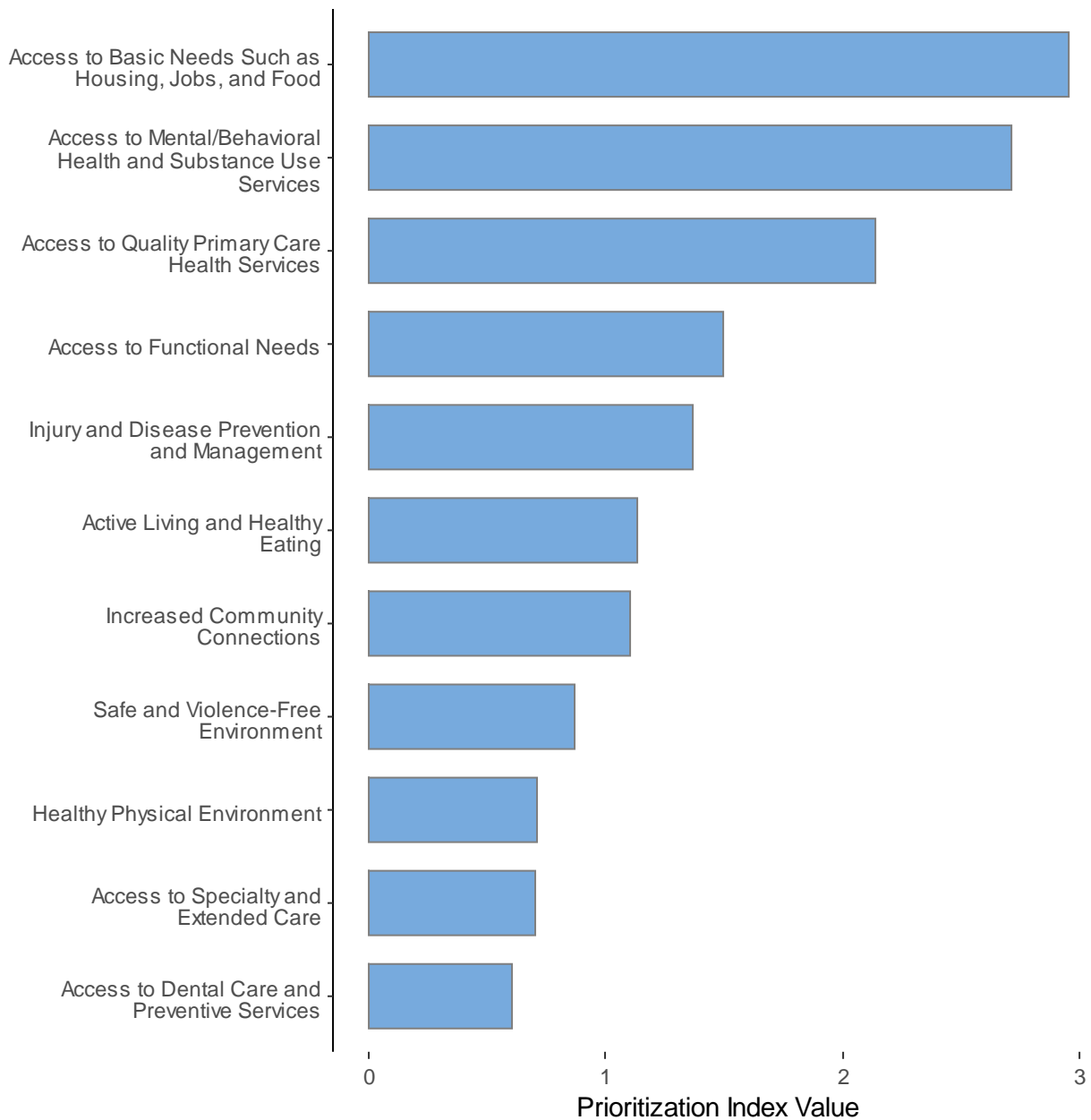


Figure 1: Prioritized significant health needs for SRMC service area.

While COVID-19 was top of mind for many participating in the primary data collection process, feedback regarding the impact of COVID-19 confirmed that the pandemic exacerbated existing needs in the community.

The significant health needs are described below. Those secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health ordered by their relationship to the conceptual model used to guide data collection for this report.

Results from primary data analysis are also provided in the table. (A full listing of all quantitative indicators can be found in the technical section of this report).

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

Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow’s Hierarchy of Needs⁴ suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.⁵

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> • Minimal funding for homeless support services. • Negative public stigma about homelessness. • Community needs more education on the needs of those experiencing homelessness. • Increase access to specialized housing and universal design for seniors. • More emergency housing vouchers through United States Department of Housing and Urban Development (HUD). • Pandemic created a challenge for parents who are essential workers, as children were home alone due to homeschooling. • Health access, literacy, and numeracy that is culturally and linguistically appropriate. • Improve the healthiness of food | <ul style="list-style-type: none"> • Lack of affordable housing is a significant issue in the area. • The area needs additional low-income housing options. • It is difficult to find affordable childcare. • Services for homeless residents in the area are insufficient. • Many people in the area do not make a living wage. • Many residents struggle with food insecurity. • Services are inaccessible for Spanish-speaking and immigrant residents. • Poverty in the county is high. | <ul style="list-style-type: none"> • Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Hypertension Mortality • COVID-19 Case Fatality • Diabetes Prevalence • Low Birthweight • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Asthma ED Rates • Asthma ED Rates for Children • Drug Induced Death • Adult Obesity • Limited Access to Healthy |

⁴ McLeod, S. 2020. Maslow’s Hierarchy of Needs. Retrieved 31 Jan 2022 from <http://www.simplypsychology.org/maslow.html>.

⁵ Robert Wood Johnson Foundation, and University of Wisconsin, 2022. Research Articles. Retrieved 31 Jan 2022 from <http://www.countyhealthrankings.org/learn-others/research-articles#Rankingsrationale>.

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <p>provided by local food banks.</p> <ul style="list-style-type: none"> • Improve access to affordable shelf food as well as more nutritious food like fresh fruits and veggies. • Technology access is a barrier to receive care and resources for many families. • Immigrant community members needs more health and social support. • Many in Placer County have a Not In My Backyard (NIMBY) viewpoint around homelessness in the community. • Placer County has made progress in permanent housing in the last few years. • Affordable housing in the area often located in areas with high crime. • Increased need in supportive housing for those experiencing homelessness. • Increased opportunities for economic security for area families. • Immigrants gaining livable wages that match the high cost of living. • Many multi-generational families living in one house. • Disparities difficult to see in the service area as they are overshadowed by the affluence of the area. • More health and social services needed for low income families. • Stigma against Asian community members when they access social support services. • Increase job training in the area, | <ul style="list-style-type: none"> • Employment opportunities in the area are limited. • Educational attainment in the area is low. | <p>Foods</p> <ul style="list-style-type: none"> • Food Environment Index • Medically Underserved Area • COVID-19 Cumulative Full Vaccination Rate • Disconnected Youth • Third Grade Reading Level • Third Grade Math Level • Children in Single-Parent Households • Children Eligible for Free Lunch • Children in Poverty • Median Household Income |

| Primary Data Analysis | | Secondary Data Analysis |
|--|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <p>especially for youth.</p> <ul style="list-style-type: none"> • Improve access to quality education – advanced placement (AP) classes are not available in many schools. • Increase support services/case management for people to meet their basic needs (i.e., job, housing, food, safety, transportation). • Food insecurity has increased as food prices have risen. • More rental and utility financial assistance. • Many middle class families are seeking financial and food assistance for the first time. • Increased need for parenting courses, help parents manage stress. • Provide hygiene mobile access for the homeless. • There is not enough affordable and quality childcare for parents. • Improve access to affordable and better health insurance. • Increased access to higher education for area residents. | | |

2. Access to Mental/Behavioral Health and Substance Use Services

Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.

| Primary Data Analysis | Secondary Data Analysis |
|--|--|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | The following indicators performed worse in the service area when compared |

| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | to state averages: |
|--|---|--|
| <ul style="list-style-type: none"> • Stable and safe housing for those with mental illness and substance use. • Focus should be on whole person care in addressing mental health. • Many area families experience systemic and community racism which impacts their mental health. • Not enough bilingual and bicultural therapists. • Isolation due to COVID-19 has made mental health worse in the area. • Not enough mental health therapists available to meet the community need. • Spanish speaking community members have a lack of mental health services. • Suicide rate has increased among children in the service area. • Need for a crisis stabilization unit in the area. • High number of overdose deaths due to synthetic opioids like fentanyl. • High use of alcohol in the service area. • Increase hospital partnership in a mental health crisis response unit. • Lack of access to technology for many community residents means no access to virtual mental health services. | <ul style="list-style-type: none"> • There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups). • Substance-abuse is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse). • Additional services for those who are homeless and experiencing mental/behavioral health issues are needed. • There aren't enough services here for those who are homeless and dealing with substance-abuse issues. • It's difficult for people to navigate for mental/behavioral healthcare. • Treatment options in the area for those with Medi-Cal are limited. • Substance-use treatment options for those with Medi-Cal are limited. • There are too few substance-abuse treatment services in the area (e.g., detox centers, rehabilitation centers). • Additional services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in the schools). • The area lacks the infrastructure to support acute mental health crises. • The stigma around seeking mental health treatment keeps people out of care. • The cost for mental/behavioral health treatment is too high. • Awareness of mental health issues among community members is low. • Substance-abuse is an issue among youth in particular. • The use of nicotine delivery products such as e-cigarettes and tobacco is a problem in the community. | <ul style="list-style-type: none"> • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Liver Disease Mortality • Suicide Mortality • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Excessive Drinking • Drug Induced Death • Adult Smoking • Primary Care Shortage Area • Mental Health Care Shortage Area • Medically Underserved Area • Mental Health Providers • Firearm Fatalities Rate • Disconnected Youth |

| Primary Data Analysis | | Secondary Data Analysis |
|--|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> • Need for more services focused on intimate partner violence prevention. • Increase coordination between local mental health providers and county services. • Stigma around mental health care prevents many communities from seeking care. • Not enough psychiatric facilities in the area to meet the need. • Lack of psychiatrists for Medi-Cal population. • More adolescent psychiatric care providers needed. • Culturally and linguistically appropriate mental health services are lacking. • Lack of access to afterschool activities greatly affects youth mental health. • Minimal mental health and substance use rehabilitation services. • Treatment options for substance use is very expensive. • Homeless struggle with getting the mental health resources they need. • Senior population has a lot of anxiety and depression. | <ul style="list-style-type: none"> • Mental/behavioral health services are available in the area, but people do not know about them. • There are substance-abuse treatment services available here, but people do not know about them. | |

3. Access to Quality Primary Care Health Services

Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

| Primary Data Analysis | | Secondary Data Analysis |
|--|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> Increased access to culturally and linguistically appropriate care for Spanish Speaking community. Transportation is a significant barrier to access to primary care in the area. Longer hours and Saturday hours for care at local clinics. Technology access (computers, internet) is a barrier to care (making appts, telehealth calls, etc.). Bring primary health care to communities that have multiple barriers, come to their neighborhood. Improve access to affordable medication that will allow people to be compliant. Limited federally qualified health centers (FQHC) in the area. Provider shortages in many areas of Placer County (specifically mentioned were Kings Beach and Auburn). Many community members lack a healthcare home due to barriers. Disparity in care, a lot of doctors do not take Medi-Cal, yet the | <ul style="list-style-type: none"> Patients have difficulty obtaining appointments outside of regular business hours. Wait-times for appointments are excessively long. There aren't enough primary care service providers in the area. Patients seeking primary care overwhelm local emergency departments. Too few providers in the area accept Medi-Cal. Quality health insurance is unaffordable. Primary care services are available but are difficult for many people to navigate. The quality of care is low (e.g., appointments are rushed, providers lack cultural competence). It is difficult to recruit and retain primary care providers in the region. Out-of-pocket costs are too high. Specific services are unavailable here (e.g., 24- | <ul style="list-style-type: none"> Infant Mortality Child Mortality Life Expectancy Premature Age-Adjusted Mortality Premature Death Stroke Mortality Chronic Lower Respiratory Disease Mortality Diabetes Mortality Heart Disease Mortality Hypertension Mortality Cancer Mortality Liver Disease Mortality COVID-19 Case Fatality Alzheimer's Disease Mortality Influenza and Pneumonia Mortality Diabetes Prevalence Low Birthweight Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health Colorectal Cancer Prevalence Breast Cancer Prevalence Lung Cancer Prevalence Prostate Cancer Prevalence |

| Primary Data Analysis | | Secondary Data Analysis |
|---|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| Medi-Cal population is growing. <ul style="list-style-type: none"> • Need to improve follow up for those leaving the emergency department with Medi-Cal. • Community is growing rapidly and area hospitals are challenged to keep up with the demand for care. • Improve reimbursement rates for area physicians to treat the under and uninsured. • Long wait list for appointments to see a doctor. | hour pharmacies, urgent care, telemedicine). | <ul style="list-style-type: none"> • Asthma ED Rates • Asthma ED Rates for Children • Primary Care Shortage Area • Medically Underserved Area • Preventable Hospitalization • COVID-19 Cumulative Full Vaccination Rate |

4. Access to Functional Needs

Functional needs refers to needs related to adequate transportation access and conditions which promote access for individuals with physical disabilities. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those needs that promote and support a healthy life. The number of people with a disability is also an important indicator for community health and must be examined to ensure that all community members have access to necessities for a high quality of life.

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> • Placer County has little public transit. • Many residents lack transportation in order to access social and health services. • In Placer County, many need to drive out of the area for imaging and specialty care appointments. Usually takes a day or half a day to travel to see a specialist. • Lack of sidewalks in the area for walking. | <ul style="list-style-type: none"> • Many residents do not have reliable personal transportation. • Medical transport in the area is limited. • Public transportation service routes are limited. • The geography of the area makes it difficult for those without reliable transportation to get | <ul style="list-style-type: none"> • Disability • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Adult Obesity • COVID-19 Cumulative Full Vaccination Rate • Access to Public Transit |

| Primary Data Analysis | | Secondary Data Analysis |
|---|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> • Lack of transportation to appointments for lower income residents serves as a barrier. • Service area is very car centric. • Need for increased resources for those with physical disabilities. • Community safety, coupled with inadequate transportation, results in youth not signing up for afterschool activities. • Lack of reliable transportation for families trying to get to appointments with kids. • Car seats are expensive and many families lack access. • Gas is very expensive for those that have reliable personal transportation. • Need to have door to door transportation to take people to health and social appointments on short notice. • Need more public transportation bus stops and routes to get seniors where they need to go. • Nonemergency medical transport is inadequate and often too expensive. • Improve environmental signage and markings in parking lot to improve safety. Improve parking lot lighting, re-painting spaces and crosswalks, and signs to reduce speed. | <p>around.</p> <ul style="list-style-type: none"> • Public transportation is more difficult for some to residents to use (e.g., non-English speakers, seniors, parents with young children). • Public transportation schedules are limited. • Using public transportation to reach providers can take a very long time. • The cost of public transportation is too high. • The distance between service providers is inconvenient for those using public transportation. • Roads and sidewalks in the area are not well-maintained. • There aren't enough taxi and ride-share options (e.g., Uber, Lyft). | |

5. Injury and Disease Prevention and Management

Knowledge is important for individual health and well-being, and efforts aimed at injury and disease prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focus on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection (STI) prevention and influenza shots), and intensive strategies in the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

| Primary Data Analysis | | Secondary Data Analysis |
|--|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> • Access to care must include diabetes management. • Need for preventive services for women and children. • Bringing vaccinations out into the community to reduce access barriers. • Improve the built environment to make the healthy choice the easy choice. • Increase access to culturally and linguistically appropriate disease prevention education. • Improve trust in the community regarding vaccine safety. • Isolation in the aging population due to COVID-19 has reduced engagement in preventive actions. • Not enough resources for people with disabilities. • More investment in youth opportunities. • Support educational attainment to improve wage earnings. • Increase access for parental education. • Bring clinical care to where seniors live. Provide things like immunizations, education about managing chronic conditions. • Put in a designated | <ul style="list-style-type: none"> • There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease). • Health education in the schools needs to be improved. • Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision). • Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, the elderly, LGBTQ individuals, immigrants). • The community needs nutrition education opportunities. • There isn't really a focus on prevention around here. | <ul style="list-style-type: none"> • Infant Mortality • Child Mortality • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Liver Disease Mortality • Suicide Mortality • Unintentional Injuries Mortality • COVID-19 Case Fatality • Alzheimer's Disease Mortality • Diabetes Prevalence • Low Birthweight • Poor Mental Health Days • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Asthma ED Rates • Asthma ED Rates for Children • Excessive Drinking • Drug Induced Death • Adult Obesity • Physical Inactivity • Chlamydia Incidence • Adult Smoking • COVID-19 Cumulative Full Vaccination Rate • Firearm Fatalities Rate • Motor Vehicle Crash Death • Disconnected Youth • Third Grade Reading |

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| smoking area away from the buildings (complex specific). <ul style="list-style-type: none"> • Increase senior fall prevention resources in the community. • Improve road and traffic safety to reduce motor vehicle accidents. • Senior programming in Roseville is very expensive, causing many seniors to travel out of the area for access. | | Level <ul style="list-style-type: none"> • Third Grade Math Level |

6. Active Living and Healthy Eating

Physical activity and eating a healthy diet are important for one’s overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes often live in areas with fast food and other establishments where unhealthy food is sold. Under resourced communities may be challenged with food insecurity, absent the means to consistently secure food for themselves or their families, relying on food pantries and school meals often lacking in sufficient nutrition for maintaining health

| Primary Data Analysis | | Secondary Data Analysis |
|--|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> • Abundance of fast food available, but fewer grocery stores to purchase healthy foods. • Increase the number of farmers markets for fresh fruits and vegetables. • Need more healthy food | <ul style="list-style-type: none"> • The community needs nutrition education programs. • There are food deserts in the area where fresh, unprocessed foods are not available. • Food insecurity is an issue here. • Homelessness in parks or other public spaces deters their use. | <ul style="list-style-type: none"> • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality |

| Primary Data Analysis | | Secondary Data Analysis |
|--|--|--|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <p>like fresh fruits and veggies given out by the food banks.</p> <ul style="list-style-type: none"> • Many recreational programs closed in the pandemic, limiting opportunities for exercise. • Have to travel outside the community to access grocery stores for healthy food options. • Create more food choices for those with food allergies, those that are gluten free, and people with diabetes. • The need for cultural appropriate affordable opportunities to exercise in the community. • Parks need shade in the summertime as they become unusable due to heat. • Add streetlights to or by area walking trails. | <ul style="list-style-type: none"> • Students need healthier food options in schools. • The built environment doesn't support physical activity (e.g., neighborhoods aren't walk-able, roads aren't bike-friendly, or parks are inaccessible). • There aren't enough recreational opportunities in the area (e.g., organized activities, youth sports leagues). • Fresh, unprocessed foods are unaffordable. • Grocery store options in the area are limited. • Recreational opportunities in the area are unaffordable (e.g., gym memberships, recreational activity programming). • The food available in local homeless shelters and food banks is not nutritious. | <ul style="list-style-type: none"> • Cancer Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Colorectal Cancer Prevalence • Breast Cancer Prevalence • Prostate Cancer Prevalence • Asthma ED Rates • Asthma ED Rates for Children • Adult Obesity • Physical Inactivity • Limited Access to Healthy Foods • Food Environment Index • Access to Public Transit |

7. Increased Community Connections

As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests “individuals who feel a sense of security, belonging, and trust in their community have better health. People who don’t feel connected are less inclined to act in healthy ways or work with others to promote well-being for all.”⁶ Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a

⁶ Robert Wood Johnson Foundation. 2016. Building a Culture of Health: Sense of Community. Retrieved 31 Jan 2022 from <https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html>

healthy community. Further, healthcare and community support services are more effective when they are delivered in a coordinate fashion, where individual organizations collaborate with others to build a network of care.

| Primary Data Analysis | | Secondary Data Analysis |
|--|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> • Healthcare systems crossing over into programs to address social needs like housing. • Bring health care services to homeless shelters. • Increase collaboration between healthcare, schools, and churches for underserved population groups. • Fund projects that address more than one health need. • Facilitate opportunities for service providers in the area to meet and strategize on key partnerships. • Break down the silos that many community based organizations work in; encourage and fund cross-collaboration work only. • Placer County is politically divided on many issues. Important to bring leaders together and heal the community. • People feel isolated and few people to connect with. • Lacking opportunities for youth to come together. • Seniors need more resources to allow them to engage socially. • Invest in schools to continue to bring families together. • Free or low cost activities for area adults to gather. | <ul style="list-style-type: none"> • City and county leaders need to work together. • Health and social-service providers operate in silos; cross-sector connections needed. • Relations between law enforcement and the community need to be improved. • Building community connections doesn't seem like a focus in the area. • There isn't enough funding for social services in the county. • Health and social-service providers operate in silos.; Cross-sector connections needed. • People in the community face discrimination from local service providers. • The community needs to invest more in the local public schools. | <ul style="list-style-type: none"> • Infant Mortality • Child Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Suicide Mortality • Unintentional Injuries Mortality • Diabetes Prevalence • Low Birthweight • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Excessive Drinking • Drug Induced Death • Physical Inactivity • Primary Care Shortage Area • Mental Health Care Shortage Area • Medically Underserved Area • Mental Health Providers • Preventable Hospitalization • COVID-19 Cumulative Full Vaccination Rate • Homicide Rate • Firearm Fatalities Rate • Violent Crime Rate • Disconnected Youth • Children in Single-Parent |

| Primary Data Analysis | | Secondary Data Analysis |
|--|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| | | Households <ul style="list-style-type: none"> • Access to Public Transit |

8. Safe and Violence-Free Environment

Feeling safe in one’s home and community are fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) is having physical safety. Feeling unsafe affects the way people act and react to everyday life occurrences. Further, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.⁷

| Primary Data Analysis | | Secondary Data Analysis |
|---|---|--|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> • Domestic violence (DV) and intimate partner violence (IPV) related to substance use are a significant concern. • Gang activity involving adults and youth. • Lack of support staff for the domestic violence shelter in Placer County. • DV and IPV are driving up homelessness in the area. • Safety and security is of concern related to frequency of wildfires in the area. • DV and IPV resources that are culturally and linguistically appropriate. • Theft has increased in the community, especially among | <ul style="list-style-type: none"> • There are not enough resources to address domestic violence and sexual assault. • Human trafficking is an issue in the area. • People feel unsafe because of crime. • Specific groups in this community are targeted because of characteristics like race/ethnicity or age. • Youth need more safe places to go after school. • The current political environment makes some concerned for their safety. • Public parks seem unsafe because of illegal activity | <ul style="list-style-type: none"> • Life Expectancy • Premature Death • Hypertension Mortality • Poor Mental Health Days • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Physical Inactivity • Homicide Rate • Firearm Fatalities Rate • Violent Crime Rate • Motor Vehicle Crash Death • Disconnected Youth |

⁷ Lynn-Whaley, J., & Sugarmann, J. July 2017. The Relationship Between Community Violence and Trauma. Los Angeles: Violence Policy Center.

| Primary Data Analysis | | Secondary Data Analysis |
|--|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| area youth. <ul style="list-style-type: none"> • Need safe outdoor programs for youth. • Add more lights to parking lots. | taking place. <ul style="list-style-type: none"> • Gang activity is an issue in the area. • Isolated or poorly-lit streets make pedestrian travel unsafe. | |

9. Healthy Physical Environment

Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one's living environment, including the physical (natural and built) and sociocultural environment, has more impact on individual health than one's lifestyle, heredity, or access to medical services.⁸

| Primary Data Analysis | | Secondary Data Analysis |
|--|--|--|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> • Asthma is a major concern in the area. • Air quality is an issue with high levels of particulate matter. • Wildfire frequency is getting worse. • Area is heavily car based; many commuters travel for work out of the area. • Water shortage and drought a large concern in the area. • Need to increase sidewalks | <ul style="list-style-type: none"> • Low-income housing is substandard. • The air quality contributes to high rates of asthma. • Wildfires in the region harm the air quality. • Heavy traffic in the area harms the air quality. • Poor water quality is a concern in the area. • Residents' use of tobacco and e-cigarettes harms the air quality. | <ul style="list-style-type: none"> • Infant Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Chronic Lower Respiratory Disease Mortality • Hypertension Mortality • Cancer Mortality • Frequent Mental Distress • Frequent Physical Distress • Poor or Fair Health • Colorectal Cancer Prevalence |

⁸ Blum, H. L. 1983. Planning for Health. New York: Human Sciences Press

| Primary Data Analysis | | Secondary Data Analysis |
|---|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| and other walkways in the communities. <ul style="list-style-type: none"> • Need more places to exercise safely. • Smoking is very present in Placer County. Need designated areas. | <ul style="list-style-type: none"> • Industrial activity in the area harms the air quality. | <ul style="list-style-type: none"> • Breast Cancer Prevalence • Lung Cancer Prevalence • Prostate Cancer Prevalence • Asthma ED Rates • Asthma ED Rates for Children • Adult Smoking • Air Pollution - Particulate Matter • Drinking Water Violations |

10. Access to Specialty and Extended Care

Extended care services, which include specialty care, are care provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists, such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services that is needed in the community to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

| Primary Data Analysis | | Secondary Data Analysis |
|---|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> • Access to durable medical equipment. • Patients must travel out of the area because not enough providers to serve the underserved locally. • Specifically need more women's care providers and pediatrics specialists in Placer County. • Need for more respite care in the area. • In home support services for patients is lacking due to few | <ul style="list-style-type: none"> • Wait-times for specialist appointments are excessively long. • People must travel to reach specialists. • Too few specialty and extended care providers accept Medi-Cal. • The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care). • Not all specialty care is | <ul style="list-style-type: none"> • Infant Mortality • Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Diabetes Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Liver Disease Mortality • COVID-19 Case Fatality |

| Primary Data Analysis | | Secondary Data Analysis |
|--|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| providers. <ul style="list-style-type: none"> • Area lacks resources for sub-acute care for seniors. • More providers and beds to care for geriatric and pediatric patients. • Need more access to chiropractors and ophthalmologists. • Undocumented community members don't see specialists due to lack of coverage and affordability. | covered by insurance. <ul style="list-style-type: none"> • It is difficult to recruit and retain specialists in the area. • Additional hospice and palliative care options are needed. • Out-of-pocket costs for specialty and extended care are too high. • The area lacks a kind of specialist or extended care option not listed here. • There isn't enough OB/GYN care available. | <ul style="list-style-type: none"> • Alzheimer's Disease Mortality • Diabetes Prevalence • Poor Mental Health Days • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Lung Cancer Prevalence • Asthma ED Rates • Asthma ED Rates for Children • Drug Induced Death • Preventable Hospitalization |

11. Access to Dental Care and Preventive Services

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

| Primary Data Analysis | | Secondary Data Analysis |
|---|--|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| <ul style="list-style-type: none"> • Lack of dental coverage for those with Denti-Cal. • Long wait times for those un and underinsured with dental coverage. • Need more providers for both adult and pediatric dentistry. | <ul style="list-style-type: none"> • There aren't enough dental providers in the area. • There aren't enough providers in the area who accept Denti-Cal. • Dental care here is unaffordable, even if you have insurance. • People in the area have to travel to receive dental care. • Quality dental services for kids | <ul style="list-style-type: none"> • Frequent Mental Distress • Poor Physical Health Days • Frequent Physical Distress • Poor or Fair Health • Dental Care Shortage Area • Dentists |

| Primary Data Analysis | | Secondary Data Analysis |
|--|---|---|
| The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents: | | The following indicators performed worse in the service area when compared to state averages: |
| Key Informant and Focus Group Responses | Community Service Provider Survey Responses | |
| | <p>are lacking.</p> <ul style="list-style-type: none"> • The lack of access to dental care here leads to overuse of emergency departments. • It's hard to get an appointment for dental care. | |

Methods Overview

Conceptual and Process Models

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation’s County Health Rankings model.⁹ This model of population health includes the many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. For a detailed review of methods, see the technical section.

Public Comments from Previously Conducted CHNAs

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted implementation strategies. SRMC requested written comments from the public on its 2019 CHNA and most recently adopted Implementation Strategy through SHCB@sutterhealth.org.

At the time of the development of this CHNA report, SRMC had not received written comments. However, input from the broader community was incorporated in the 2022 CHNA through key informant interviews, focus groups, and the service provider survey. SRMC will continue to use its website as a tool to solicit public comments and ensure that these comments are considered as community input in the development of future CHNAs.

Data Used in the CHNA

Data collected and analyzed included both primary or qualitative data and secondary or quantitative data. Primary data included 17 interviews with 33 community health experts, 4 focus groups conducted with a total of 59 community residents or community-facing service providers, and 69 responses to the

⁹ Robert Wood Johnson Foundation, and University of Wisconsin, 2021. County Health Rankings Model. Retrieved 31 Jan 2022 from <http://www.countyhealthrankings.org/>.

Community Service Provider survey. (A full listing of all participants can be seen in the technical section of this report.)

Secondary data included multiple datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at subcounty levels was used to identify portions of the hospital service area with greater concentrations of disadvantaged populations and poor health outcomes. A set of county-level indicators was collected from various sources to help identify and prioritize significant health needs. Additionally, socioeconomic indicators were collected to help describe the overall social conditions within the service area. Health outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health factor indicators included measures of 1) health behaviors, such as diet, exercise, and tobacco, alcohol, and drug use; 2) clinical care, including access to quality care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, neighborhood safety, and similar; and 4) physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 86 different health-outcome and health factor indicators were collected for the CHNA.

Data Analysis

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the SRMC service area. This included identifying 12 PHNs in these communities. These potential health needs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the hospital's service area. After these were identified, health needs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need.

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

Description of Community Served

The definition of the community served was the primary service area of SRMC, located in Roseville, California. The service area was defined by 21 ZIP Codes that stretch over Placer, Sacramento, and Sutter Counties. This service area was designated because the majority of patients served by SRMC resided in these ZIP Codes.

Though located in Placer County, the hospital serves a diverse population across both Sacramento and Placer Counties. Situated in Roseville along the I-80 corridor that runs from the San Francisco Bay area to Reno, Nevada and beyond, SRMC sits near the border of these two counties. There were 11 ZIP codes included in the service area in Placer County (one ZIP code is shared with Sutter County) and contain communities such as Granite Bay, Lincoln, Loomis, Penryn, Rocklin, Roseville, and Sheridan. In Sacramento County there were 10 ZIP Codes included in the assessment, and these encompassed communities such as Antelope, Carmichael, Citrus Heights, Folsom, North Highlands, and Orangevale. Collectively, the SRMC service area is home to 725,725 residents. The service area is shown in Figure 2.

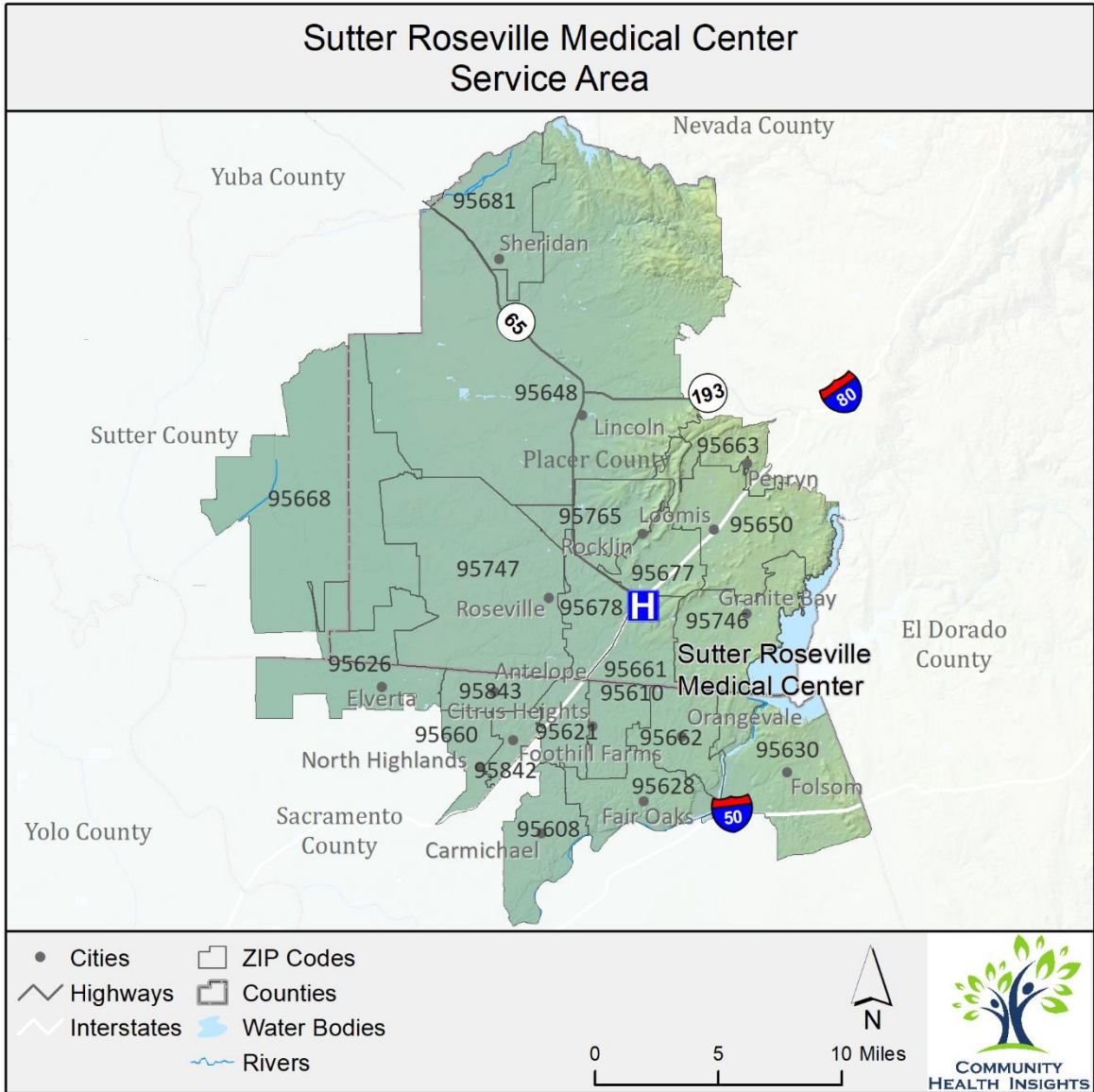


Figure 2: Community served by SRMC.

Population characteristics for each ZIP Code in the service area are presented in Table 2. These are compared to the state and county characteristics for descriptive purposes. Any ZIP Code with values that compared negatively to the state or county is highlighted.

Table 2: Population characteristics for each ZIP Code located in the SRMC service area.

| ZIP Code | Total Population | % Non-White or Hispanic\Latinx | Median Age (yrs.) | Median Income | % Poverty | % Unemployment | % Uninsured | % Without High School Graduation | % With High Housing Costs | % With Disability |
|------------|------------------|--------------------------------|-------------------|---------------|-----------|----------------|-------------|----------------------------------|---------------------------|-------------------|
| 95608 | 62,539 | 30.8 | 41.7 | \$64,059 | 14.7 | 6.5 | 6 | 6.7 | 38.7 | 15.4 |
| 95610 | 46,305 | 31.8 | 36.5 | \$61,461 | 12.1 | 6.2 | 6.8 | 10 | 41.6 | 15.9 |
| 95621 | 41,740 | 29 | 39.7 | \$63,214 | 10.8 | 6.2 | 4.7 | 9.3 | 36.5 | 15.5 |
| 95626 | 6,065 | 28.2 | 41.4 | \$75,481 | 11.4 | 4.4 | 7.5 | 12.2 | 35.9 | 10.1 |
| 95628 | 40,855 | 25.7 | 45.4 | \$86,181 | 8.4 | 4.7 | 4.7 | 5.5 | 31.6 | 11.1 |
| 95630 | 78,159 | 38.2 | 40.7 | \$114,405 | 5.6 | 3.1 | 2.5 | 6.2 | 28.2 | 7.6 |
| 95660 | 35,461 | 54.4 | 31.1 | \$45,845 | 25.1 | 4.6 | 7.2 | 18.2 | 44.6 | 11.6 |
| 95662 | 32,172 | 23.6 | 41.2 | \$80,434 | 7.9 | 5.4 | 5.2 | 6.6 | 34.9 | 13.7 |
| 95842 | 33,522 | 48.6 | 32.9 | \$53,458 | 19.7 | 8.3 | 7.2 | 13.3 | 45.8 | 12.9 |
| 95843 | 47,823 | 41.3 | 32.9 | \$81,028 | 11.2 | 3.5 | 5.8 | 7.2 | 35.8 | 8.5 |
| Sacramento | 1,524,553 | 55.3 | 36.2 | \$67,151 | 14.7 | 6.5 | 5.5 | 12.3 | 37.9 | 11.8 |
| 95648 | 52,949 | 30.4 | 43.5 | \$88,158 | 8 | 3.4 | 3.5 | 6.9 | 33.8 | 11.8 |
| 95650 | 14,808 | 16.7 | 48 | \$102,107 | 5.5 | 3 | 3.1 | 4.9 | 33.2 | 8.9 |
| 95661 | 31,315 | 25.5 | 41.6 | \$86,823 | 8 | 4.4 | 4.6 | 5.6 | 34.7 | 11.6 |
| 95663 | 2,493 | 16.1 | 48.5 | \$106,500 | 5 | 4.9 | 2.9 | 5.6 | 33 | 8.8 |
| 95677 | 25,477 | 25.1 | 38.6 | \$87,742 | 8.6 | 4.8 | 5.2 | 5.7 | 35.5 | 10.2 |
| 95678 | 42,053 | 35.5 | 37 | \$73,253 | 10.8 | 4.6 | 6.2 | 6.5 | 38.6 | 10.3 |
| 95681 | 1,246 | 5.9 | 48.5 | \$44,833 | 2.4 | 0 | 3.3 | 13.7 | 69.9 | 11.2 |
| 95746 | 23,934 | 27.6 | 45.9 | \$147,201 | 3.7 | 4.4 | 2.3 | 3.2 | 27.1 | 9.3 |
| 95747 | 66,931 | 34.9 | 39.5 | \$105,431 | 7.6 | 4.8 | 2.6 | 4.9 | 31.4 | 10.2 |
| 95765 | 39,214 | 32.2 | 36.6 | \$108,188 | 3.7 | 4 | 3.4 | 2.8 | 33.4 | 7.1 |
| 95668 | 664 | 18.1 | 40.6 | \$64,063 | 11.6 | 7.9 | 10.5 | 7.6 | 31.9 | 15.4 |
| Placer | 385,512 | 27.3 | 42 | \$89,691 | 7.7 | 4.2 | 4 | 5.5 | 34.5 | 10.6 |
| California | 39,283,497 | 62.8 | 36.5 | \$75,235 | 13.4 | 6.1 | 7.5 | 16.7 | 40.6 | 10.6 |

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

Health Equity

The Robert Wood Johnson Foundation’s definition of health equity and social justice is used here to help establish a common understanding for the concept of health equity.

“Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”¹⁰

Inequities experienced early and throughout one’s life, such as limited access to a quality education, have health consequences that appear later in life as health disparities. Health disparities are defined as “preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation.”¹¹

In the US, and many parts of the world inequities are most apparent when comparing various racial and ethnic groups to one another. Using these comparisons between racial and ethnic populations, it’s clear that health inequities persist across communities, including Sacramento and Placer Counties.

This section of the report shows inequities in health outcomes, comparing these between race and ethnic groups. These differences inform better planning for more targeted interventions.

Health Outcomes - the Results of Inequity

The table below displays disparities among race and ethnic groups for the HSA for life expectancy, mortality, and low birthweight.

Table 3: Health outcomes comparing race and ethnicity in the SRMC service area.

| Health Outcomes | Description | American Indian\ Alaska Native | Asian | Black | Hispanic | White | Overall |
|-------------------|--|--------------------------------|-------|-------|----------|-------|---------|
| Sacramento | | | | | | | |
| Life Expectancy | Average number of years a person can expect to live. | 81.7 | 89 | 80.1 | 85.6 | 81.8 | 82.4 |
| Child Mortality | Number of deaths among children under age 18 per 100,000 population. | ~ | ~ | ~ | 24.5 | 28.9 | 27.1 |

¹⁰ Robert Wood Johnsons Foundation. 2017. What is Health Equity? And What Difference Does a Definition Make?. Health Equity Issue Brief #1. Retrieved 31 Jan 2022 from https://buildhealthyplaces.org/content/uploads/2017/05/health_equity_brief_041217.pdf .

¹¹ Center for Disease Control and Prevention. 2008. Health Disparities Among Racial/Ethnic Populations. Community Health and Program Services (CHAPS): Atlanta: U.S. Department of Health and Human Services.

| Health Outcomes | Description | American Indian\ Alaska Native | Asian | Black | Hispanic | White | Overall |
|----------------------------------|--|--------------------------------|---------|----------|----------|---------|---------|
| Premature Age-Adjusted Mortality | Number of deaths among residents under age 75 per 100,000 population (age-adjusted). | 369.6 | 125.6 | 294.3 | 179.1 | 240.3 | 226.4 |
| Premature Death | Years of potential life lost before age 75 per 100,000 population (age-adjusted). | ~ | 2,651.3 | 5,369.3 | 3,684.5 | 4,779.9 | 4,471.2 |
| Low Birthweight | Percentage of live births with low birthweight (< 2,500 grams). | ~ | 7.1% | 10.5% | 6.5% | 5.1% | 5.7% |
| Placer | | | | | | | |
| Infant Mortality | Number of all infant deaths (within 1 year), per 1,000 live births. | ~ | 4.6 | 8.6 | 4.7 | 3.8 | 4.9 |
| Life Expectancy | Average number of years a person can expect to live. | 74.8 | 84.9 | 75.1 | 82.8 | 78.9 | 79.6 |
| Child Mortality | Number of deaths among children under age 18 per 100,000 population. | ~ | 35.9 | 62.3 | 39.8 | 37.9 | 41.5 |
| Premature Age-Adjusted Mortality | Number of deaths among residents under age 75 per 100,000 population (age-adjusted). | 479 | 217.8 | 523.2 | 258.5 | 338.7 | 325 |
| Premature Death | Years of potential life lost before age 75 per 100,000 population (age-adjusted). | 10,827.8 | 4,368.2 | 10,712.7 | 5,352.6 | 6,430.7 | 6,381.6 |
| Low Birthweight | Percentage of live births with low birthweight (< 2,500 grams). | 7.9% | 8.1% | 11% | 6.4% | 5.4% | 6.9% |

~ Data Not Available

Data sources included in the technical section of the report.

Health outcome data by race and ethnic group for Sacramento County showed that the Black community had the lowest life expectancy, highest premature age-adjusted mortality, highest premature death, and highest percentage of low birthweight babies. Data showed the Black community with the highest infant mortality rate, at almost twice the overall Placer County rate. Other Placer County health outcome data showed the American Indian/Alaska Native community with the lowest life expectancy, high premature age-adjusted mortality, and highest premature death rate. Black community members had the highest low birthweight percentage at 11%, drastically higher than any other group in Placer County and the state percentage..

Health Factors - Inequities in the Service Area

Inequalities can be seen in data that help describe health factors in the HSA, such as education attainment and income. These health factors are displayed in the table below and are compared across race and ethnic groups.

Table 4: Health factors comparing race and ethnicity in the SRMC service area.

| Health Factors | Description | American Indian\ Alaska Native | Asian | Black | Hispanic | White | Overall |
|-------------------------------------|---|--------------------------------|-----------|----------|----------|----------|----------|
| Sacramento | | | | | | | |
| Some College ^a | Percentage of adults ages 25 and over with some post-secondary education. | 66.3% | 83.1% | 79.6% | 59.5% | 78.4% | 76.6% |
| High School Completion ^a | Percentage of adults ages 25 and over with at least a high school diploma or equivalent. | 89.6% | 94.3% | 96.7% | 81.9% | 96.4% | 94.5% |
| Third Grade Reading Level | Average grade level performance for 3rd graders on English Language Arts standardized tests | ~ | 3.7 | 2.7 | 2.8 | 3.3 | 3.2 |
| Third Grade Math Level | Average grade level performance for 3rd graders on math standardized tests | ~ | 3.6 | 2.6 | 2.6 | 3.1 | 3.1 |
| Children in Poverty | Percentage of people under age 18 in poverty. | 29.3% | 7.4% | 4.8% | 15.3% | 5.9% | 7.5% |
| Median Household Income | The income where half of households in a county earn more and half of households earn less. | \$44,574 | \$121,425 | \$85,429 | \$72,709 | \$90,077 | \$97,688 |
| Uninsured Population ^b | Percentage of the civilian non-institutionalized population without health insurance. | 3.9% | 3.5% | 4.1% | 6.9% | 3.5% | 4% |
| Placer | | | | | | | |
| Some College ^a | Percentage of adults ages 25 and over with some post-secondary education. | 55.7% | 65% | 65.3% | 46.7% | 72.6% | 65.3% |
| High School Completion ^a | Percentage of adults ages 25 and over with at least a high school diploma or equivalent. | 81.5% | 82.2% | 90.1% | 74% | 94.2% | 87.7% |

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

~ Data Not Available

Unless otherwise noted, data sources included in the technical section of the report.

^aFrom 2019 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.

^bFrom 2019 American Community Survey 5-year estimates table S2701.

Health factor data for Sacramento County showed that Hispanics have the lowest percentage of some college and high school completion, low third grade reading and math levels and highest percentage of uninsured population compared to other race and ethnic groups. Data also revealed the American Indian/Alaska Native community with the highest percentage of children living in poverty and the lowest median household income. Placer County health factor data by race and ethnicity showed low college and high school completion percentages for Hispanics, along with the highest percentage of uninsured. Further data for the Black Community in Placer County showed the lowest third grade reading and math levels, high percent of children in poverty and lowest median household income.

Population Groups Experiencing Disparities

The figure below describes populations in the SRMC service area identified through qualitative data analysis that were identified as experiencing health disparities. Interview participants were asked, “What specific groups of community members experience health issues the most?” Responses were analyzed by counting the total number of times all key informants and focus-group participants mentioned a particular group as one experiencing disparities. Figure 3 displays the results of this analysis. The groups are not mutually exclusive—one group could be a subset of another group. One of the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups.

Frequency of Mentions in Interviews

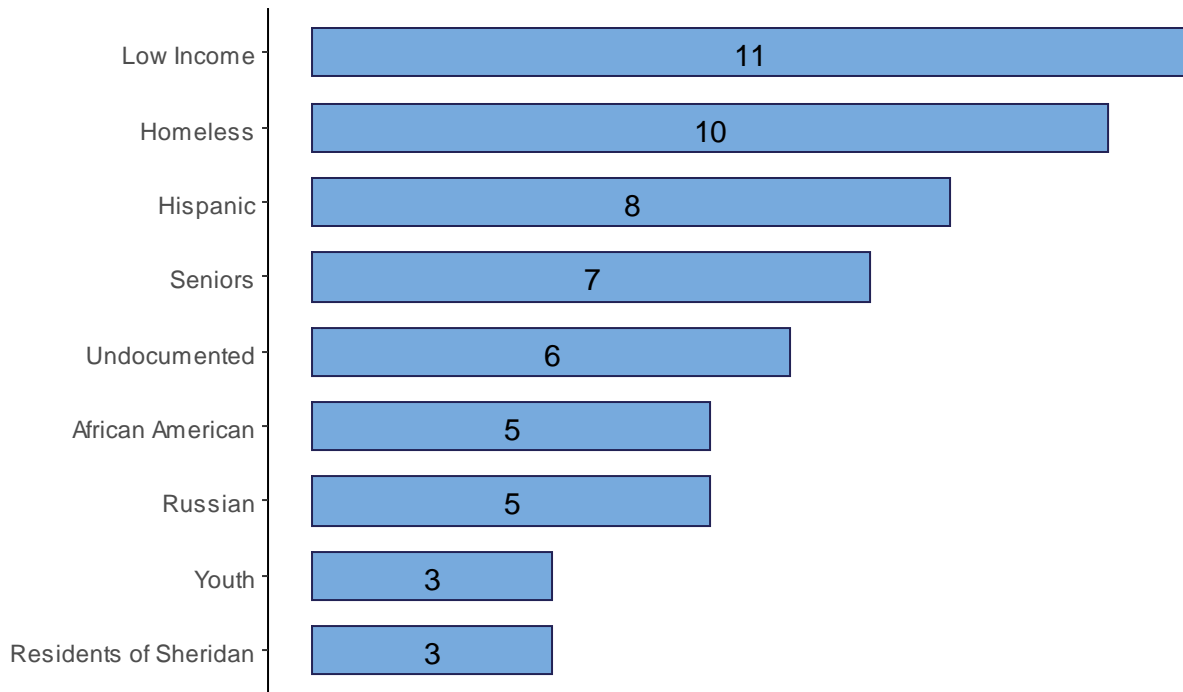


Figure 3: Populations experiencing disparities the SRMC service area.

California Healthy Places Index

Figure 4 displays the California Healthy Places Index (HPI)¹² values for the SRMC service area. The HPI is an index based on 25 health-related measures for communities across California. These measures included in the HPI were selected based on their known relationship to life expectancy and other health outcomes. These values are combined into a final score representing the overall health and well-being of the community which can then be used to compare the factors influencing health between communities. Higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present.

¹² Public Health Alliance of Southern California. 2021. The California Health Places Index (HPI): About. Retrieved 26 July 2021 from <https://healthyplacesindex.org/about/>.

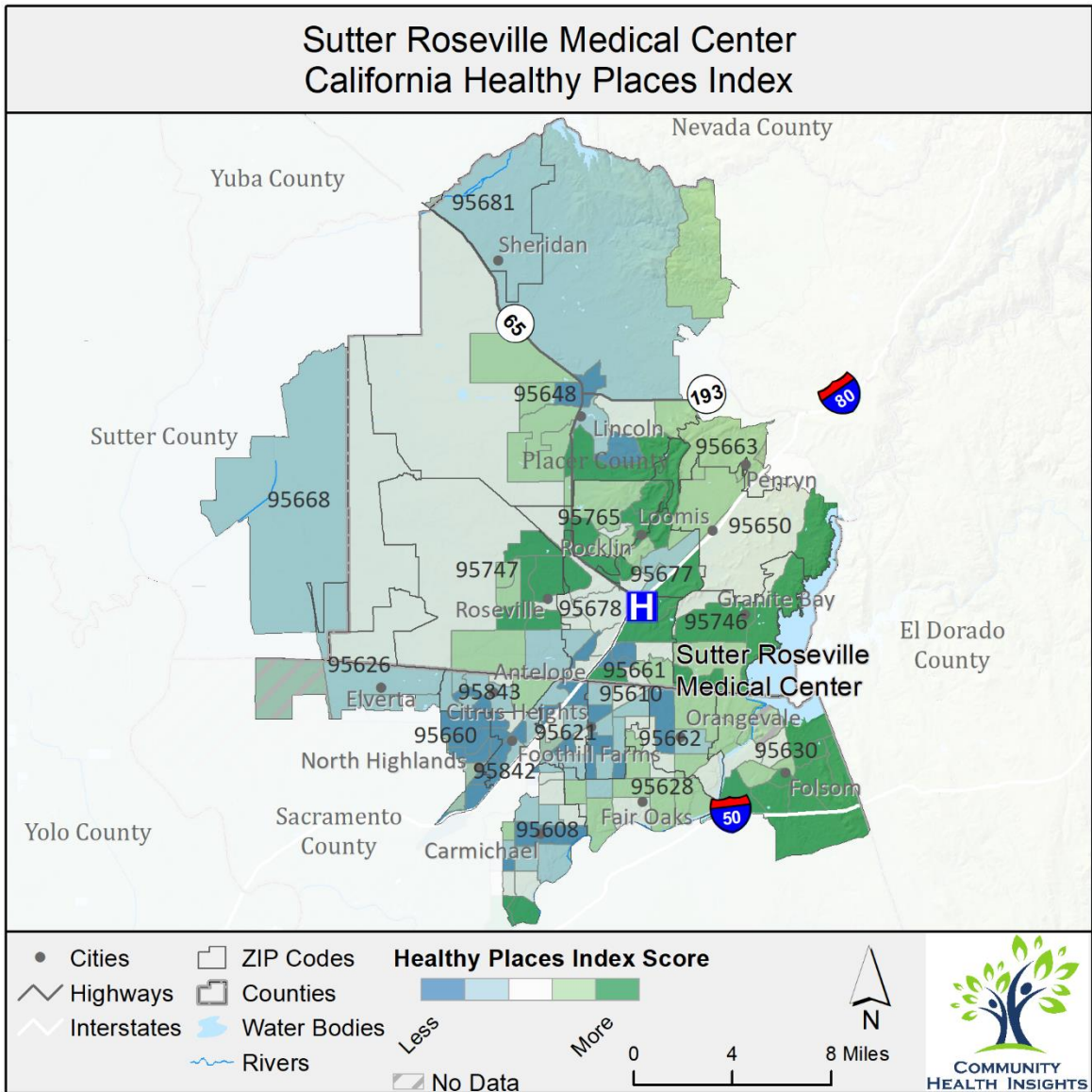


Figure 4: Healthy Places Index for SRMC.

Areas with the darkest blue shading in Figure 4 have the lowest overall HPI scores, indicating factors leading to less healthy neighborhoods. Many of the smaller census tracts in Sacramento County along HWY 80, portions of Auburn in ZIP code 95648 have lower scores. There are likely to be a higher concentration of residents in these locations experiencing health disparities.

Communities of Concern

Communities of Concern are geographic areas within the service area that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA methodology because, after the service area has been assessed more broadly, they allow for a focus on those portions of the region likely experiencing the greatest health disparities. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the technical section of this report for an in-depth description of how these are identified). Analysis of both primary and secondary data revealed 8 ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 5, with the census population provided for each, and are displayed in Figure 5.

Table 5: Identified Communities of Concern for the SRMC service area.

| ZIP Code | Community\Area | Population |
|--|-----------------|----------------|
| 95608 | Carmichael | 62,539 |
| 95610 | Citrus Heights | 46,305 |
| 95621 | Citrus Heights | 41,740 |
| 95648 | Lincoln | 52,949 |
| 95660 | North Highlands | 35,461 |
| 95661 | Roseville | 31,315 |
| 95662 | Orangevale | 32,172 |
| 95678 | Roseville | 42,053 |
| <i>Total Population in Communities of Concern</i> | | <i>344,534</i> |
| <i>Total Population in Hospital Service Area</i> | | <i>725,725</i> |
| <i>Percentage of Service Area Population in Community of Concern</i> | | <i>47.5%</i> |

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

Figure 5 displays the ZIP Codes highlighted in pink that are Communities of Concern for the SRMC service area.

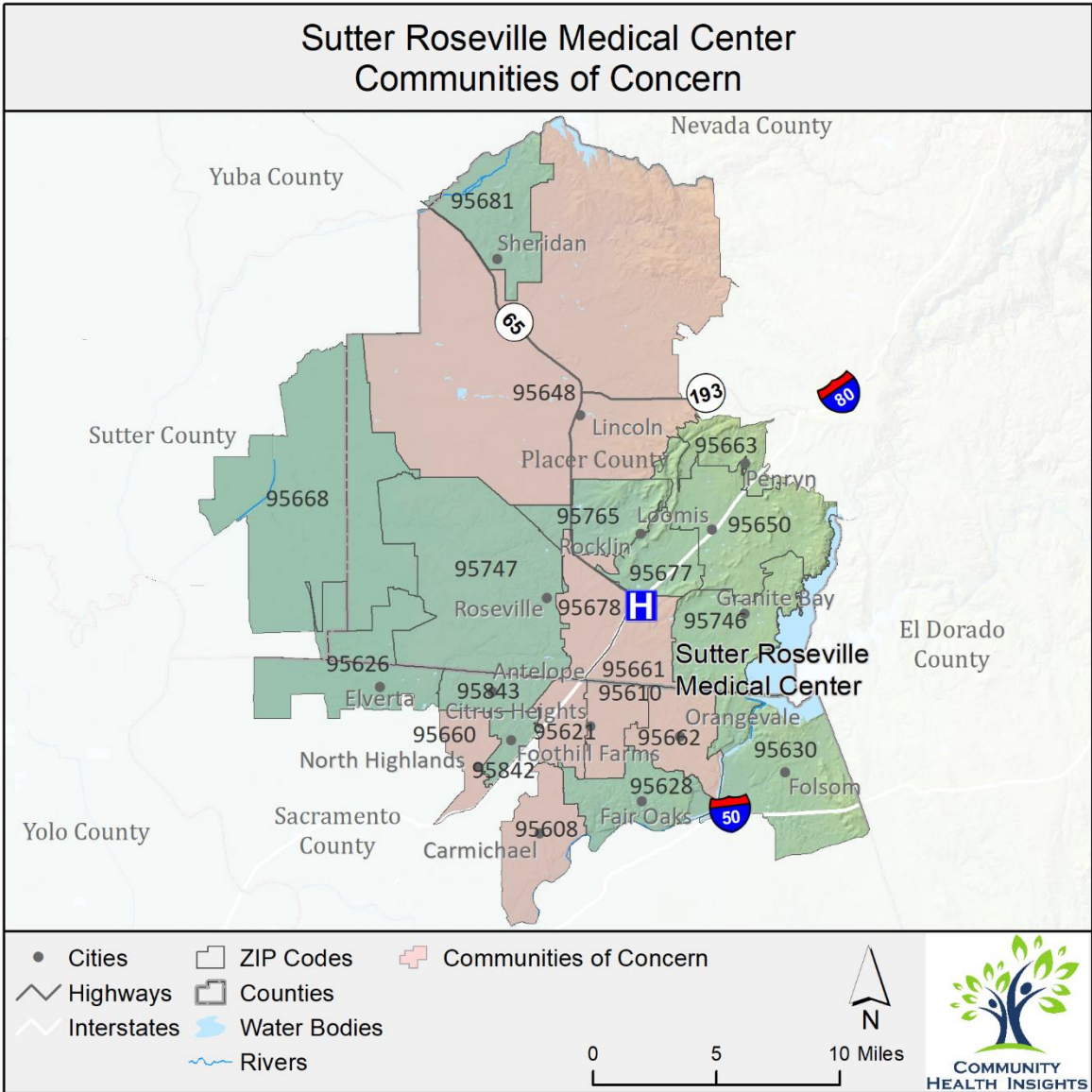


Figure 5: SRMC Communities of Concern.

The Impact of COVID-19 on Health Needs

COVID-19 related health indicators regard the HSA are noted in Table 6.

Table 6: COVID-19-related rates for the SRMC service area.

| Indicators | Description | Sacramento | Placer | California | |
|---|--|------------|----------|------------|--|
| COVID-19 Mortality | Number of deaths due to COVID-19 per 100,000 population. | 198.2 | 162.4 | 229.7 | Sacramento: 198.2 Placer: 162.4 California: 229.7 |
| COVID-19 Case Fatality | Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases. | 1.0% | 1.0% | 1.0% | Sacramento: 1% Placer: 1% California: 1% |
| COVID-19 Cumulative Incidence | Number of laboratory-confirmed COVID-19 cases per 100,000 population. | 18,912.8 | 16,713.4 | 22,294.0 | Sacramento: 18,912.8 Placer: 16,713.4 California: 22,294 |
| COVID-19 Cumulative Full Vaccination Rate | Number of completed COVID-19 vaccinations per 100,000 population. | 69,060.2 | 69,453.1 | 71,068.4 | Sacramento: 69,060.2 Placer: 69,453.1 California: 71,068.4 |

COVID-19 data collected on May 19 2022

COVID-19 data revealed that both Sacramento and Placer Counties had lower COVID-19 mortality rates, equal case fatality rates, and lower cumulative incidence rates in comparison to the state. Both counties also had lower full vaccination rates in comparison to the state benchmarks.

Key informants and focus group participants were asked how the COVID-19 pandemic had impacted the health needs they described during interviews. Community survey provider survey respondents were also asked to identify ways in which COVID-19 impacted health needs in the communities they served. A summary of their responses is shown in Table 7.

Table 7: The impacts of COVID-19 on health need as identified in primary data sources.

| Key Informant and Focus Group Responses | Community Service Provider Survey Responses |
|--|---|
| <ul style="list-style-type: none"> • Food insecurity worsened. • There was an increase in homelessness. • It was difficult for community organizations to keep up with changing rules and guidelines around the pandemic. • Kids fell behind in school due to the digital divide. • People who were poorly housed struggled to stay healthy. • Youth struggled with a loss of resources. • There was an increase in addiction and relapse. • There were more financial and emotional stressors. • A lack of trust developed in the community between those that chose to be vaccinated and those that did not get vaccinated. • Public Health was underfunded to meet needs that came up during the pandemic. • The pandemic put stress on the health care delivery system. • Access to care was impacted in that people could not get in for routine care and screenings. • Mental health issues increased for youth feeling isolated when schools and other activities shut down. • Affordable housing has been an issue in the community and it seemed to get worse during the pandemic because options were so limited. • People who were isolated did not make the healthiest choices and became less healthy during the pandemic. • Many residents dealt with isolation issues that resulted in more mental health and behavioral health issues and needs. • People with chronic illness did not keep up with their care and their conditions got worse. • Dental care and other preventative services were put off. • People lost their jobs and struggled with economic hardship. Many are still trying to catch up on bills. • There was an increase in alcohol use. • More people were showing up in the emergency department in a mental health crisis. • Seniors became fearful and afraid to go out and that added to their isolation. • People were experiencing more domestic violence and child abuse due to increased stress and being home. • Teens served by one community-based organization | <ul style="list-style-type: none"> • Isolation is harming the mental health of community members. • Residents encounter economic hardships from lost or reduced employment. • Residents delay or forgo healthcare to limit their exposure to the virus. • Youth no longer have ready access to the services they previously received at school (e.g., free/reduced lunch, mental and physical health services). • Residents in the community are being evicted from their homes. |

| Key Informant and Focus Group Responses | Community Service Provider Survey Responses |
|---|---|
| <p>had a 40% increase in suicide ideation.</p> <ul style="list-style-type: none"> • Accessing needed services and resources that switch to a virtual format was difficult for those with limited access to the internet and computers. • Stress and anxiety went up across the community. • Families struggled with online learning due to a lack of technology in the home. • Language barriers created challenges to the flow of information about the pandemic in the community. • People from the Bay Area moved to the community, which drove up housing costs, resulting in people losing their rentals because property owners wanted to sell their homes for a big profit. Service workers were especially impacted by this situation. | |

Resources Potentially Available to Meet the Significant Health Needs

In all, 361 resources were identified in the SRMC service area that were potentially available to meet the identified significant health needs. These resources were provided by a total of 131 social service, nonprofit, and governmental organizations, agencies, and programs identified in the CHNA. The identification method included starting with the list of resources from the 2019 Sutter Roseville Medical Center CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 8.

Table 8: Resources potentially available to meet significant health needs in priority order.

| Significant Health Needs (in Priority Order) | Number of Resources |
|---|---------------------|
| Access to Basic Needs Such as Housing, Jobs, and Food | 70 |
| Access to Mental/Behavioral Health and Substance Use Services | 54 |
| Access to Quality Primary Care Health Services | 40 |
| Access to Functional Needs | 5 |
| Injury and Disease Prevention and Management | 49 |
| Active Living and Healthy Eating | 35 |
| Increased Community Connections | 51 |
| Safe and Violence-Free Environment | 22 |
| Healthy Physical Environment | 3 |
| Access to Specialty and Extended Care | 22 |
| Access to Dental Care and Preventive Services | 10 |
| Total Resources | 361 |

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

Impact and Evaluation of Actions Taken by Hospital

Regulations require that each hospital's CHNA report include "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s) (p. 78969)." ¹³ SRMC invested efforts to address the significant health needs identified in the prior CHNA. Appendix A includes details of those efforts.

Conclusion

CHNAs play an important role in helping nonprofit hospitals and other community organizations determine where to focus community benefit and health improvement efforts, including targeting efforts in geographic locations and on specific populations experiencing inequities leading to health disparities. Data in the CHNA report can help provide nonprofit hospitals and community service providers with content to work in collaboration to engage in meaningful community work.

¹³ Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

2022 CHNA Technical Section

The following section presents a detailed account of data collection, analysis, and results for the Sutter Roseville Medical Center (SRMC) Hospital Service Area (HSA).

Results of Data Analysis

Compiled Secondary Data

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

Length of Life

Table 9: County length of life indicators compared to state benchmarks.

| Indicators | Description | Sacramento | Placer | California | |
|----------------------------------|--|------------|--------|------------|---|
| Early Life | | | | | |
| Infant Mortality | Number of all infant deaths (within 1 year), per 1,000 live births. | 4.9 | 3.5 | 4.2 | Sacramento: 4.9 Placer: 3.5 California: 4.2 |
| Child Mortality | Number of deaths among children under age 18 per 100,000 population. | 41.5 | 27.1 | 36.0 | Sacramento: 41.5 Placer: 27.1 California: 36 |
| Life Expectancy | Average number of years a person can expect to live. | 79.6 | 82.4 | 81.7 | Sacramento: 79.6 Placer: 82.4 California: 81.7 |
| Overall | | | | | |
| Premature Age-Adjusted Mortality | Number of deaths among residents under age 75 per 100,000 population (age-adjusted). | 325.0 | 226.4 | 268.4 | Sacramento: 325 Placer: 226.4 California: 268.4 |

| Indicators | Description | Sacramento | Placer | California | |
|---|---|------------|---------|------------|---|
| Premature Death | Years of potential life lost before age 75 per 100,000 population (age-adjusted). | 6,381.6 | 4,471.2 | 5,253.1 | Sacramento: 6,381.6 Placer: 4,471.2 California: 5,253.1 |
| Stroke Mortality | Number of deaths due to stroke per 100,000 population. | 47.0 | 54.5 | 41.2 | Sacramento: 47 Placer: 54.5 California: 41.2 |
| Chronic Lower Respiratory Disease Mortality | Number of deaths due to chronic lower respiratory disease per 100,000 population. | 40.6 | 46.8 | 34.8 | Sacramento: 40.6 Placer: 46.8 California: 34.8 |
| Diabetes Mortality | Number of deaths due to diabetes per 100,000 population. | 30.2 | 24.1 | 24.1 | Sacramento: 30.2 Placer: 24.1 California: 24.1 |
| Heart Disease Mortality | Number of deaths due to heart disease per 100,000 population. | 171.1 | 186.5 | 159.5 | Sacramento: 171.1 Placer: 186.5 California: 159.5 |
| Hypertension Mortality | Number of deaths due to hypertension per 100,000 population. | 17.8 | 12.8 | 13.8 | Sacramento: 17.8 Placer: 12.8 California: 13.8 |
| Cancer, Liver, and Kidney Disease | | | | | |
| Cancer Mortality | Number of deaths due to cancer per 100,000 population. | 169.7 | 199.9 | 152.9 | Sacramento: 169.7 Placer: 199.9 California: 152.9 |
| Liver Disease Mortality | Number of deaths due to liver disease per 100,000 population. | 13.7 | 15.3 | 13.9 | Sacramento: 13.7 Placer: 15.3 California: 13.9 |


| Indicators | Description | Sacramento | Placer | California | |
|---|---|------------|--------|------------|---|
| Kidney Disease Mortality | Number of deaths due to kidney disease per 100,000 population. | 3.6 | 9.5 | 9.7 | Sacramento: 3.6 Placer: 9.5 California: 9.7 |
| Intentional and Unintentional Injuries | | | | | |
| Suicide Mortality | Number of deaths due to suicide per 100,000 population. | 13.6 | 13.8 | 11.2 | Sacramento: 13.6 Placer: 13.8 California: 11.2 |
| Unintentional Injuries Mortality | Number of deaths due to unintentional injuries per 100,000 population. | 43.5 | 39.6 | 35.7 | Sacramento: 43.5 Placer: 39.6 California: 35.7 |
| COVID-19 | | | | | |
| COVID-19 Mortality | Number of deaths due to COVID-19 per 100,000 population. | 198.2 | 162.4 | 229.7 | Sacramento: 198.2 Placer: 162.4 California: 229.7 |
| COVID-19 Case Fatality | Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases. | 1.0% | 1.0% | 1.0% | Sacramento: 1% Placer: 1% California: 1% |
| Other | | | | | |
| Alzheimer's Disease Mortality | Number of deaths due to Alzheimer's disease per 100,000 population. | 47.3 | 62.4 | 41.2 | Sacramento: 47.3 Placer: 62.4 California: 41.2 |
| Influenza and Pneumonia Mortality | Number of deaths due to influenza and pneumonia per 100,000 population. | 16.2 | 17.5 | 16.0 | Sacramento: 16.2 Placer: 17.5 California: 16 |

Quality of Life

Table 10: County quality of life indicators compared to state benchmarks.

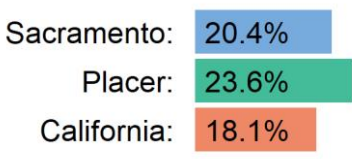
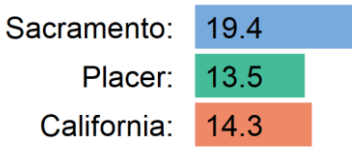
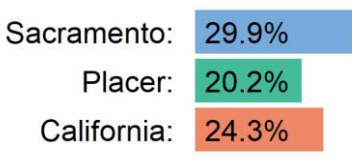
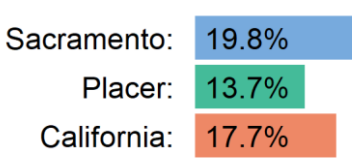
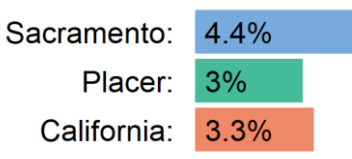
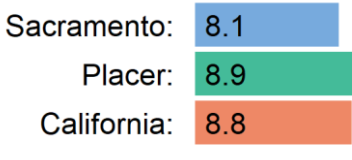
| Indicators | Description | Sacramento | Placer | California | |
|---------------------------|--|------------|--------|------------|---|
| Chronic Disease | | | | | |
| Diabetes Prevalence | Percentage of adults ages 20 and above with diagnosed diabetes. | 9.4% | 7.0% | 8.8% | Sacramento: 9.4% Placer: 7% California: 8.8% |
| Low Birthweight | Percentage of live births with low birthweight (< 2,500 grams). | 6.9% | 5.7% | 6.9% | Sacramento: 6.9% Placer: 5.7% California: 6.9% |
| HIV Prevalence | Number of people ages 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population. | 335.2 | 105.6 | 395.9 | Sacramento: 335.2 Placer: 105.6 California: 395.9 |
| Disability | Percentage of the total civilian noninstitutionalized population with a disability | 11.8% | 10.6% | 10.6% | Sacramento: 11.8% Placer: 10.6% California: 10.6% |
| Mental Health | | | | | |
| Poor Mental Health Days | Average number of mentally unhealthy days reported in past 30 days (age-adjusted). | 4.5 | 3.8 | 3.7 | Sacramento: 4.5 Placer: 3.8 California: 3.7 |
| Frequent Mental Distress | Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted). | 13.3% | 11.8% | 11.3% | Sacramento: 13.3% Placer: 11.8% California: 11.3% |
| Poor Physical Health Days | Average number of physically unhealthy days reported in past 30 days (age-adjusted). | 4.2 | 3.7 | 3.9 | Sacramento: 4.2 Placer: 3.7 California: 3.9 |



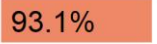
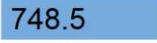

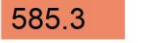
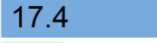

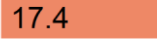
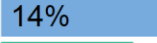
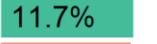
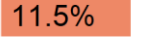
| Indicators | Description | Sacramento | Placer | California | |
|-------------------------------|--|------------|----------|------------|--|
| Frequent Physical Distress | Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted). | 12.6% | 10.8% | 11.6% | Sacramento: 12.6% Placer: 10.8% California: 11.6% |
| Poor or Fair Health | Percentage of adults reporting fair or poor health (age-adjusted). | 18.3% | 12.5% | 17.6% | Sacramento: 18.3% Placer: 12.5% California: 17.6% |
| Cancer | | | | | |
| Colorectal Cancer Prevalence | Colon and rectum cancers per 100,000 population (age-adjusted). | 37.8 | 34.9 | 34.8 | Sacramento: 37.8 Placer: 34.9 California: 34.8 |
| Breast Cancer Prevalence | Female in situ breast cancers per 100,000 female population (age-adjusted). | 31.8 | 37.9 | 27.9 | Sacramento: 31.8 Placer: 37.9 California: 27.9 |
| Lung Cancer Prevalence | Lung and bronchus cancers per 100,000 population (age-adjusted). | 52.1 | 44.3 | 40.9 | Sacramento: 52.1 Placer: 44.3 California: 40.9 |
| Prostate Cancer Prevalence | Prostate cancers per 100,000 male population (age-adjusted). | 79.2 | 112.8 | 91.2 | Sacramento: 79.2 Placer: 112.8 California: 91.2 |
| COVID-19 | | | | | |
| COVID-19 Cumulative Incidence | Number of laboratory-confirmed COVID-19 cases per 100,000 population. | 18,912.8 | 16,713.4 | 22,294.0 | Sacramento: 18,912.8 Placer: 16,713.4 California: 22,294 |
| Other | | | | | |
| Asthma ED Rates | Emergency department visits due to asthma per 10,000 (age-adjusted). | 641.0 | 329.0 | 422.0 | Sacramento: 641 Placer: 329 California: 422 |

| Indicators | Description | Sacramento | Placer | California | |
|------------------------------|---|------------|--------|------------|--|
| Asthma ED Rates for Children | Emergency department visits due to asthma among ages 5-17 per 10,000 population ages 5-17 (age-adjusted). | 759.0 | 355.0 | 601.0 | Sacramento:  Sacramento: 759 Placer: 355 California: 601 |

Health Behavior

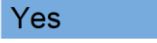



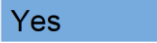

Table 11: County health behavior indicators compared to state benchmarks.






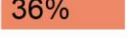
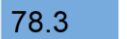



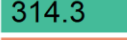
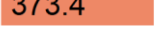
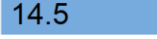
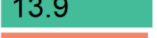

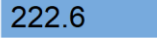
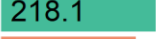
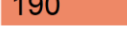
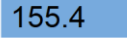

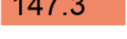
| Indicators | Description | Sacramento | Placer | California | |
|---------------------------------|---|------------|--------|------------|--|
| Excessive Drinking | Percentage of adults reporting binge or heavy drinking (age-adjusted). | 20.4% | 23.6% | 18.1% | Sacramento:  Sacramento: 20.4% Placer: 23.6% California: 18.1% |
| Drug Induced Death | Drug induced deaths per 100,000 (age-adjusted). | 19.4 | 13.5 | 14.3 | Sacramento:  Sacramento: 19.4 Placer: 13.5 California: 14.3 |
| Adult Obesity | Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2. | 29.9% | 20.2% | 24.3% | Sacramento:  Sacramento: 29.9% Placer: 20.2% California: 24.3% |
| Physical Inactivity | Percentage of adults ages 20 and over reporting no leisure-time physical activity. | 19.8% | 13.7% | 17.7% | Sacramento:  Sacramento: 19.8% Placer: 13.7% California: 17.7% |
| Limited Access to Healthy Foods | Percentage of population who are low-income and do not live close to a grocery store. | 4.4% | 3.0% | 3.3% | Sacramento:  Sacramento: 4.4% Placer: 3% California: 3.3% |
| Food Environment Index | Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best). | 8.1 | 8.9 | 8.8 | Sacramento:  Sacramento: 8.1 Placer: 8.9 California: 8.8 |

| Indicators | Description | Sacramento | Placer | California | |
|----------------------------------|---|------------|--------|------------|---|
| Access to Exercise Opportunities | Percentage of population with adequate access to locations for physical activity. | 97.4% | 93.9% | 93.1% | Sacramento:  Placer:  California:  |
| Chlamydia Incidence | Number of newly diagnosed chlamydia cases per 100,000 population. | 748.5 | 291.3 | 585.3 | Sacramento:  Placer:  California:  |
| Teen Birth Rate | Number of births per 1,000 female population ages 15-19. | 17.4 | 7.1 | 17.4 | Sacramento:  Placer:  California:  |
| Adult Smoking | Percentage of adults who are current smokers (age-adjusted). | 14.0% | 11.7% | 11.5% | Sacramento:  Placer:  California:  |

Clinical Care

Table 12: County clinical care indicators compared to state benchmarks.

| Indicators | Description | Sacramento | Placer | California | |
|----------------------------------|---|------------|--------|------------|---|
| Primary Care Shortage Area | Presence of a primary care health professional shortage area within the county. | Yes | Yes | | Sacramento:  Placer:  California: |
| Dental Care Shortage Area | Presence of a dental care health professional shortage area within the county. | No | Yes | | Sacramento:  Placer:  California: |
| Mental Health Care Shortage Area | Presence of a mental health professional shortage area within the county. | Yes | Yes | | Sacramento:  Placer:  California: |

| Indicators | Description | Sacramento | Placer | California | |
|----------------------------|---|------------|--------|------------|---|
| Medically Underserved Area | Presence of a medically underserved area within the county. | Yes | No | | Sacramento:  Yes Placer:  No California:  |
| Mammography Screening | Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening. | 37.0% | 46.0% | 36.0% | Sacramento:  37% Placer:  46% California:  36% |
| Dentists | Dentists per 100,000 population. | 78.3 | 105.7 | 87.0 | Sacramento:  78.3 Placer:  105.7 California:  87 |
| Mental Health Providers | Mental health providers per 100,000 population. | 385.9 | 314.3 | 373.4 | Sacramento:  385.9 Placer:  314.3 California:  373.4 |
| Psychiatry Providers | Psychiatry providers per 100,000 population. | 14.5 | 13.9 | 13.5 | Sacramento:  14.5 Placer:  13.9 California:  13.5 |
| Specialty Care Providers | Specialty care providers (non-primary care physicians) per 100,000 population. | 222.6 | 218.1 | 190.0 | Sacramento:  222.6 Placer:  218.1 California:  190 |
| Primary Care Providers | Primary care physicians per 100,000 population + other primary care providers per 100,000 population. | 155.4 | 186.9 | 147.3 | Sacramento:  155.4 Placer:  186.9 California:  147.3 |

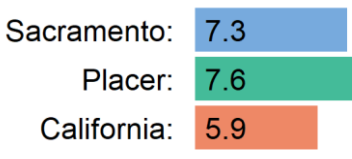
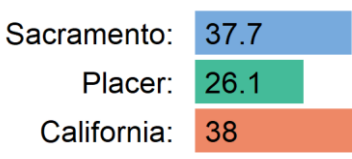
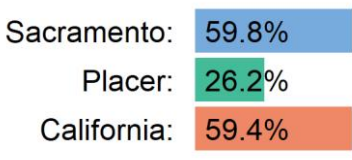
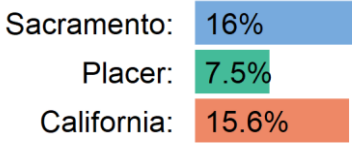

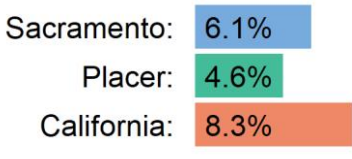
| Indicators | Description | Sacramento | Placer | California | |
|---|---|------------|----------|------------|--|
| Preventable Hospitalization | Preventable hospitalizations per 100,000 (age-sex-poverty adjusted) | 1,042.8 | 706.7 | 948.3 | Sacramento: 1,042.8 Placer: 706.7 California: 948.3 |
| COVID-19 | | | | | |
| COVID-19 Cumulative Full Vaccination Rate | Number of completed COVID-19 vaccinations per 100,000 population. | 69,060.2 | 69,453.1 | 71,068.4 | Sacramento: 69,060.2 Placer: 69,453.1 California: 71,068.4 |

Socio-Economic and Demographic Factors

Table 13: County socio-economic and demographic factors indicators compared to state benchmarks.

| Indicators | Description | Sacramento | Placer | California | |
|---------------------------|---|------------|--------|------------|---|
| Community Safety | | | | | |
| Homicide Rate | Number of deaths due to homicide per 100,000 population. | 5.9 | 2.1 | 4.8 | Sacramento: 5.9 Placer: 2.1 California: 4.8 |
| Firearm Fatalities Rate | Number of deaths due to firearms per 100,000 population. | 9.7 | 6.4 | 7.8 | Sacramento: 9.7 Placer: 6.4 California: 7.8 |
| Violent Crime Rate | Number of reported violent crime offenses per 100,000 population. | 508.2 | 162.0 | 420.9 | Sacramento: 508.2 Placer: 162 California: 420.9 |
| Juvenile Arrest Rate | Felony juvenile arrests per 1,000 juveniles | 2.0 | 1.5 | 2.1 | Sacramento: 2 Placer: 1.5 California: 2.1 |
| Motor Vehicle Crash Death | Number of motor vehicle crash deaths per 100,000 population. | 10.6 | 7.6 | 9.5 | Sacramento: 10.6 Placer: 7.6 California: 9.5 |
| Education | | | | | |

| Indicators | Description | Sacramento | Placer | California | |
|--------------------------------------|---|------------|--------|------------|--|
| Some College | Percentage of adults ages 25-44 with some post-secondary education. | 66.9% | 78.6% | 65.7% | Sacramento: 66.9% Placer: 78.6% California: 65.7% |
| High School Completion | Percentage of adults ages 25 and over with a high school diploma or equivalent. | 87.7% | 94.5% | 83.3% | Sacramento: 87.7% Placer: 94.5% California: 83.3% |
| Disconnected Youth | Percentage of teens and young adults ages 16-19 who are neither working nor in school. | 8.2% | 5.6% | 6.4% | Sacramento: 8.2% Placer: 5.6% California: 6.4% |
| Third Grade Reading Level | Average grade level performance for 3rd graders on English Language Arts standardized tests | 2.8 | 3.2 | 2.9 | Sacramento: 2.8 Placer: 3.2 California: 2.9 |
| Third Grade Math Level | Average grade level performance for 3rd graders on math standardized tests | 2.7 | 3.1 | 2.7 | Sacramento: 2.7 Placer: 3.1 California: 2.7 |
| Employment | | | | | |
| Unemployment | Percentage of population ages 16 and older unemployed but seeking work. | 3.7% | 3.1% | 4.0% | Sacramento: 3.7% Placer: 3.1% California: 4% |
| Family and Social Support | | | | | |
| Children in Single-Parent Households | Percentage of children that live in a household headed by single parent. | 25.8% | 14.7% | 22.5% | Sacramento: 25.8% Placer: 14.7% California: 22.5% |



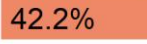


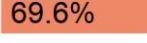


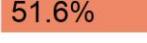



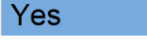
| Indicators | Description | Sacramento | Placer | California | |
|---|---|------------|------------|------------|---|
| Social Associations | Number of membership associations per 10,000 population. | 7.3 | 7.6 | 5.9 | Sacramento:  |
| Residential Segregation (Non-White/White) | Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents. | 37.7 | 26.1 | 38.0 | Sacramento:  |
| Income | | | | | |
| Children Eligible for Free Lunch | Percentage of children enrolled in public schools that are eligible for free or reduced price lunch. | 59.8% | 26.2% | 59.4% | Sacramento:  |
| Children in Poverty | Percentage of people under age 18 in poverty. | 16.0% | 7.5% | 15.6% | Sacramento:  |
| Median Household Income | The income where half of households in a county earn more and half of households earn less. | \$71,891.0 | \$97,688.0 | \$80,423.0 | Sacramento:  |
| Uninsured Population under 64 | Percentage of population under age 65 without health insurance. | 6.1% | 4.6% | 8.3% | Sacramento:  |

| Indicators | Description | Sacramento | Placer | California |
|-------------------|--|------------|--------|---|
| Income Inequality | Ratio of household income at the 80th percentile to income at the 20th percentile. | 4.7 | 4.6 | 5.2 |
| | | | | Sacramento: 4.7 Placer: 4.6 California: 5.2 |

Physical Environment

Table 14: County physical environment indicators compared to state benchmarks.

| Indicators | Description | Sacramento | Placer | California |
|--------------------------------------|---|------------|--------|---|
| Housing | | | | |
| Severe Housing Problems | Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. | 22.1% | 17.7% | 26.4% |
| | | | | Sacramento: 22.1% Placer: 17.7% California: 26.4% |
| Severe Housing Cost Burden | Percentage of households that spend 50% or more of their household income on housing. | 17.9% | 14.9% | 19.7% |
| | | | | Sacramento: 17.9% Placer: 14.9% California: 19.7% |
| Homeownership | Percentage of occupied housing units that are owned. | 56.4% | 71.9% | 54.8% |
| | | | | Sacramento: 56.4% Placer: 71.9% California: 54.8% |
| Homelessness Rate | Number of homeless individuals per 100,000 population. | 361.5 | 193.0 | 411.2 |
| | | | | Sacramento: 361.5 Placer: 193 California: 411.2 |
| Transit | | | | |
| Households with no Vehicle Available | Percentage of occupied housing units that have no vehicles available. | 6.6% | 3.8% | 7.1% |
| | | | | Sacramento: 6.6% Placer: 3.8% California: 7.1% |

| Indicators | Description | Sacramento | Placer | California | |
|------------------------------------|---|------------|--------|------------|--|
| Long Commute - Driving Alone | Among workers who commute in their car alone, the percentage that commute more than 30 minutes. | 39.4% | 39.8% | 42.2% | Sacramento:  Placer:  California:  |
| Access to Public Transit | Percentage of population living near a fixed public transportation stop | 72.9% | 45.2% | 69.6% | Sacramento:  Placer:  California:  |
| Air and Water Quality | | | | | |
| Pollution Burden Percent | Percentage of population living in a census tract with a CalEnviroScreen 3.0 pollution burden score percentile of 50 or greater | 24.1% | 8.3% | 51.6% | Sacramento:  Placer:  California:  |
| Air Pollution - Particulate Matter | Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). | 8.7 | 7.2 | 8.1 | Sacramento:  Placer:  California:  |
| Drinking Water Violations | Presence of health-related drinking water violations in the county. | Yes | No | | Sacramento:  Placer: No California: |

Community Service Provider Survey Results

Below are the results from the service provider survey for Placer and Sacramento Counties. For the purposes of health need identification, this survey data was aggregated. However, it is provided here broken down by county for ease of interpretation.

Table 15: Service provider survey results for Sacramento and Placer Counties.

| Service Provider Survey Snapshot Placer County (N=22) | |
|---|-------------|
| Health Needs | % Reporting |
| Most Frequently Reported | |
| Access to Basic Needs Such as Housing, Jobs, and Food | 86.4% |
| System Navigation | 81.8% |
| Access to Mental/Behavioral Health and Substance-Abuse Services | 72.7% |

| | |
|---|-------|
| Access to Quality Primary Care Health Services | 68.2% |
| Access to Specialty and Extended Care | 59.1% |
| Top 3/ Priority (Most Frequently Reported Characteristics) | |
| Access to Basic Needs Such as Housing, Jobs, and Food | 77.2% |
| <i>Services for homeless residents in the area are insufficient.</i> | |
| <i>The area needs additional low-income housing options.</i> | |
| <i>Lack of affordable housing is a significant issue in the area.</i> | |
| <i>It is difficult to find affordable childcare.</i> | |
| <i>Many residents struggle with food insecurity.</i> | |
| Access to Mental/Behavioral Health and Substance Abuse Services | 54.5% |
| <i>Substance-abuse is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse).</i> | |
| <i>There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).</i> | |
| <i>Treatment options (both mental health and substance-use) for those with Medi-Cal are limited.</i> | |
| <i>Additional services for those who are homeless and experiencing mental/behavioral health issues are needed.</i> | |
| Access to Specialty and Extended Care | 36.4% |
| <i>People have to travel to reach specialists.</i> | |
| <i>Too few specialty and extended care providers accept Medi-Cal.</i> | |
| <i>Not all specialty care is covered by insurance.</i> | |
| <i>Wait-times for specialist appointments are excessively long.</i> | |

| Service Provider Survey Snapshot Sacramento County (N=47) | |
|---|--------------------|
| Health Needs | % Reporting |
| Most Frequently Reported | |
| Access to Mental/Behavioral Health and Substance-Abuse Services | 96.8% |
| Access to Basic Needs | 96.8% |
| A Safe and Violence-Free Environment | 83.9% |
| System Navigation | 80.6% |
| Top 3/ Priority (Most Frequently Reported Characteristics) | |
| Access to Mental/Behavioral Health and Substance-Abuse Services. | 77.4% |
| <i>It's difficult for people to navigate for mental/behavioral healthcare.</i> | |
| <i>There aren't enough services here for those who are homeless and dealing with substance-abuse issues.</i> | |
| <i>Additional services for those who are homeless and experiencing mental/behavioral health issues are needed.</i> | |
| <i>There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).</i> | |
| <i>Substance-abuse is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse).</i> | |
| Access to Basic Needs | 74.2% |

| | | |
|--|---|-------|
| | <i>Lack of affordable housing is a significant issue in the area.</i> | |
| | <i>The area needs additional low-income housing options.</i> | |
| | <i>Services for homeless residents in the area are insufficient.</i> | |
| | <i>It is difficult to find affordable childcare.</i> | |
| | Access to Quality Primary Care Health Services | 32.3% |
| | <i>Patients have difficulty obtaining appointments outside of regular business hours.</i> | |
| | <i>Wait-times for appointments are excessively long.</i> | |

CHNA Methods and Processes

Two related models were foundational in this CHNA. The first is a conceptual model that expresses the theoretical understanding of community health used in the analysis. This understanding is important because it provides the framework underpinning the collection of primary and secondary data. It is the tool used to ensure that the results are based on a rigorous understanding of those factors that influence the health of a community. The second model is a process model that describes the various stages of the analysis. It is the tool that ensures that the resulting analysis is based on a tight integration of community voice and secondary data and that the analysis meets federal regulations for conducting hospital CHNAs.

Conceptual Model

The conceptual model used in this needs assessment is shown in Figure 6. This model organizes populations' individual health-related characteristics in terms of how they relate to up- or downstream health and health-disparities factors. In this model, health outcomes (quality and length of life) are understood to result from the influence of health factors describing interrelated individual, environmental, and community characteristics, which in turn are influenced by underlying policies and programs.

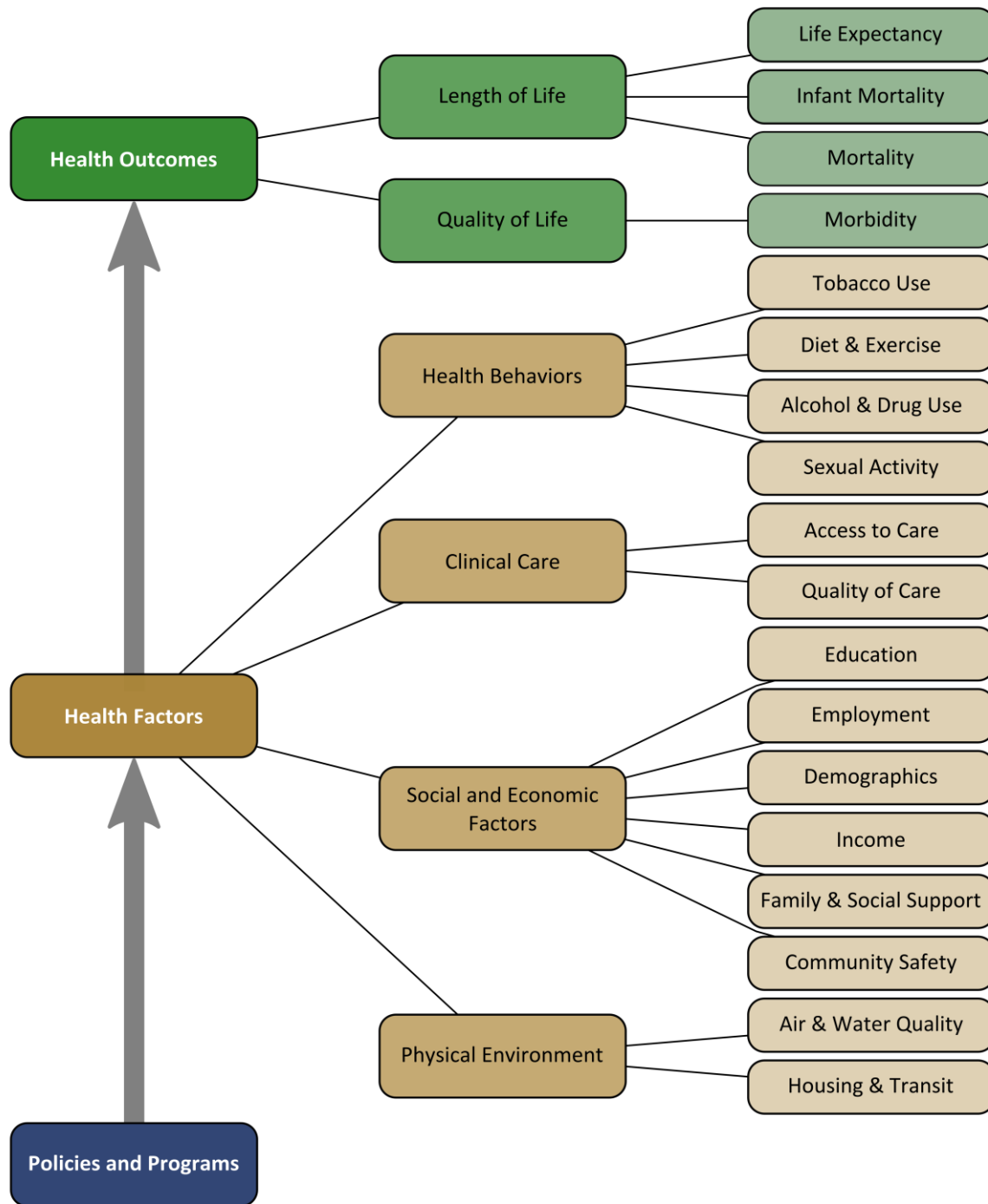


Figure 6: Community Health Assessment Conceptual Model as modified from the County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2015.

This model was used to guide the selection of secondary indicators in this analysis as well as to express in general how these upstream health factors lead to the downstream health outcomes. It also suggests that poor health outcomes within the service area can be improved through policies and programs that address the health factors contributing to them. This conceptual model is a slightly modified version of

the County Health Rankings Model used by the Robert Wood Johnson Foundation. It was primarily altered by adding a “Demographics” category to the “Social and Economic Factors” in recognition of the influence of demographic characteristics on health outcomes.

To generate the list of secondary indicators used in the assessment, each conceptual model category was reviewed to identify potential indicators that could be used to fully represent the category. The results of this discussion were then used to guide secondary data collection.

Process Model

Figure 7 outlines the data collection and analysis stages of this process. The project began by confirming the HSA for Sutter Roseville Medical Center for which the CHNA would be conducted. Primary data collection included key informant interviews and focus-groups with community health experts and residents as well as a community survey provider survey. Initial key informant interviews were used to identify Communities of Concern which are areas or population subgroups within the county experiencing health disparities.

Overall primary and secondary data were integrated to identify significant health needs for the HSA. Significant health needs were then prioritized based on analysis of the primary data. Finally, information was collected regarding the resources available within the community to meet the identified health needs. An evaluation of the impact of the hospital’s prior efforts was obtained from hospital representatives and any written comments on the previous CHNA were gathered and included in the report.

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

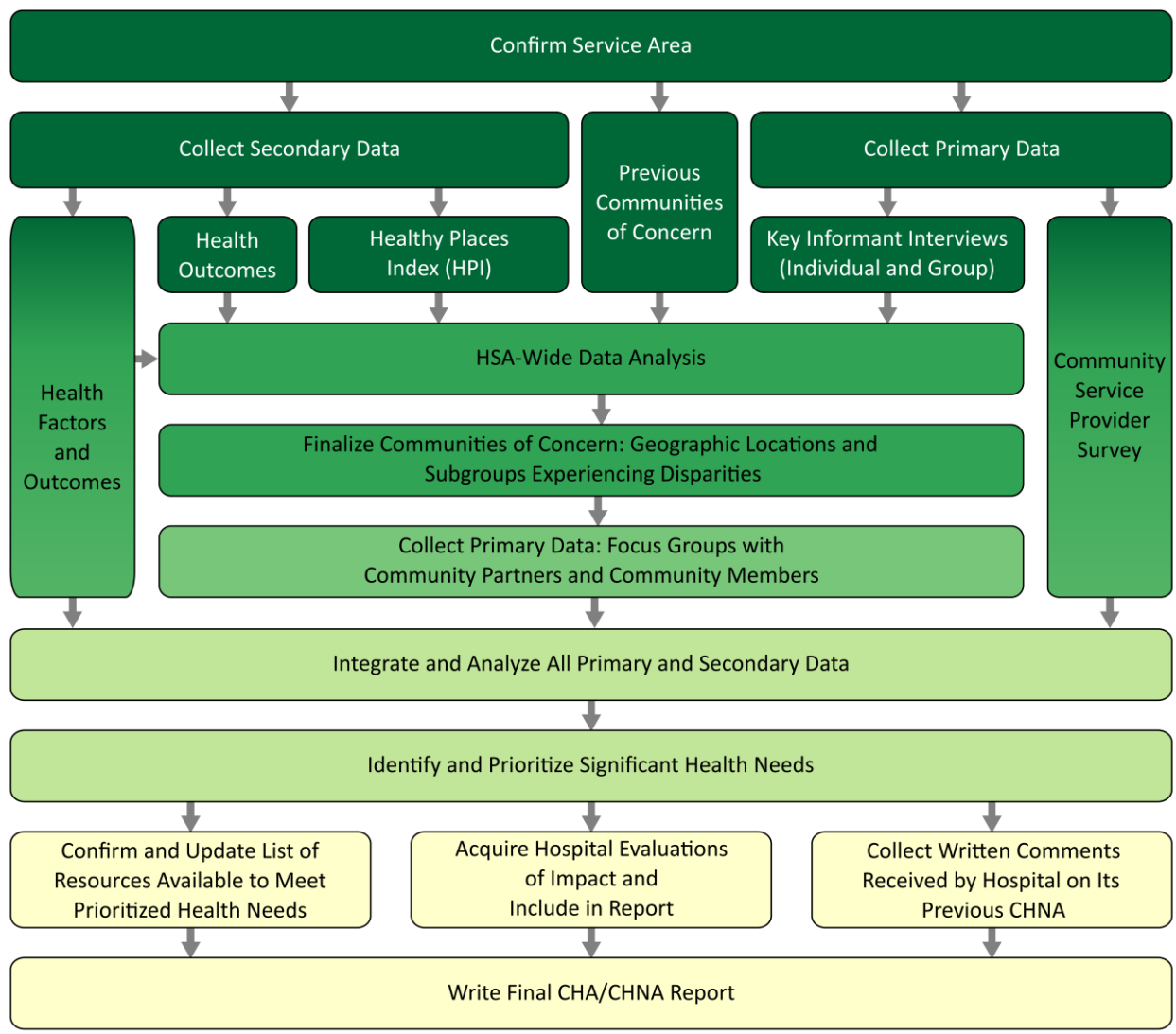


Figure 7: CHNA process model for SRMC.

Primary Data Collection and Processing

Primary Data Collection

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

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

Key Informant Results

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

As a part of the interview process, all key informants were asked to identify vulnerable populations. The interviewer asked each participant to verbally explain what vulnerable populations existed in the county. As needed for a visual aid, key informants were provided a map of the HSA to directly point to the geographic locations of these vulnerable communities. Additional key informant interviews were focused on the geographic locations and/or subgroups identified in the earlier phase.

Table 16 contains a listing of community health experts, or key informants, which contributed input to the CHNA. The table describes the name of the represented organization, the number of participants and area of expertise, the populations served by the organization, and the date of the interview. Some of the interviews listed below were conducted as a part of a data sharing agreement with Kaiser Permanente (Harder and Co) conducting a similar assessment in Placer and Sacramento Counties. A few interviews are listed below that were conducted by CHI as a part of Sutter Hospital CHNA work throughout Sacramento County.

Table 16: Key informant list.

| Organization | Date | Number of Participants | Area of Expertise | Populations Served |
|--|------------|------------------------|--|---|
| Chapa-De Indian Health* | 08/20/2021 | 1 | Healthcare services | Native American community |
| Homeless Resource Council of the Sierras; Gathering Inn Placer; Roseville Housing Authority* | 09/01/2021 | 3 | Housing | Homeless |
| Latino Leadership Council* | 08/03/2021 | 1 | Health, education, and youth development | Spanish speaking; Undocumented; uninsured |
| Lighthouse Counseling and Family Resource Center | 03/03/2022 | 1 | Counseling and social services | Low income families |
| Mercy Hospital of Folsom** | 05/21/2021 | 4 | Acute Care Hospital: Healthcare services | All residents of Sacramento County and parts of Placer County |
| Mercy San Juan Medical Center** | 06/01/2021 | 9 | Acute Care Hospital: Healthcare services | All residents of Sacramento County and parts of Placer County |

| Organization | Date | Number of Participants | Area of Expertise | Populations Served |
|---------------------------------------|------------|------------------------|---|---|
| Mutual Assistance Center** | 07/02/2021 | 1 | Community based organization; Social and economic infrastructure | Low income, medically underserved, racial or ethnic minorities |
| People Reaching Out** | 06/08/2021 | 1 | Youth development and prevention services | Low income, underserved communities |
| Placer County Office of Education | 03/15/2022 | 1 | Education | Students and families |
| Placer County Public Health* | 08/02/2021 | 1 | Public Health | Placer County |
| Placer Food Bank | 03/04/2022 | 1 | Food insecurity | Low income; food insecure families; Spanish speaking; seniors |
| Placer People of Faith Together* | 08/04/2021 | 1 | Faith based support and advocacy | Low income |
| Seniors First Placer* | 09/01/2021 | 1 | Support services for independence | Seniors |
| Slavic Assistance Center** | 06/10/2021 | 1 | Community based organization; health promotion, education, and training | Low income Slavic immigrants and refugee individuals and families |
| Sutter Roseville Medical Center Staff | 03/03/2022 | 2 | Acute Care Hospital: Healthcare services | Placer County and parts of Sacramento County |
| Wellspace Health | 03/08/2022 | 3 | FQHC; Healthcare services | Medi-Cal and underserved |
| World Relief Sacramento* | 08/11/2021 | 1 | Refugee assistance | Focus on Syrian & broader Middle Eastern communities |

*Data shared by Kaiser Permanente (Harder and Company) via a data sharing agreement.

**Data collected by CHI for other Sutter Hospital CHNAs in Sacramento County.

Key Informant Interview Guide

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

2022 CHNA Group/Key Informant Interview Protocol

1. BACKGROUND

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

i. Probe for:

1. Public health (division or unit)
2. Hospital health system
3. Local non-profit

4. Community member
- b. **How would you define the community (ies) you or your organization serves?**
 - i. Probe for:
 1. Specific geographic areas?
 2. Specific populations served?
 3. *Who? Where? Racial/ethnic make-up, physical environment (urban/rural, large/small)*
2. **CHARACTERISTICS OF A HEALTHY COMMUNITY**
 - a. **In your view, what does a healthy community look like?**
 - i. Probe for:
 1. Social factors
 2. Economic factors
 3. Clinical care
 4. Physical/built environment (food environment, green spaces)
 5. Neighborhood safety
3. **HEALTH ISSUES**
 - a. **What would you say are the biggest health needs in the community?**
 - i. Probe for:
 1. How has the presence of COVID-19 impacted these health needs?
 - b. **INSERT MAP exercise: Please use the map provided to help our team understand where communities that experience the greatest health disparities live?**
 - i. Probe for:
 1. What specific geographic locations struggle with health issues the most?
 2. What specific groups of community members experience health issues the most?
4. **CHALLENGES/BARRIERS**
 - a. **Looking through the lens of equity, what are the challenges (barriers or drivers) to being healthy for the community as a whole?**
 - i. **Do these inequities exist among certain population groups?**
 - ii. Probe for:
 1. Health Behaviors (maladaptive, coping)
 2. Social factors (social connections, family connectedness, relationship with law enforcement)
 3. Economic factors (income, access to jobs, affordable housing, affordable food)
 4. Clinical Care factors (access to primary care, secondary care, quality of care)
 5. Physical (Built) environment (safe and healthy housing, walkable communities, safe parks)
5. **SOLUTIONS**
 - a. **What solutions are needed to address the health needs and or challenges mentioned?**
 - i. Probe for:
 1. Policies
 2. Care coordination
 3. Access to care
 4. Environmental change
6. **PRIORITY**

- a. **Which would you say are currently the most important or urgent health issues or challenges to address (at least 3 to 5) in order to improve the health of the community?**
- 7. **RESOURCES**
 - a. **What resources exist in the community to help people live healthy lives?**
 - i. Probe for:
 - 1. Barriers to accessing these resources.
 - 2. New resources that have been created since 2019
 - 3. New partnerships/projects/funding
- 8. **PARTICIPANT DRIVEN SAMPLING:**
 - a. **What other people, groups or organizations would you recommend we speak to about the health of the community?**
 - i. Name 3 types of service providers that you would suggest we include in this work?
 - ii. Name 3 types of community members that you would recommend we speak to in this work?
- 9. **OPEN: Is there anything else you would like to share with our team about the health of the community?**

Focus Group Results

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

Table 17 contains a listing of community resident groups that contributed input to the CHNA. The table describes the hosting organization of the focus group, the date it occurred, the total number of participants, and population represented for focus group members.

Table 17: Focus group list.

| Hosting Organization | Date | Number of Participants | Populations Represented |
|--|------------|------------------------|---|
| Health Education Council | 03/08/2022 | 14 | Community of Roseville |
| Project Go, Inc. | 03/24/2022 | 25 | Low-income seniors |
| Lighthouse Counseling & Family Resource Center | 03/25/2022 | 6 | Low-income families and individuals; Spanish speaking |
| Latino Leadership Council | 03/25/2022 | 14 | Spanish speaking and Latino community in Sacramento and Placer Counties |

Focus Group Interview Guide

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

2022 CHNA Focus Group Interview Protocol

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

Primary Data Processing

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

Community Service Provider Survey

A web-based survey was administered to community service providers (CSP) who delivered health and social services to community residents of the HSA. A list of CSPs affiliated with the nonprofit hospitals included in this report was used as an initial sampling frame. An email recruitment message was sent to these CSPs detailing the survey aims and inviting them to participate. Participants were also encouraged to forward the recruitment message to other CSPs in their networks. The survey was designed using Qualtrics, an online survey platform, and was available for approximately two weeks. 69 respondents completed the survey. Survey respondents were also given the opportunity to be acknowledged for their participation in the report and are listed as follows:

Bridget Alexander, Ron Arneson, Louise Arquilla, Janine Bera, Brandon Bettencourt, Jessica Brown, Johnny Burke, Kathilynn Carpenter, Sharon Chandler, Lesia Chase, Sunjung Cho, Darla Clark, Kaitlynn DiCicco, Keith Diederich, Rebecca Dorcich-Fyfe, Elizabeth Duffy, Amy Eargle, Meredith Evans, Rosa Flores, Terri Galvan, Neil Goforth, Crystal Harding, Bob Harlan, Beth Hassett, Eric Hernandez, Anthony Hill, Josiah Kitonga, Steve Kroeger, Mai Lee, Kelsey Long, Mollie Murbach, Manena Ng'ambi, John Nicoletti, Bonnie Rea, Julie Rhoten, Shari Roeseler, Alicia Rozum, Aimee Sagan, Marbella Sala, Robina

Sana, Genelle Smiht, Geoff Smith, Eileen Speaker, Lisa Stark, Alinea Stevens, Dimitrius Stone, Greg Stone, Ericka Summers, Nilda Valmores, Sabrin Vella, and Gina Warren

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

When the survey period was over, incomplete, and duplicate responses were removed from the dataset and the survey responses were double-checked for accuracy. Descriptive statistics and frequencies were used to summarize the health needs. This information was used along with other data sources to both identify and rank significant health needs in the community, and to describe how the health needs are expressed.

Secondary Data Collection and Processing

We use “secondary data” to refer to those quantitative variables used in this analysis that were obtained from third party sources. Secondary data were used to 1) inform the identification of Communities of Concern, 2) support the identification of health needs within the SRMC HSA. This section details the data sources and processing steps used to obtain the secondary data used in each of these steps and prepare them for analysis.

Community of Concern Identification Datasets

Two main secondary data sources were used in the identification of Communities of Concern: California Healthy Places Index (HPI),¹⁴ derived from health factor indicators available at the US Census tract level, and mortality data from the California Department of Public Health (CDPH),¹⁵ health outcome indicators available at the ZIP Code level. The CDPH mortality data reports the number of deaths that occurred in each ZIP Code from 2015-2019 due to each of the causes listed in Table 18.

Table 18: Mortality indicators used in Community of Concern Identification.

| Cause of Death | ICD 10 Codes |
|-------------------------------|--------------|
| Alzheimer's disease | G30 |
| Malignant neoplasms (cancers) | C00-C97 |

¹⁴ Public Health Alliance of Southern California. 2021. HPI_MasterFile_2021-04-22.zip. Data file. Retrieved 1 May 2021 from https://healthyplacesindex.org/wp-content/uploads/2021/04/HPI_MasterFile_2021-04-22.zip.

¹⁵ State of California, Department of Public Health. 2021. California Comprehensive Master Death File (Static), 2015-2019.

| Cause of Death | ICD 10 Codes |
|---|----------------------------|
| Chronic lower respiratory disease (CLRD) | J40-J47 |
| Diabetes mellitus | E10-E14 |
| Diseases of heart | I00-I09, I11, I13, I20-I51 |
| Essential hypertension and hypertensive renal disease | I10, I12, I15 |
| Accidents (unintentional injuries) | V01-X59, Y85-Y86 |
| Chronic liver disease and cirrhosis | K70, K73-K74 |
| Nephritis, nephrotic syndrome, and nephrosis | N00-N07, N17-N19, N25-N27 |
| Pneumonia and influenza | J09-J18 |
| Cerebrovascular disease (stroke) | I60-I69 |
| Intentional self-harm (suicide) | *U03, X60-X84, Y87.0 |

While the HPI dataset was used as-is, additional processing was required to prepare the mortality data for analysis. This included two main steps. First, ZIP Codes associated with PO Boxes needed to be merged with the larger ZIP Codes in which they were located. Once this was completed, smoothed mortality rates were calculated for each resulting ZIP Code.

ZIP Code Consolidation

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

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

To incorporate these patients into the analysis, the point location (latitude and longitude) of all ZIP Codes in California¹⁶ were compared to ZCTA boundaries.¹⁷ These unique ZIP Codes were then assigned

¹⁶ Datasheer, L.L.C. 2018. ZIP Code Database Free. Retrieved 16 Jul 2018 from <http://www.Zip-Codes.com>.

to either the ZCTA in which they fell or, in the case of rural areas that are not completely covered by ZCTAs, the ZCTA closest to them. The CDPH information associated with these PO Boxes or unique ZIP Codes were then added to the ZCTAs to which they were assigned.

Rate Calculation and Smoothing

The next step in the analysis process was to calculate rates for each of these indicators. However, rather than calculating raw rates, empirical bayes smoothed rates (EBRs) were created for all indicators possible.¹⁸ Smoothed rates are considered preferable to raw rates for two main reasons. First, the small population of many ZCTAs meant that the rates calculated for these areas would be unstable. This problem is sometimes referred to as the small-number problem. Empirical bayes smoothing seeks to address this issue by adjusting the calculated rate for areas with small populations so that they more closely resemble the mean rate for the entire study area. The amount of this adjustment is greater in areas with smaller populations, and less in areas with larger populations.

Because the EBR were created for all ZCTAs in the state, ZCTAs with small populations that may have unstable high rates had their rates “shrunk” to more closely match the overall indicator rate for ZCTAs in the entire state. This adjustment can be substantial for ZCTAs with very small populations. The difference between raw rates and EBRs in ZCTAs with very large populations, on the other hand, is negligible. In this way, the stable rates in large-population ZIP Codes are preserved, and the unstable rates in smaller-population ZIP Codes are shrunk to more closely match the state norm. While this may not entirely resolve the small-number problem in all cases, it does make the comparison of the resulting rates more appropriate. Because the rate for each ZCTA is adjusted to some degree by the EBR process, this also has a secondary benefit of better preserving the privacy of patients within the ZCTAs.

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

Significant Health Need Identification Dataset

The second main set of data used in the CHNA includes the health factor and health outcome indicators used to identify significant health needs. The selection of these indicators was guided by the previously identified conceptual model. Table 19 lists these indicators, their sources, the years they were measured, and the health-related characteristics from the conceptual model they are primarily used to represent.

¹⁷ US Census Bureau. 2021. TIGER/Line Shapefile, 2019, 2010 nation, U.S., 2010 Census 5-Digit ZIP Code Tabulation Area (ZCTA5) National. Retrieved 9 Feb 2021 from <https://www.census.gov/cgi-bin/geo/shapefiles/index.php>.

¹⁸ Anselin, Luc. 2003. Rate Maps and Smoothing. Retrieved 14 Jan 2018 from http://www.dpi.inpe.br/gilberto/tutorials/software/geoda/tutorials/w6_rates_slides.pdf

Table 19: Health factor and health outcome indicators used in health need identification.

| Conceptual Model Alignment | | Indicator | Data Source | Time Period | | |
|----------------------------|-----------------------------------|-----------------------------------|---|---|---------------------------------------|-------------|
| Health Outcomes | Length of Life | Infant Mortality | Infant Mortality | County Health Rankings | 2013 - 2019 | |
| | | Life Expectancy | Child Mortality | Child Mortality | County Health Rankings | 2016 - 2019 |
| | | | Life Expectancy | Life Expectancy | County Health Rankings | 2017 - 2019 |
| | | | Premature Age-Adjusted Mortality | Premature Age-Adjusted Mortality | County Health Rankings | 2017 - 2019 |
| | | | Premature Death | Premature Death | County Health Rankings | 2017 - 2019 |
| | | | Stroke Mortality | Stroke Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Chronic Lower Respiratory Disease Mortality | Chronic Lower Respiratory Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Diabetes Mortality | Diabetes Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Heart Disease Mortality | Heart Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | | | Hypertension Mortality | Hypertension Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 |
| | Cancer Mortality | Cancer Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | Liver Disease Mortality | Liver Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | Kidney Disease Mortality | Kidney Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | Suicide Mortality | Suicide Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | Unintentional Injuries Mortality | Unintentional Injuries Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | COVID-19 Mortality | COVID-19 Mortality | CDPH COVID-19 Time-Series Metrics by County and State | Collected on 2022-05-19 | | |
| | COVID-19 Case Fatality | COVID-19 Case Fatality | CDPH COVID-19 Time-Series Metrics by County and State | Collected on 2022-05-19 | | |
| | Alzheimer's Disease Mortality | Alzheimer's Disease Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |
| | Influenza and Pneumonia Mortality | Influenza and Pneumonia Mortality | CDPH California Vital Data (Cal-ViDa) | 2015 - 2019 | | |

| Conceptual Model Alignment | | | Indicator | Data Source | Time Period |
|----------------------------|---|-------------------------------|--|-------------------------|------------------------|
| Quality of Life | Morbidity | Diabetes Prevalence | County Health Rankings | 2017 | |
| | | Low Birthweight | County Health Rankings | 2013 - 2019 | |
| | | HIV Prevalence | County Health Rankings | 2018 | |
| | | Disability | 2019 American Community Survey 5 year estimate variable S1810_C03_001E | 2015 - 2019 | |
| | | Poor Mental Health Days | County Health Rankings | 2018 | |
| | | Frequent Mental Distress | County Health Rankings | 2018 | |
| | | Poor Physical Health Days | County Health Rankings | 2018 | |
| | | Frequent Physical Distress | County Health Rankings | 2018 | |
| | | Poor or Fair Health | County Health Rankings | 2018 | |
| | | Colorectal Cancer Prevalence | California Cancer Registry | 2013 - 2017 | |
| | | Breast Cancer Prevalence | California Cancer Registry | 2013 - 2017 | |
| | | Lung Cancer Prevalence | California Cancer Registry | 2013 - 2017 | |
| | | Prostate Cancer Prevalence | California Cancer Registry | 2013 - 2017 | |
| | | COVID-19 Cumulative Incidence | CDPH COVID-19 Time-Series Metrics by County and State | Collected on 2022-05-19 | |
| | | Asthma ED Rates | Tracking California | 2018 | |
| | | Asthma ED Rates for Children | Tracking California | 2018 | |
| | | Health Factors | Alcohol and Drug Use | Excessive Drinking | County Health Rankings |
| Drug Induced Death | CDPH 2021 County Health Status Profiles | | | 2017 - 2019 | |
| Diet and Exercise | Adult Obesity | | County Health Rankings | 2017 | |
| | Physical Inactivity | | County Health Rankings | 2017 | |
| | Limited Access to Healthy Foods | | County Health Rankings | 2015 | |
| | Food Environment Index | | County Health Rankings | 2015 & 2018 | |
| | Access to Exercise Opportunities | | County Health Rankings | 2010 & 2019 | |
| Sexual Activity | Chlamydia Incidence | | County Health Rankings | 2018 | |

| Conceptual Model Alignment | | Indicator | Data Source | Time Period | |
|----------------------------|--|------------------|---|---|-------------------------|
| | | | Teen Birth Rate | County Health Rankings | 2013 - 2019 |
| | | Tobacco Use | Adult Smoking | County Health Rankings | 2018 |
| | Clinical Care | Access to Care | Primary Care Shortage Area | U.S. Heath Resources and Services Administration | 2021 |
| | | | Dental Care Shortage Area | U.S. Heath Resources and Services Administration | 2021 |
| | | | Mental Health Care Shortage Area | U.S. Heath Resources and Services Administration | 2021 |
| | | | Medically Underserved Area | U.S. Heath Resources and Services Administration | 2021 |
| | | | Mammography Screening | County Health Rankings | 2018 |
| | | | Dentists | County Health Rankings | 2019 |
| | | | Mental Health Providers | County Health Rankings | 2020 |
| | | | Psychiatry Providers | County Health Rankings | 2020 |
| | | | Specialty Care Providers | County Health Rankings | 2020 |
| | | | Primary Care Providers | County Health Rankings | 2018; 2020 |
| | | Quality Care | Preventable Hospitalization | California Office of Statewide Health Planning and Development Prevention Quality Indicators for California | 2019 |
| | | | COVID-19 Cumulative Full Vaccination Rate | CDPH COVID-19 Vaccine Progress Dashboard Data | Collected on 2022-05-19 |
| | Socio-Economic and Demographic Factors | Community Safety | Homicide Rate | County Health Rankings | 2013 - 2019 |
| | | | Firearm Fatalities Rate | County Health Rankings | 2015 - 2019 |
| | | | Violent Crime Rate | County Health Rankings | 2014 & 2016 |
| | | | Juvenile Arrest Rate | Criminal Justice Data: Arrests, OpenJustice, California Department of Justice | 2015 - 2019 |
| | | | Motor Vehicle Crash Death | County Health Rankings | 2013 - 2019 |

| Conceptual Model Alignment | | Indicator | Data Source | Time Period | |
|----------------------------|--------------------------------------|---------------------------|---|--|------------------------|
| | Education | Some College | County Health Rankings | 2015 - 2019 | |
| | | High School Completion | County Health Rankings | 2015 - 2019 | |
| | | Disconnected Youth | County Health Rankings | 2015 - 2019 | |
| | | Third Grade Reading Level | County Health Rankings | 2018 | |
| | | Third Grade Math Level | County Health Rankings | 2018 | |
| | | Employment | Unemployment | County Health Rankings | 2019 |
| | | Family and Social Support | Children in Single-Parent Households | County Health Rankings | 2015 - 2019 |
| | | | Social Associations | County Health Rankings | 2018 |
| | | | Residential Segregation (Non-White/White) | County Health Rankings | 2015 - 2019 |
| | | Income | Children Eligible for Free Lunch | County Health Rankings | 2018 - 2019 |
| | | | Children in Poverty | County Health Rankings | 2019 |
| | | | Median Household Income | County Health Rankings | 2019 |
| | | | Uninsured Population under 64 | County Health Rankings | 2018 |
| | | | Income Inequality | County Health Rankings | 2015 - 2019 |
| | | Physical Environment | Housing and Transit | Severe Housing Problems | County Health Rankings |
| | Severe Housing Cost Burden | | | County Health Rankings | 2015 - 2019 |
| | Homeownership | | | County Health Rankings | 2015 - 2019 |
| | Homelessness Rate | | | US Dept. of Housing and Urban Development 2020 Annual Homeless Assessment Report | 2020 |
| | Households with no Vehicle Available | | | 2019 American Community Survey 5-year estimate variable DP04_0058PE | 2015 - 2019 |
| | Long Commute - Driving Alone | | | County Health Rankings | 2015 - 2019 |

| Conceptual Model Alignment | | Indicator | Data Source | Time Period |
|----------------------------|-----------------------|------------------------------------|---|-------------|
| | | Access to Public Transit | OpenMobilityData, Transitland, TransitWiki.org, Santa Ynez Valley Transit; US Census Bureau | 2021; 2020 |
| | Air and Water Quality | Pollution Burden Percent | California Office of Environmental Health Hazard Assessment | 2018 |
| | | Air Pollution - Particulate Matter | County Health Rankings | 2016 |
| | | Drinking Water Violations | County Health Rankings | 2019 |

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

County Health Rankings Data

All indicators listed with County Health Rankings (CHR) as their source were obtained from the 2021 County Health Rankings¹⁹ dataset. This was the most common source of data, with 52 associated indicators included in the analysis. Indicators were collected at both the county and state levels. County-level indicators were used to represent the health factors and health outcomes in the service area. State-level indicators were collected to be used as benchmarks for comparison purposes. All variables included in the CHR dataset were obtained from other data providers. The original data providers for each CHR variable are given in Table 20.

Table 20: Sources and time periods for indicators obtained from County Health Rankings.

| CHR Indicator | Time Period | Data Source |
|----------------------------------|-------------|---|
| Infant Mortality | 2013 - 2019 | National Center for Health Statistics - Mortality Files |
| Child Mortality | 2016 - 2019 | National Center for Health Statistics - Mortality Files |
| Life Expectancy | 2017 - 2019 | National Center for Health Statistics - Mortality Files |
| Premature Age-Adjusted Mortality | 2017 - 2019 | National Center for Health Statistics - Mortality Files |
| Premature Death | 2017 - 2019 | National Center for Health Statistics - Mortality Files |

¹⁹ University of Wisconsin Population Health Institute. 2021. County Health Rankings State Report 2021. Retrieved 6 May 2021 from <https://www.countyhealthrankings.org/app/oregon/2021/downloads> and <https://www.countyhealthrankings.org/app/california/2021/downloads>.

| CHR Indicator | Time Period | Data Source |
|----------------------------------|-------------|---|
| Diabetes Prevalence | 2017 | United States Diabetes Surveillance System |
| Low Birthweight | 2013 - 2019 | National Center for Health Statistics - Natality files |
| HIV Prevalence | 2018 | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention |
| Poor Mental Health Days | 2018 | Behavioral Risk Factor Surveillance System |
| Frequent Mental Distress | 2018 | Behavioral Risk Factor Surveillance System |
| Poor Physical Health Days | 2018 | Behavioral Risk Factor Surveillance System |
| Frequent Physical Distress | 2018 | Behavioral Risk Factor Surveillance System |
| Poor or Fair Health | 2018 | Behavioral Risk Factor Surveillance System |
| Excessive Drinking | 2018 | Behavioral Risk Factor Surveillance System |
| Adult Obesity | 2017 | United States Diabetes Surveillance System |
| Physical Inactivity | 2017 | United States Diabetes Surveillance System |
| Limited Access to Healthy Foods | 2015 | USDA Food Environment Atlas |
| Food Environment Index | 2015 & 2018 | USDA Food Environment Atlas, Map the Meal Gap from Feeding America |
| Access to Exercise Opportunities | 2010 & 2019 | Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files |
| Chlamydia Incidence | 2018 | National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention |
| Teen Birth Rate | 2013 - 2019 | National Center for Health Statistics - Natality files |
| Adult Smoking | 2018 | Behavioral Risk Factor Surveillance System |
| Mammography Screening | 2018 | Mapping Medicare Disparities Tool |
| Dentists | 2019 | Area Health Resource File/National Provider Identification file |
| Mental Health Providers | 2020 | CMS, National Provider Identification |
| Psychiatry Providers | 2020 | Area Health Resource File |
| Specialty Care Providers | 2020 | Area Health Resource File |
| Primary Care Providers | 2018; 2020 | Area Health Resource File/American Medical Association; CMS, National Provider Identification |
| Homicide Rate | 2013 - 2019 | National Center for Health Statistics - Mortality Files |
| Firearm Fatalities Rate | 2015 - 2019 | National Center for Health Statistics - Mortality Files |
| Violent Crime Rate | 2014 & 2016 | Uniform Crime Reporting - FBI |
| Motor Vehicle Crash Death | 2013 - 2019 | National Center for Health Statistics - Mortality Files |
| Some College | 2015 - 2019 | American Community Survey, 5-year estimates |
| High School Completion | 2015 - 2019 | American Community Survey, 5-year estimates |

| CHR Indicator | Time Period | Data Source |
|---|-------------|--|
| Disconnected Youth | 2015 - 2019 | American Community Survey, 5-year estimates |
| Third Grade Reading Level | 2018 | Stanford Education Data Archive |
| Third Grade Math Level | 2018 | Stanford Education Data Archive |
| Unemployment | 2019 | Bureau of Labor Statistics |
| Children in Single-Parent Households | 2015 - 2019 | American Community Survey, 5-year estimates |
| Social Associations | 2018 | County Business Patterns |
| Residential Segregation (Non-White/White) | 2015 - 2019 | American Community Survey, 5-year estimates |
| Children Eligible for Free Lunch | 2018 - 2019 | National Center for Education Statistics |
| Children in Poverty | 2019 | Small Area Income and Poverty Estimates |
| Median Household Income | 2019 | Small Area Income and Poverty Estimates |
| Uninsured Population under 64 | 2018 | Small Area Health Insurance Estimates |
| Income Inequality | 2015 - 2019 | American Community Survey, 5-year estimates |
| Severe Housing Problems | 2013 - 2017 | Comprehensive Housing Affordability Strategy (CHAS) data |
| Severe Housing Cost Burden | 2015 - 2019 | American Community Survey, 5-year estimates |
| Homeownership | 2015 - 2019 | American Community Survey, 5-year estimates |
| Long Commute - Driving Alone | 2015 - 2019 | American Community Survey, 5-year estimates |
| Air Pollution - Particulate Matter | 2016 | Environmental Public Health Tracking Network |
| Drinking Water Violations | 2019 | Safe Drinking Water Information System |

The provider rates for the primary care physicians and other primary care providers indicators obtained from CHR were summed to create the final primary care provider indicator used in this analysis.

California Department of Public Health

By-Cause Mortality Data

By-cause mortality data were obtained at the county and state level from the CDPH Cal-ViDa²⁰ online data query system for the years 2015-2019. Empirically bayes smoothed rates (EBRs) were calculated for each mortality indicator using the total county population figure reported in the 2017 American Community Survey 5-year Estimates table B03002. Data for 2017 were used because this represented the central year of the 2015–2019 range of years for which CDPH data were collected. The population

²⁰ State of California, Department of Public Health. 2021. California Vital Data (Cal-ViDa), Death Query. Retrieved 1 Jun 2021 from <https://cal-vida.cdph.ca.gov/>.

data for 2017 were multiplied by five to match the five years of mortality data used to calculate smoothed rates. The smoothed mortality rates were then multiplied by 100,000 so that the final rates represented deaths per 100,000 people.

CDPH masks the actual number of deaths that occur in a county for a given year and cause if there are between 1 and 10 total deaths recorded. Because of this, the following process was used to estimate the total number of deaths for counties whose actual values were masked. First, mortality rates for each cause and year were calculated for the state. The differences between the by-cause mortality for the state and the total by-cause mortality reported across all counties in the state for each cause and year were also calculated.

Next, we applied the state by-cause mortality rate for each cause and year to estimate mortality at the county level if the reported value was masked. This was done by multiplying the cause/year appropriate state-level mortality rate by the 2017 populations of counties with masked values. Resulting estimates that were less than 1 or greater than 10 were set to 1 and 10 respectively to match the known CDPH masking criteria.

The total number of deaths estimated for counties that had masked values for each year/cause was then compared to the difference between the reported total county and state deaths for the corresponding year/cause. If the number of estimated county deaths exceeded this difference, county estimates were further adjusted. This was done by iteratively ranking county estimates for a given year/cause, then from highest to lowest, reducing the estimates by 1 until they reached a minimum of 1 death. This continued until the estimated deaths for counties with masked values equaled the difference between the state and total reported county values.

COVID-19 Data

Data on the cumulative number of cases and deaths²¹ and completed vaccinations²² for COVID-19 were used to calculate mortality, case-fatality, incidence, and vaccination rates. County mortality, incidence, and vaccination rates were calculated by dividing each of the respective values by the total population variable from the 2019 American Community Survey 5-year estimates table B01001, and then multiplying the resulting value by 100,000 to create rates per 100,000. Case-fatality rates were calculated by dividing COVID-19 mortality by the total number of cases, then multiplying by 100, representing the percentage of cases that ended in death.

²¹ State of California, Department of Public Health. 2021. Statewide COVID-19 Cases Deaths Tests. Retrieved May 19 2022 from https://data.chhs.ca.gov/dataset/f333528b-4d38-4814-bebb-12db1f10f535/resource/046cdd2b-31e5-4d34-9ed3-b48cdbc4be7a/download/covid19cases_test.csv.

²² State of California, Department of Public Health. 2021. COVID-19 Vaccine Progress Dashboard Data . Retrieved May 19 2022 from <https://data.chhs.ca.gov/dataset/e283ee5a-cf18-4f20-a92c-ee94a2866ccd/resource/130d7ba2-b6eb-438d-a412-741bde207e1c/download/covid19vaccinesbycounty.csv>.

Drug-Induced Deaths Data

Drug-induced death rates were obtained from Table 19 of the 2021 County Health Status Profiles²³ and report age-adjusted deaths per 100,000.

U.S. Health Resources and Services Administration

Indicators related to the availability of healthcare providers were obtained from the Health Resources and Services Administration²⁴ (HRSA). These included Dental, Mental Health, and Primary Care Health Professional Shortage Areas and Medically Underserved Areas/Populations. They also included the number of specialty care providers and psychiatrists per 100,000 residents, derived from the county-level Area Health Resource Files.

Health Professional Shortage Areas

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

Psychiatry and Specialty Care Providers

The HRSA's Area Health Resource Files provide information on physicians and allied healthcare providers for U.S. counties. This information was used to determine the rate of specialty care providers and the rate of psychiatrists for each county and for the state. For the purposes of this analysis, a specialty care provider was defined as a physician who was not defined by the HRSA as a primary care provider. This was found by subtracting the total number of primary care physicians (both MDs and DOs, primary care, patient care, and non-federal, excluding hospital residents and those 75 years of age or older) from the total number of physicians (both MDs and DOs, patient care, non-federal) in 2018. This number was then divided by the 2018 total population given in the 2018 American Community Survey 5-year Estimates table B03002, and then multiplied by 100,000 to give the total number of specialty care physicians per 100,000 residents.

The total of specialty care physicians in each county was summed to find the total specialty care physicians in the state, and state rates were calculated following the same approach as used for county rates. This same process was also used to calculate the number of psychiatrists per 100,000 for each county and the state using the number of total patient care, non-federal psychiatrists from the Area Health Resource Files. It should be noted that psychiatrists are included in the list of specialty care

²³ State of California, Department of Public Health, Vital Records Data and Statistics. 2021. County Health Status Profiles 2021: CHSP 2021 Tables 1-29. Spreadsheet. Retrieved 21 Jul 2021 from https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP_2021_Tables_1-29_04.16.2021.xlsx.

²⁴ US Health Resources & Services Administration. 2021. Area Health Resources Files and Shortage Areas. Retrieved on 3 Feb 2021 from <https://data.hrsa.gov/data/download>.

physicians, so that indicator represents a subset of specialty care providers rather than a separate group.

California Cancer Registry

Data obtained from the California Cancer Registry²⁵ includes age-adjusted incidence rates for colon and rectum, female breast, lung and bronchus, and prostate cancer sites for counties and the state. Reported rates were based on data from 2013 to 2017, and report cases per 100,000. For low-population counties, rates were calculated for a group of counties rather than for individual counties. That group rate was used in this report to represent incidence rates for each individual county in the group.

Tracking California

Data on emergency department visits rates for all ages as well as children aged 5 to 17 were obtained from Tracking California.²⁶ These data reported age-adjusted rates per 10,000. They were multiplied by 100 in this analysis to convert them to rates per 100,000 to make them more comparable to the standard used for other rate indicators.

US Census Bureau

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

California Office of Environmental Health Hazard Assessment

Data used to calculate the pollution burden percent indicator were obtained from the CalEnviroScreen 3.0²⁷ dataset produced by the California Office of Environmental Health Hazard Assessment. This indicator reports the percentage of the population within a given county, or within the state as a whole, that live in a US Census tract with a CalEnviroScreen 3.0 Pollution Burden score in the 50th percentile or higher. Data on total population came from Table B03002 from the 2019 American Community Survey 5-year Estimates dataset.

²⁵ California Cancer Registry. 2021. Age-Adjusted Invasive Cancer Incidence Rates in California. Retrieved on 22 Jan 2021 from <https://www.cancer-rates.info/ca/>.

²⁶ Tracking California, Public Health Institute. 2021. Asthma Related Emergency Department & Hospitalization data. Retrieved on 24 Jun 2021 from www.trackingcalifornia.org/asthma/query.

²⁷ California Office of Environmental Health Hazard Assessment. 2018. CalEnviroScreen 3.0. Retrieved on 22 Jan 2021 from <https://oehha.ca.gov/calenviroscreen/maps-data>.

California Department of Health Care Access and Information

Data on preventable hospitalizations were obtained from the California Department of Health Care Access and Information (formerly Office of Statewide Health Planning and Development) Prevention Quality Indicators.²⁸ These data are reported as risk-adjusted rates per 100,000.

California Department of Justice

Data reporting the total number of juvenile felony arrests was obtained from the California Department of Justice.²⁹ This indicator reports the rate of felony arrests per 1,000 juveniles under the age of 18. It was calculated by dividing the total number of juvenile felony arrests for each county or state from 2015 - 2019 by the total population under 18 as reported in Table B01001 in the 2017 American Community Survey 5-year Estimates program. Population data from 2017 were used as this was the central year of the period over which juvenile felony arrest data were obtained. Population figures from 2017 were multiplied by 5 to match the years of arrest data used. Empirical bayes smoothed rates were calculated to increase the reliability of rates calculated for small counties. Finally, juvenile felony arrest rates were also calculated for Black, White, and Hispanic populations following the same manner, but using input population data from 2017 American Community Survey 5-year Estimates Tables B01001H, B01001B, and B01001I, respectively.

US Department of Housing and Urban Development

Data from the US Department of Housing and Urban Development's 2020 Annual Homeless Assessment Report³⁰ were used to calculate homelessness rates for the counties and state. This data reported point-in-time (PIT) homelessness estimates for individual Continuum of Care (CoC) organizations across the state. Each CoC works within a defined geographic area, which could be a group of counties, an individual county, or a portion of a county.

To calculate county rates, CoC were first related to county boundaries. Rates for CoC that covered single counties were calculated by dividing the CoC PIT estimate by the county population. If a given county was covered by multiple CoC, their PIT were totaled and then divided by the total county population to calculate the rate. When a single CoC covered multiple counties, the CoC PIT was divided by the total of all included county populations, and the resulting rate was applied to each individual county.

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

²⁸ Office of Statewide Health Planning and Development. 2021. Prevention Quality Indicators (PQI) for California. Data files for Statewide and County. Retrieved 12 Mar 2021 from <https://oshpd.ca.gov/data-and-reports/healthcare-quality/ahrq-quality-indicators/>.

²⁹ California Department of Justice, OpenJustice. 2021. Criminal Justice Data: Arrests. Retrieved 17 Jun 2021 from <https://data-openjustice.doj.ca.gov/sites/default/files/dataset/2020-07/OnlineArrestData1980-2019.csv>.

³⁰ US Department of Housing and Urban Development. 2021. 2020 Annual Homeless Assessment Report: 2007 - 2020 Point-in-Time Estimates by CoC. Retrieved 14 Jul 2021 from <https://www.huduser.gov/portal/sites/default/files/xls/2007-2020-PIT-Estimates-by-CoC.xlsx>.

Proximity to Transit Stops

The proximity to transit stops variable reports the percent of county and state population that lives in a US Census block located within 1/4 mile of a fixed transit stop. Two sets of information were needed in order to calculate this indicator: total population at the Census block level, and the location of transit stops. Likely due to delays in data releases stemming from the COVID-19 pandemic, the most recent Census block population data available at the time of the analysis was from the 2010 Decennial Census,³¹ so this was the data used to represent the distribution of population for this indicator.

Transit stop data were identified first by using tools in the TidyTransit³² library for the R statistical programming language.³³ This was used to identify transit providers with stops located within 100 miles of the state boundaries. A search for transit stops for these agencies, as well as all other transit agencies in the state, was conducted by reviewing three main online sources: OpenMobilityData,³⁴ Transitland,³⁵ Transitwiki.org,³⁶ and Santa Ynez Valley Transit.³⁷ Each of these websites list public transit data that have been made public by transit agencies. Transit data from all providers that could be identified were downloaded, and fixed transit stop locations were extracted from them.

The sf³⁸ library in R was then used to calculate 1/4 mile (402.336 meter) buffers around each of these transit stops, and then to identify which Census blocks fell within these areas. The total population of all tracts within the buffer of the stops was then divided by the total population of each county or state to generate the final indicator value.

Detailed Analytical Methodology

The collected and processed primary and secondary data were integrated in three main analytical stages. First, secondary health outcome and health factor data were combined with area-wide key informant interviews help identify Communities of Concern. These Communities of Concern could potentially include geographic regions as well as specific sub-populations bearing disproportionate

³¹ US Census Bureau. 2011. Census Blocks with Population and Housing Counts. Retrieved 7 Jun 2021 from <https://www2.census.gov/geo/tiger/TIGER2010BLKPOPHU/>.

³² Flavio Poletti, Daniel Herszenhut, Mark Padgham, Tom Buckley, and Danton Noriega-Goodwin. 2021. tidytransit: Read, Validate, Analyze, and Map Files in the General Transit Feed Specification. R package version 1.0.0. Retrieved 10 Sep 2021 from <https://CRAN.R-project.org/package=tidytransit>.

³³ R Core Team (2021). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL <https://www.R-project.org/>.

³⁴ OpenMobilityData. 2021. California, USA. Retrieved all feeds listed on 31 May to 1 June 2021 from <https://openmobilitydata.org/l/67-california-usa>.

³⁵ Transitland. 2021. Transitland Operators. Retrieved all operators with California locations on 31 May to 1 June 2021 from <https://www.transit.land/operators>.

³⁶ Transitwiki.org. 2021. List of publicly-accessible transportation data feeds: dynamic and others. Retrieved on 31 May to 1 June 2021 from https://www.transitwiki.org/TransitWiki/index.php/Publicly-accessible_public_transportation_data#List_of_publicly-accessible_public_transportation_data_feeds:_dynamic_data_and_others.

³⁷ Santa Ynez Valley Transit. GTFS Files. Retrieved 1 Jun 2021 from http://www.cityofsolvang.com/DocumentCenter/View/2756/syvt_gtfs_011921.

³⁸ Pebesma, E., 2018. Simple Features for R: Standardized Support for Spatial Vector Data. The R Journal 10 (1), 439-446, <https://doi.org/10.32614/RJ-2018-009>.

health burdens. This information was used to focus the remaining interview and focus-group collection efforts on those areas and subpopulations. Next, the resulting data, along with the results from the service provider survey, were combined with secondary health need identification data to identify significant health needs within the service area. Finally, primary data were used to prioritize those identified significant health needs. The specific details for these analytical steps are given in the following three sections.

Community of Concern Identification

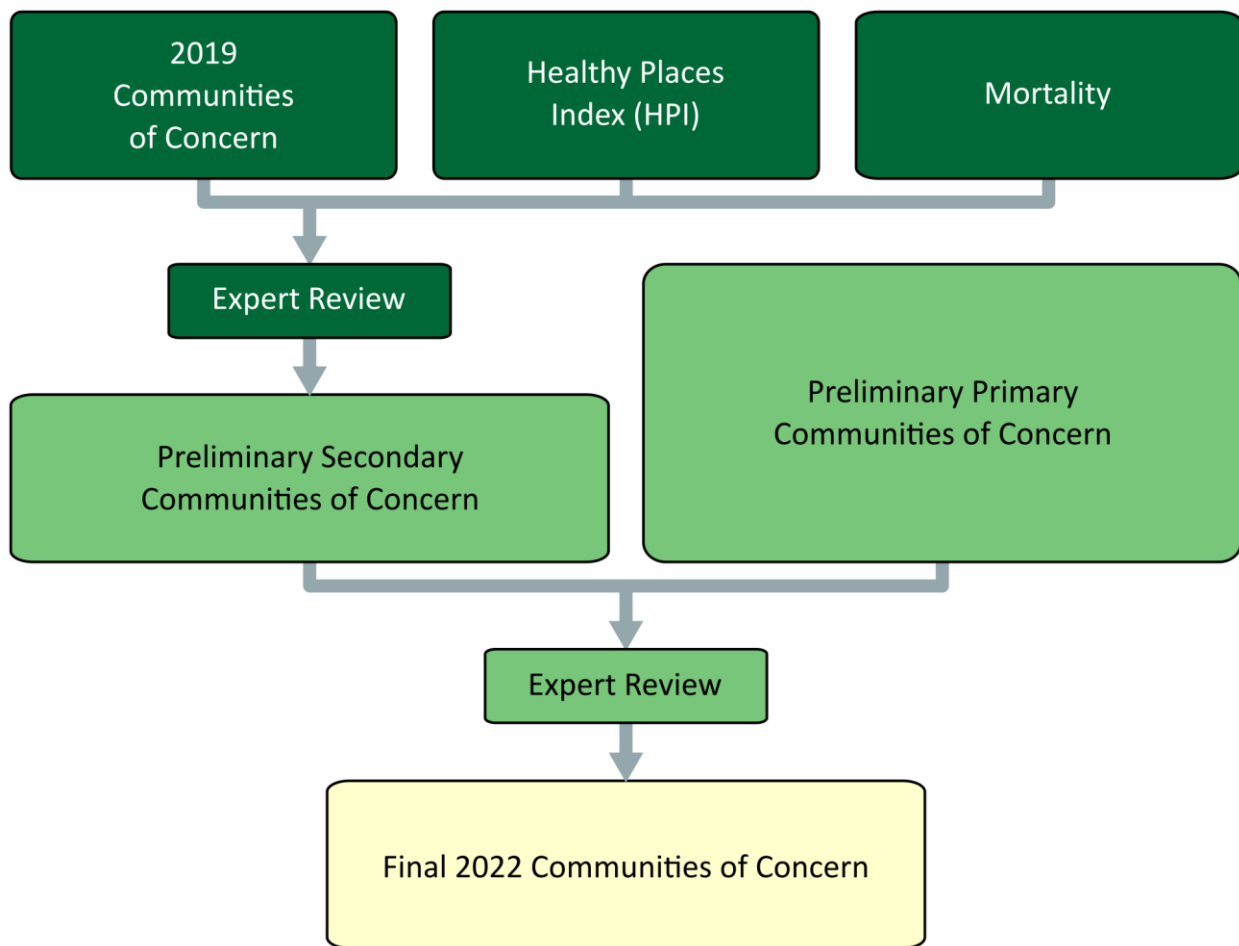


Figure 8: Community of Concern identification process.

As illustrated in Figure 8, 2022 Communities of Concern were identified through a process that drew upon both primary and secondary data. Three main secondary data sources were used in this analysis: Communities of Concern identified in the 2019 CHNA; the census tract-level California Healthy Places Index (HPI); and the CDPH ZCTA-level mortality data.

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

2019 Community of Concern

A ZCTA was included if it was included in the 2019 CHNA Community of Concern list for the HSA. This was done to allow greater continuity between CHNA rounds and reflects the work of the hospital systems oriented to serve these disadvantaged communities.

Healthy Places Index (HPI)

A ZCTA was included if it intersected a census tract whose HPI value fell within the lowest 20% of those in the HSA. These census tracts represent areas with consistently high concentrations of demographic subgroups identified in the research literature as being more likely to experience health-related disadvantages.

CDPH Mortality Data

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

Integration of Secondary Criteria

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

Preliminary Primary Communities of Concern

Preliminary primary Communities of Concern were identified by reviewing the geographic locations or population subgroups that were consistently identified by the area-wide primary data sources.

Integration of Preliminary Primary and Secondary Communities of Concern

Any ZCTA that was identified in either the Preliminary Primary or Secondary Community of Concern list was considered for inclusion as a 2022 Community of Concern. An additional round of expert review was then applied to determine if, based on any primary or secondary data consideration, any final adjustments should be made to this list. The resulting set of ZCTAs was then used as the final 2022 Communities of Concern.

Significant Health Need Identification

The general methods through which significant health needs (SHNs) were identified are shown in Figure 9 and described here in greater detail. The first step in this process was to identify a set of potential

health needs (PHNs) from which significant health needs could be selected. This was done by reviewing the health needs identified during prior CHNAs among various hospitals throughout Central and Northern California and then supplementing this list based on a preliminary analysis of the primary qualitative data collected for the current CHNA. This resulted the list of PHNs shown in Table 21.

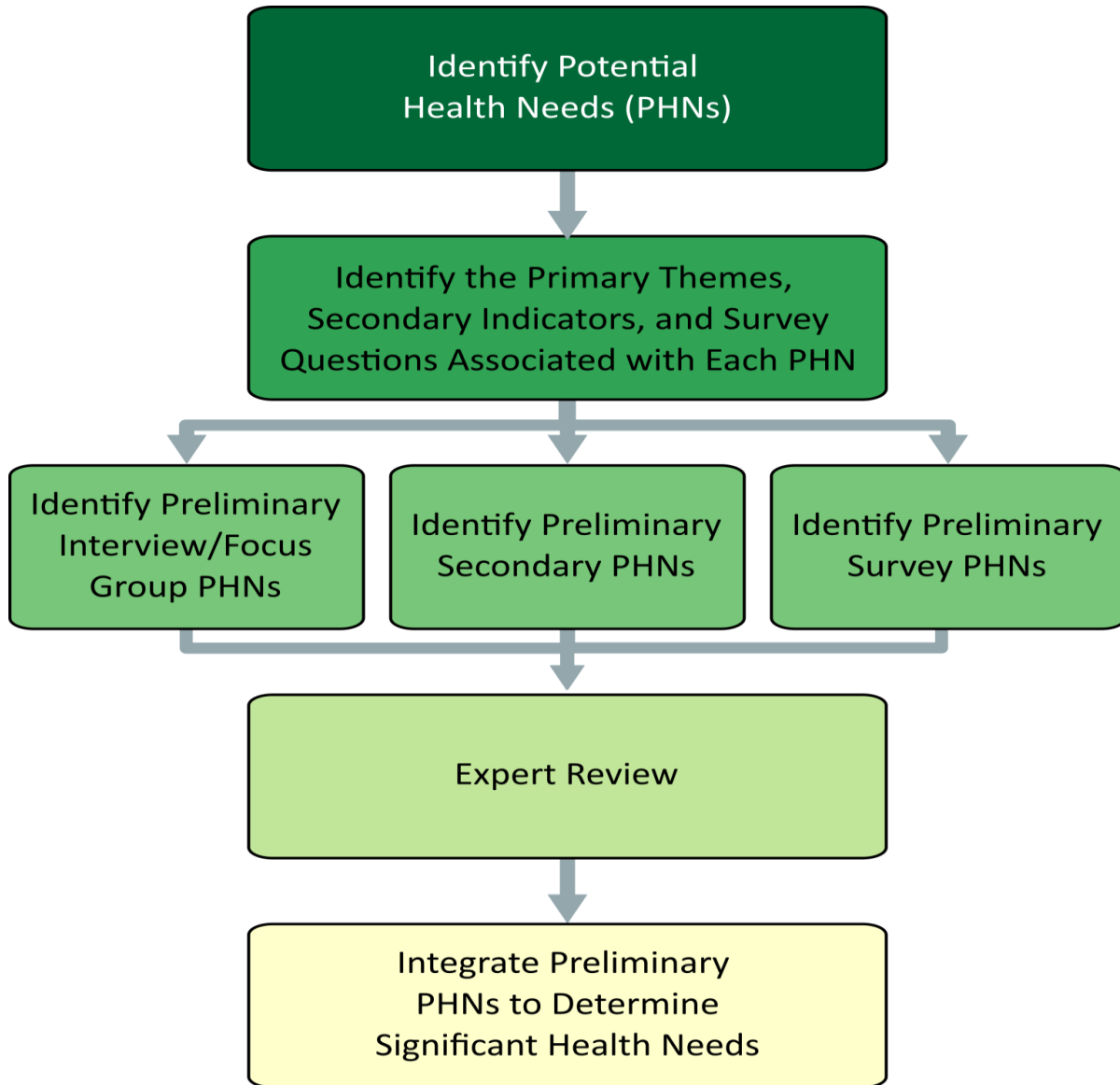


Figure 9: Significant health need identification process.

Table 21: 2022 Potential Health Needs.

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

The next step in the process was to identify primary themes and secondary indicators associated with each of these health needs as shown in Tables 22 through 33. Primary theme associations were used to guide coding of the primary data sources to specific PHNs.

Access to Mental/Behavioral Health and Substance Use Services

Table 22: Primary themes and secondary indicators associated with PHN1.

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

| Primary Themes | Secondary Indicators |
|---|---|
| problem in the community. | Social Associations |
| Substance use is an issue among youth in particular. | Residential Segregation |
| There are substance use treatment services available here, but people do not know about them. | (Non-White/White) Income Inequality Severe Housing Cost Burden Homelessness Rate |

Access to Quality Primary Care Health Services

Table 23: Primary themes and secondary indicators associated with PHN2.

| Primary Themes | Secondary Indicators |
|---|---|
| Insurance is unaffordable. | Infant Mortality |
| Wait-times for appointments are excessively long. | Child Mortality |
| Out-of-pocket costs are too high. | Life Expectancy |
| There aren't enough primary care service providers in the area. | Premature Age-Adjusted Mortality |
| Patients have difficulty obtaining appointments outside of regular business hours. | Premature Death |
| Too few providers in the area accept Medi-Cal. | Stroke Mortality |
| It is difficult to recruit and retain primary care providers in the region. | Chronic Lower Respiratory Disease Mortality |
| Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine). | Diabetes Mortality |
| The quality of care is low (e.g., appointments are rushed, providers lack cultural competence). | Heart Disease Mortality |
| Patients seeking primary care overwhelm local emergency departments. | Hypertension Mortality |
| Primary care services are available but are difficult for many people to navigate. | Cancer Mortality |
| | Liver Disease Mortality |
| | Kidney Disease Mortality |
| | COVID-19 Mortality |
| | COVID-19 Case Fatality |
| | Alzheimer's Disease Mortality |
| | Influenza and Pneumonia Mortality |
| | Diabetes Prevalence |
| | Low Birthweight |
| | Poor Mental Health Days |
| | Frequent Mental Distress |
| | Poor Physical Health Days |
| | Frequent Physical Distress |
| | Poor or Fair Health |
| | Colorectal Cancer Prevalence |
| | Breast Cancer Prevalence |
| | Lung Cancer Prevalence |
| | Prostate Cancer Prevalence |
| | Asthma ED Rates |
| | Asthma ED Rates for Children |
| | Primary Care Shortage Area |

| Primary Themes | Secondary Indicators |
|----------------|--|
| | Medically Underserved Area Mammography Screening Primary Care Providers Preventable Hospitalization COVID-19 Cumulative Full Vaccination Rate Residential Segregation (Non- White/White) Uninsured Population under 64 Income Inequality Homelessness Rate |

Active Living and Healthy Eating

Table 24: Primary themes and secondary indicators associated with PHN3.

| Primary Themes | Secondary Indicators |
|--|---|
| There are food deserts in the area where fresh, unprocessed foods are not available. Fresh, unprocessed foods are unaffordable. Food insecurity is an issue here. Students need healthier food options in schools. The built environment doesn't support physical activity (e.g., neighborhoods aren't walk-able, roads aren't bike-friendly, or parks are inaccessible). The community needs nutrition education programs. Homelessness in parks or other public spaces deters their use. Recreational opportunities in the area are unaffordable (e.g., gym memberships, recreational activity programming). There aren't enough recreational opportunities in the area (e.g., organized activities, youth sports leagues) The food available in local homeless shelters and food banks is not nutritious. Grocery store option in the area are limited. | Life Expectancy Premature Age-Adjusted Mortality Premature Death Stroke Mortality Diabetes Mortality Heart Disease Mortality Hypertension Mortality Cancer Mortality Kidney Disease Mortality Diabetes Prevalence Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health Colorectal Cancer Prevalence Breast Cancer Prevalence Prostate Cancer Prevalence Asthma ED Rates Asthma ED Rates for Children Adult Obesity Physical Inactivity Limited Access to Healthy Foods Food Environment Index |

| Primary Themes | Secondary Indicators |
|----------------|---|
| | Access to Exercise Opportunities Residential Segregation (Non-White/White) Income Inequality Severe Housing Cost Burden Homelessness Rate Long Commute - Driving Alone Access to Public Transit |

Safe and Violence-Free Environment

Table 25: Primary themes and secondary indicators associated with PHN4.

| Primary Themes | Secondary Indicators |
|---|--|
| People feel unsafe because of crime. There are not enough resources to address domestic violence and sexual assault. Isolated or poorly-lit streets make pedestrian travel unsafe. Public parks seem unsafe because of illegal activity taking place. Youth need more safe places to go after school. Specific groups in this community are targeted because of characteristics like race/ethnicity or age. There isn't adequate police protection police protection. Gang activity is an issue in the area. Human trafficking is an issue in the area. The current political environment makes some concerned for their safety. | Life Expectancy Premature Death Hypertension Mortality Poor Mental Health Days Frequent Mental Distress Frequent Physical Distress Poor or Fair Health Physical Inactivity Access to Exercise Opportunities Homicide Rate Firearm Fatalities Rate Violent Crime Rate Juvenile Arrest Rate Motor Vehicle Crash Death Disconnected Youth Social Associations Income Inequality Severe Housing Problems Severe Housing Cost Burden Homelessness Rate |

Access to Dental Care and Preventive Services

Table 26: Primary themes and secondary indicators associated with PHN5.

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

Healthy Physical Environment

Table 27: Primary themes and secondary indicators associated with PHN6.

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

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

Table 28: Primary themes and secondary indicators associated with PHN7.

| Primary Themes | Secondary Indicators |
|---|---|
| Lack of affordable housing is a significant issue in the area. | Infant Mortality |
| The area needs additional low-income housing options. | Child Mortality |
| Poverty in the county is high. | Life Expectancy |
| Many people in the area do not make a living wage. | Premature Age-Adjusted Mortality |
| Employment opportunities in the area are limited. | Premature Death |
| Services for homeless residents in the area are insufficient. | Hypertension Mortality |
| Services are inaccessible for Spanish-speaking and immigrant residents. | COVID-19 Mortality |
| Many residents struggle with food insecurity. | COVID-19 Case Fatality |
| It is difficult to find affordable childcare. | Diabetes Prevalence |
| Educational attainment in the area is low. | Low Birthweight |
| | Poor Mental Health Days |
| | Frequent Mental Distress |
| | Poor Physical Health Days |
| | Frequent Physical Distress |
| | Poor or Fair Health |
| | COVID-19 Cumulative Incidence |
| | Asthma ED Rates |
| | Asthma ED Rates for Children |
| | Drug Induced Death |
| | Adult Obesity |
| | Limited Access to Healthy Foods |
| | Food Environment Index |
| | Medically Underserved Area |
| | COVID-19 Cumulative Full Vaccination Rate |
| | Some College |
| | High School Completion |
| | Disconnected Youth |
| | Third Grade Reading Level |
| | Third Grade Math Level |
| | Unemployment |
| | Children in Single-Parent Households |
| | Social Associations |
| | Residential Segregation (Non-White/White) |
| | Children Eligible for Free Lunch |
| | Children in Poverty |
| | Median Household Income |
| | Uninsured Population under 64 |
| | Income Inequality |
| | Severe Housing Problems |
| | Severe Housing Cost Burden |

| Primary Themes | Secondary Indicators |
|----------------|--------------------------------------|
| | Homeownership |
| | Homelessness Rate |
| | Households with no Vehicle Available |
| | Long Commute - Driving Alone |

Access to Functional Needs

Table 29: Primary themes and secondary indicators associated with PHN8.

| Primary Themes | Secondary Indicators |
|--|---|
| Many residents do not have reliable personal transportation. | Disability |
| Medical transport in the area is limited. | Frequent Mental Distress |
| Roads and sidewalks in the area are not well-maintained. | Frequent Physical Distress |
| The distance between service providers is inconvenient for those using public transportation. | Poor or Fair Health |
| Using public transportation to reach providers can take a very long time. | Adult Obesity |
| The cost of public transportation is too high. | COVID-19 Cumulative Full Vaccination Rate |
| Public transportation service routes are limited. | Income Inequality |
| Public transportation schedules are limited. | Homelessness Rate |
| The geography of the area makes it difficult for those without reliable transportation to get around. | Households with no Vehicle Available |
| Public transportation is more difficult for some to residents to use (e.g., non-English speakers, seniors, parents with young children). | Long Commute - Driving Alone |
| There aren't enough taxi and ride-share options (e.g., Uber, Lyft). | Access to Public Transit |

Access to Specialty and Extended Care

Table 30: Primary themes and secondary indicators associated with PHN9.

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

| Primary Themes | Secondary Indicators |
|----------------|---|
| | COVID-19 Mortality |
| | COVID-19 Case Fatality |
| | Alzheimer's Disease Mortality |
| | Diabetes Prevalence |
| | Poor Mental Health Days |
| | Frequent Mental Distress |
| | Poor Physical Health Days |
| | Frequent Physical Distress |
| | Poor or Fair Health |
| | Lung Cancer Prevalence |
| | Asthma ED Rates |
| | Asthma ED Rates for Children |
| | Drug Induced Death |
| | Psychiatry Providers |
| | Specialty Care Providers |
| | Preventable Hospitalization |
| | Residential Segregation (Non-White/White) |
| | Income Inequality |
| | Homelessness Rate |

Injury and Disease Prevention and Management

Table 31: Primary themes and secondary indicators associated with PHN10.

| Primary Themes | Secondary Indicators |
|---|---|
| There isn't really a focus on prevention around here. | Infant Mortality |
| Preventive health services for women are needed (e.g., breast and cervical cancer screening). | Child Mortality |
| There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease). | Stroke Mortality |
| Vaccination rates are lower than they need to be. | Chronic Lower Respiratory Disease Mortality |
| Health education in the schools needs to be improved. | Diabetes Mortality |
| Additional HIV and STI prevention efforts are needed. | Heart Disease Mortality |
| The community needs nutrition education opportunities. | Hypertension Mortality |
| Schools should offer better sexual health education. | Liver Disease Mortality |
| Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, the elderly, LGBTQ individuals, immigrants). | Kidney Disease Mortality |
| Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision). | Suicide Mortality |
| | Unintentional Injuries Mortality |
| | COVID-19 Mortality |
| | COVID-19 Case Fatality |
| | Alzheimer's Disease Mortality |
| | Diabetes Prevalence |
| | Low Birthweight |

| Primary Themes | Secondary Indicators |
|----------------|---|
| | HIV Prevalence |
| | Poor Mental Health Days |
| | Frequent Mental Distress |
| | Frequent Physical Distress |
| | Poor or Fair Health |
| | COVID-19 Cumulative Incidence |
| | Asthma ED Rates |
| | Asthma ED Rates for Children |
| | Excessive Drinking |
| | Drug Induced Death |
| | Adult Obesity |
| | Physical Inactivity |
| | Chlamydia Incidence |
| | Teen Birth Rate |
| | Adult Smoking |
| | COVID-19 Cumulative Full Vaccination Rate |
| | Firearm Fatalities Rate |
| | Juvenile Arrest Rate |
| | Motor Vehicle Crash Death |
| | Disconnected Youth |
| | Third Grade Reading Level |
| | Third Grade Math Level |
| | Income Inequality |
| | Homelessness Rate |

Increased Community Connections

Table 32: Primary themes and secondary indicators associated with PHN11.

| Primary Themes | Secondary Indicators |
|--|----------------------------------|
| Health and social-service providers operate in silos; we need cross-sector connection. | Infant Mortality |
| Building community connections doesn't seem like a focus in the area. | Child Mortality |
| Relations between law enforcement and the community need to be improved. | Life Expectancy |
| The community needs to invest more in the local public schools. | Premature Age-Adjusted Mortality |
| There isn't enough funding for social services in the county. | Premature Death |
| People in the community face discrimination from local service providers. | Stroke Mortality |
| City and county leaders need to work together. | Diabetes Mortality |
| | Heart Disease Mortality |
| | Hypertension Mortality |
| | Suicide Mortality |
| | Unintentional Injuries Mortality |

| Primary Themes | Secondary Indicators |
|----------------|---|
| | Diabetes Prevalence |
| | Low Birthweight |
| | Poor Mental Health Days |
| | Frequent Mental Distress |
| | Poor Physical Health Days |
| | Frequent Physical Distress |
| | Poor or Fair Health |
| | Excessive Drinking |
| | Drug Induced Death |
| | Physical Inactivity |
| | Access to Exercise Opportunities |
| | Teen Birth Rate |
| | Primary Care Shortage Area |
| | Mental Health Care Shortage Area |
| | Medically Underserved Area |
| | Mental Health Providers |
| | Psychiatry Providers |
| | Specialty Care Providers |
| | Primary Care Providers |
| | Preventable Hospitalization |
| | COVID-19 Cumulative Full Vaccination Rate |
| | Homicide Rate |
| | Firearm Fatalities Rate |
| | Violent Crime Rate |
| | Juvenile Arrest Rate |
| | Some College |
| | High School Completion |
| | Disconnected Youth |
| | Unemployment |
| | Children in Single-Parent Households |
| | Social Associations |
| | Residential Segregation (Non- White/White) |
| | Income Inequality |
| | Homelessness Rate |
| | Households with no Vehicle Available |
| | Long Commute - Driving Alone |
| | Access to Public Transit |

System Navigation

Table 33: Primary themes and secondary indicators associated with PHN12.

| Primary Themes | Secondary Indicators |
|---|----------------------|
| <p>People may not be aware of the services they are eligible for.</p> <p>It is difficult for people to navigate multiple, different health care systems.</p> <p>The area needs more navigators to help to get people connected to services.</p> <p>People have trouble understanding their insurance benefits.</p> <p>Automated phone systems can be difficult for those who are unfamiliar with the healthcare system</p> <p>Dealing with medical and insurance paperwork can be overwhelming.</p> <p>Medical terminology is confusing.</p> <p>Some people just don't know where to start in order to access care or benefits.</p> | |

Next, values for the secondary health-factor and health-outcome indicators identified were compared to state benchmarks to determine if a secondary indicator performed poorly within the county. Some indicators were considered problematic if they exceeded the benchmark, others were considered problematic if they were below the benchmark, and the presence of certain other indicators within the county, such as health professional shortage areas, indicated issues. Table 34 lists each secondary indicator and describes the comparison made to the benchmark to determine if it was problematic.

Table 34: Benchmark comparisons to show indicator performance.

| Indicator | Benchmark Comparison Indicating Poor Performance |
|---|--|
| Infant Mortality | Higher |
| Child Mortality | Higher |
| Life Expectancy | Lower |
| Premature Age-Adjusted Mortality | Higher |
| Premature Death | Higher |
| Stroke Mortality | Higher |
| Chronic Lower Respiratory Disease Mortality | Higher |
| Diabetes Mortality | Higher |
| Heart Disease Mortality | Higher |
| Hypertension Mortality | Higher |
| Cancer Mortality | Higher |
| Liver Disease Mortality | Higher |
| Kidney Disease Mortality | Higher |
| Suicide Mortality | Higher |
| Unintentional Injuries Mortality | Higher |
| COVID-19 Mortality | Higher |
| COVID-19 Case Fatality | Higher |
| Alzheimer's Disease Mortality | Higher |
| Influenza and Pneumonia Mortality | Higher |
| Diabetes Prevalence | Higher |

| Indicator | Benchmark Comparison Indicating Poor Performance |
|---|--|
| Low Birthweight | Higher |
| HIV Prevalence | Higher |
| Disability | Higher |
| Poor Mental Health Days | Higher |
| Frequent Mental Distress | Higher |
| Poor Physical Health Days | Higher |
| Frequent Physical Distress | Higher |
| Poor or Fair Health | Higher |
| Colorectal Cancer Prevalence | Higher |
| Breast Cancer Prevalence | Higher |
| Lung Cancer Prevalence | Higher |
| Prostate Cancer Prevalence | Higher |
| COVID-19 Cumulative Incidence | Higher |
| Asthma ED Rates | Higher |
| Asthma ED Rates for Children | Higher |
| Excessive Drinking | Higher |
| Drug Induced Death | Higher |
| Adult Obesity | Higher |
| Physical Inactivity | Higher |
| Limited Access to Healthy Foods | Higher |
| Food Environment Index | Lower |
| Access to Exercise Opportunities | Lower |
| Chlamydia Incidence | Higher |
| Teen Birth Rate | Higher |
| Adult Smoking | Higher |
| Primary Care Shortage Area | Present |
| Dental Care Shortage Area | Present |
| Mental Health Care Shortage Area | Present |
| Medically Underserved Area | Present |
| Mammography Screening | Lower |
| Dentists | Lower |
| Mental Health Providers | Lower |
| Psychiatry Providers | Lower |
| Specialty Care Providers | Lower |
| Primary Care Providers | Lower |
| Preventable Hospitalization | Higher |
| COVID-19 Cumulative Full Vaccination Rate | Lower |
| Homicide Rate | Higher |
| Firearm Fatalities Rate | Higher |
| Violent Crime Rate | Higher |
| Juvenile Arrest Rate | Higher |
| Motor Vehicle Crash Death | Higher |
| Some College | Lower |
| High School Completion | Lower |
| Disconnected Youth | Higher |
| Third Grade Reading Level | Lower |

| Indicator | Benchmark Comparison Indicating Poor Performance |
|---|--|
| Third Grade Math Level | Lower |
| Unemployment | Higher |
| Children in Single-Parent Households | Higher |
| Social Associations | Lower |
| Residential Segregation (Non-White/White) | Higher |
| Children Eligible for Free Lunch | Higher |
| Children in Poverty | Higher |
| Median Household Income | Lower |
| Uninsured Population under 64 | Higher |
| Income Inequality | Higher |
| Severe Housing Problems | Higher |
| Severe Housing Cost Burden | Higher |
| Homeownership | Lower |
| Homelessness Rate | Higher |
| Households with no Vehicle Available | Higher |
| Long Commute - Driving Alone | Higher |
| Access to Public Transit | Lower |
| Pollution Burden Percent | Higher |
| Air Pollution - Particulate Matter | Higher |
| Drinking Water Violations | Present |

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

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

For this report, a PHN was selected as a preliminary quantitative significant health need if % of the associated quantitative indicators were identified as performing poorly; as a preliminary qualitative significant health need if it was identified by % or more of the primary sources as performing poorly; and as a preliminary community survey provider survey significant health need if at least % of survey

respondents identified it. Finally, a PHN was selected as a significant health need if it was included as a preliminary significant health need in two of three of these categories.

Health Need Prioritization

The final step in the analysis was to prioritize the identified SHNs. To reflect the voice of the community, significant health need prioritization was based solely on primary data. Key informants and focus-group participants were asked to identify the three most significant health needs in their communities. These responses were associated with one or more of the potential health needs. This, along with the responses across the rest of the interviews and focus groups, was used to derive two measures for each significant health need.

First, the total percentage of all primary data sources that mentioned themes associated with a significant health need at any point was calculated. This number was taken to represent how broadly a given significant health need was recognized within the community. Next, the percentage of times a theme associated with a significant health need was mentioned as one of the top three health needs in the community was calculated. Since primary data sources were asked to prioritize health needs in this question, this number was taken to represent the intensity of the need. Finally, the number of times each health need was selected as one of the top health needs by survey respondents was also included.

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

Detailed List of Resources to Address Health Needs

Table 35: Resources available to meet health needs.

| Organization Information | | | Significant Health Needs | | | | | | | | | | | Other Health Needs |
|---|------------------|--|---|---|--|----------------------------|--|----------------------------------|---------------------------------|------------------------------------|------------------------------|---------------------------------------|---|--------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Mental/Behavioral Health and Substance Use Services | Access to Quality Primary Care Health Services | Access to Functional Needs | Injury and Disease Prevention and Management | Active Living and Healthy Eating | Increased Community Connections | Safe and Violence-Free Environment | Healthy Physical Environment | Access to Specialty and Extended Care | Access to Dental Care and Preventive Services | System Navigation |
| Agency on Aging- Area 4 | 95815 | agencyonaging4.org/placer-county | x | x | x | x | x | | | x | | x | | x |
| Alta California Regional Center | 95678 | www.altaregional.org/post/roseville-1 | x | x | | | | x | | | | | | x |
| American Red Cross | 95815 | www.redcross.org/local/california/gold-country.html | x | | x | | x | | x | | | | | |
| American River Parkway Foundation | 95608 | arpf.org | | | | | | x | x | | | | | |
| Asian Resources Inc. | 95610 | asianresources.org | x | | | | | | x | | | | | |
| Auburn Renewal Center | 95602 | www.auburnclinic.org | | x | x | | x | | x | | | | x | |
| Birth and Beyond Home Visitation – WellSpace Health | 95660 | www.wellspacehealth.org/location/north-highlands-community-health-center-birth-and-beyond | x | x | x | | | | | | | | x | |
| Boys and Girls Club of Placer County | Placer County | bgcplacercounty.org | x | | | | | | x | x | | | | |
| Brookdale Senior Living | 95602, 95661 | www.brookdale.com/en.html | | | x | | | x | x | x | | x | | |
| CalFresh Placer County | Placer County | www.placer.ca.gov/2103/CalFresh-Food-Stamps | x | | | | | | | | | | | x |
| Camp Recreation | 95662 | www.camprecreation.org | | | | | | x | | x | | | | |
| Center Joint Unified School District | 95843 | www.centerusd.org | x | x | | | | x | | | | | | x |
| Chapa-De Indian Health | 95603 | chapa-de.org | | x | x | | x | | | | | x | x | x |
| Child Abuse Prevention Center | 95660 | www.thecapcenter.org | | | | | x | | | x | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | Other Health Needs |
|---|------------------|--|---|---|--|----------------------------|--|----------------------------------|---------------------------------|------------------------------------|------------------------------|---------------------------------------|---|--------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Mental/Behavioral Health and Substance Use Services | Access to Quality Primary Care Health Services | Access to Functional Needs | Injury and Disease Prevention and Management | Active Living and Healthy Eating | Increased Community Connections | Safe and Violence-Free Environment | Healthy Physical Environment | Access to Specialty and Extended Care | Access to Dental Care and Preventive Services | System Navigation |
| Citrus Heights Homeless Assistance Resource Team (HART) | 95610 | citrusheightshart.org | x | | | | | | x | | | | | |
| Consumers Self Help-Wellness and Recovery Center | 95608 | www.consumersselfhelp.org | x | x | | | | | | | | | | x |
| County of Placer-Community Health Education | Placer County | www.placer.ca.gov/3027/Community-Health-Education | | | | | x | | | | | | | x |
| County of Placer- Whole Person Care | 95603 | www.placer.ca.gov/2972/Whole-Person-Care-WPC | x | x | x | | | | | | | | | x |
| Cycles 4 Hope | 95678 | www.cycles4hope.org | x | | | x | | x | x | | | | | |
| Del Oro Caregiver Resource Center | 95610 | www.deloro.org | | x | | | x | | | | | x | | x |
| Dignity Health | 95608, 95630 | www.dignityhealth.org | | | x | | x | x | | | | x | | x |
| Dignity Health- Mercy Hospital of Folsom | 95630 | locations.dignityhealth.org/mercy-hospital-of-folsom | | x | x | | x | x | | | | x | | x |
| Dignity Health- Mercy San Juan Medical Center | 95608 | locations.dignityhealth.org/mercy-san-juan-medical-center | | x | x | | x | x | | | | x | | x |
| Effie Yeaw Nature Center | 95608 | www.sacnaturecenter.net | | | | | | x | x | | | | | |
| Elverta Joint School District | 95626 | www.ejesd.net | | | | | | x | | | | | | x |
| Eskaton | 95608 | www.eskaton.org/eskaton-village-carmichael-senior-living-retirement-community | x | x | x | | | x | x | | | x | | |
| Excel Roseville | 95678 | excelroseville.net | x | | | | | | x | x | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | Other Health Needs |
|---|------------------|---|---|---|--|----------------------------|--|----------------------------------|---------------------------------|------------------------------------|------------------------------|---------------------------------------|---|--------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Mental/Behavioral Health and Substance Use Services | Access to Quality Primary Care Health Services | Access to Functional Needs | Injury and Disease Prevention and Management | Active Living and Healthy Eating | Increased Community Connections | Safe and Violence-Free Environment | Healthy Physical Environment | Access to Specialty and Extended Care | Access to Dental Care and Preventive Services | System Navigation |
| First 5 Placer | 95603 | www.first5placer.org | x | x | x | | x | x | x | x | | | x | |
| Granite Wellness Centers | 95661 | www.granitewellness.org | x | x | x | | x | x | | | | | | x |
| Health Education Council | 95831 | healtheducouncil.org | x | | | | | | x | | | | | |
| Interim HealthCare of Citrus Heights | 95610 | www.interimhealthcare.com/citrusheightsca/home | x | x | x | | | | x | | | x | | |
| Kaiser Permanente Roseville Medical Center | 95661 | healthy.kaiserpermanente.org/northern-california/facilities/roseville-medical-center-100331 | | x | x | | x | x | | | | x | | x |
| Keaton's Child Cancer Alliance | 95661 | childcancer.org | | x | | | x | | | | | | | x |
| KidsFirst | Placer County | www.kidsfirstnow.org | x | x | | | x | x | x | x | | | | |
| Latino Leadership Council | 95678, 95648 | www.latinoleadershipcouncil.org | x | | x | | | | x | | | | | |
| Legal Services of Northern California-Health Rights | 95603 | lsnc.net | x | | | | | | | | | | | |
| Life Matters, Inc. | 95842 | www.lifemattersinc.org | x | | | | | | x | | | | | |
| Lighthouse Counseling & Family Resource Center | 95648 | lighthousefrc.org | x | x | | | | x | x | | | | | |
| Lilliput Children's Services | 95610 | www.lilliput.org | x | | | | | | x | | | | | |
| Lincoln Community Foundation | 95648 | lincolncommunityfoundation.org/contact-us | | | | | | | x | | | | | |
| MAK- Meningitis Awareness Key to Prevention | 95608 | makinfo.org | | | | | x | | | | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | Other Health Needs |
|---|------------------|--|---|---|--|----------------------------|--|----------------------------------|---------------------------------|------------------------------------|------------------------------|---------------------------------------|---|--------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Mental/Behavioral Health and Substance Use Services | Access to Quality Primary Care Health Services | Access to Functional Needs | Injury and Disease Prevention and Management | Active Living and Healthy Eating | Increased Community Connections | Safe and Violence-Free Environment | Healthy Physical Environment | Access to Specialty and Extended Care | Access to Dental Care and Preventive Services | System Navigation |
| Meals on Wheels | Placer County | seniorsfirst.org/2017/06/23/meals-on-wheels-placer-county | x | | | | | | x | | | | | |
| Mercy General Hospital (Dignity Health) | 95819 | www.dignityhealth.org/sacramento/locations/mercy-general-hospital | | | x | | x | x | | | | x | | x |
| Mercy Hospital of Folsom | 95630 | www.dignityhealth.org/sacramento/locations/mercy-hospital-of-folsom | x | | x | | x | x | | | | x | | x |
| Mercy San Juan Medical Center (Dignity Health) | 95630 | www.dignityhealth.org/sacramento/locations/mercy-san-juan-medical-center | x | x | x | | x | x | | | | x | | x |
| Neil Orchard Senior Activities Center | 95827 | crpd.com/parks/neil-orchard-senior-activities-center | | | | | | x | x | | | | | |
| Orangevale Fair Oaks Food Bank | 95662 | www.ovfofb.org | x | | | | | x | x | | | | | |
| Pacific Counseling and Trauma Center (Pacific Trauma Specialists) | 95630 | www.pacifictraumacenter.com | | x | | | | | | | | | | x |
| Parent Project (Placer County) | 95661 | parentproject.com | x | x | | | | | x | | | | | |
| People Reaching Out (PRO) Youth and Families | 95841 | proyouthandfamilies.org | | x | | | | | x | | | | | |
| Placer Collaborative Network | 95603 | placercollaborativenetwork.org/index.html | x | | | | | | x | | | | | |
| Placer Community Foundation | 95603 | placercf.org | x | | | | | | x | | | | | |
| Placer County | 95603 | www.placer.ca.gov | x | x | | | | x | x | | | | | |
| Placer County Adult System of Care | 95678 | www.placer.ca.gov/2158/Adult-System-of-Care | x | x | x | | | | | x | | | | x |
| Placer County CalFresh | 95765 | www.placer.ca.gov/2103/CalFresh-Food-Stamps | x | | | | | | x | | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | Other Health Needs |
|---|------------------|--|---|---|--|----------------------------|--|----------------------------------|---------------------------------|------------------------------------|------------------------------|---------------------------------------|---|--------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Mental/Behavioral Health and Substance Use Services | Access to Quality Primary Care Health Services | Access to Functional Needs | Injury and Disease Prevention and Management | Active Living and Healthy Eating | Increased Community Connections | Safe and Violence-Free Environment | Healthy Physical Environment | Access to Specialty and Extended Care | Access to Dental Care and Preventive Services | System Navigation |
| Placer County Children's System of Care | 95765 | www.placer.ca.gov/2050/Childrens-System-of-Care | x | x | | | | | | x | | | | x |
| Placer County- Dial-A-Ride | 95603 | www.placer.ca.gov/1793/Dial-A-Ride | | | | x | | | x | | | | | |
| Placer County Health and Human Services | 95765 | www.placer.ca.gov/1679/Health-Human-Services | x | x | x | | | | | | | | x | x |
| Placer County Human Services | 95765 | www.placer.ca.gov/2096/Human-Services | x | | | | | | | | | | | x |
| Placer County Mental Health Services | 95678 | www.placer.ca.gov/2166/Mental-Health-Services | x | x | | | | | | | | | | x |
| Placer County Office of Education (PCOE) | 95603 | www.placercoe.org/Pages/PCOE/Home.aspx | x | | | | | | | | | | | x |
| Placer County Public Health | 95603 | www.placer.ca.gov/2863/Public-Health | | | | | | | | | | | | |
| Placer County Public Health Nursing | 95603 | www.placer.ca.gov/2912/Public-Health-Nursing | x | | x | | x | x | | | | | | |
| Placer County Sexual Assault Response Team (SART) | 95661 | www.placer.ca.gov/3354/Sexual-Assault-Response-Team-SART | | | x | | | | | x | | | | |
| Placer County Veterans Services | 95765 | www.placer.ca.gov/1875/Veterans | x | x | | | | | | | | | | |
| Placer County WIC | 95765 | www.placer.ca.gov/2918/Women-Infants-Children-WIC | x | | x | | x | x | | | | | | x |
| Placer Food Bank | 95678 | placerfoodbank.org | x | | | | | x | x | | | | | |
| Placer Independent Resource Services (PIRS) | 95603 | www.pirs.org | x | | | | | x | x | | | | | |
| Placer People of Faith Together | 95650 | www.ppoft.org | x | | | | | | | | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | Other Health Needs |
|---|-------------------|--|---|---|--|----------------------------|--|----------------------------------|---------------------------------|------------------------------------|------------------------------|---------------------------------------|---|--------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Mental/Behavioral Health and Substance Use Services | Access to Quality Primary Care Health Services | Access to Functional Needs | Injury and Disease Prevention and Management | Active Living and Healthy Eating | Increased Community Connections | Safe and Violence-Free Environment | Healthy Physical Environment | Access to Specialty and Extended Care | Access to Dental Care and Preventive Services | System Navigation |
| Planned Parenthood North Highlands Health Center | 95660 | www.plannedparenthood.org/health-center/california/north-highlands/95660/north-highlands-health-center-2201-90130 | | | X | | X | | | | | | | X |
| Planned Parenthood Roseville Health Center | 95661 | www.plannedparenthood.org/health-center/california/roseville/95661/roseville-health-center-2197-90130 | | | X | | X | | | | | | | X |
| Powerhouse Ministries - Transformation Center | 95630 | www.phmfolsom.org | X | X | | | | | X | | | | | |
| PRIDE Industries | 95660, 95747 | www.prideindustries.com | X | | | X | | | X | | | | | |
| PRO Youth and Families | 95841 | proyouthandfamilies.org | | X | | | X | | X | | | | | |
| Roseville Adult School | 95678 | www.rjuhsd.us/rosevilleadult | X | | | | | | | | | | | X |
| Roseville Family Resource Center-KidsFirst | Placer County | www.kidsfirstnow.org | X | X | | | X | X | X | X | | | | |
| Roseville Housing Authority | 95678 | www.roseville.ca.us/residents/affordable_housing/rental_programs/housing_choice_voucher_program_hcv | X | | | | | | | | | | | |
| Roseville Joint Union High School District | 95661 | www.rjuhsd.us | X | | | | | | | X | | | | X |
| Sacramento County-Department of Health Services | Sacramento County | dhs.saccounty.gov/Pages/DHS-Home.aspx | | X | X | | X | X | | X | X | | | |
| Sacramento County-Department of Human Assistance Benefits | Sacramento County | ha.saccounty.gov/benefits/Pages/default.aspx | X | | | | | | | | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | Other Health Needs |
|---|-------------------|---|---|---|--|----------------------------|--|----------------------------------|---------------------------------|------------------------------------|------------------------------|---------------------------------------|---|--------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Mental/Behavioral Health and Substance Use Services | Access to Quality Primary Care Health Services | Access to Functional Needs | Injury and Disease Prevention and Management | Active Living and Healthy Eating | Increased Community Connections | Safe and Violence-Free Environment | Healthy Physical Environment | Access to Specialty and Extended Care | Access to Dental Care and Preventive Services | System Navigation |
| Sacramento County- First 5 Every Smile Counts | Sacramento County | first5sacdentel.org/esc | | | | | X | | | | | | X | X |
| Sacramento County- Oral Health Program | Sacramento County | dhs.saccounty.gov/PUB/OralHealth/Pages/Oral-Health.aspx | | | | | | | | | | | X | X |
| Sacramento County Public Health- African American Perinatal Health | Sacramento County | dhs.saccounty.gov/PUB/Pages/African-American-Perinatal-Health-Program/SP-African-American-Perinatal-Health-Program.aspx#:~:text=The%20African%20American%20Perinatal%20Health%20Program%20was%20established%20to%20reduce,women%2C%20residing%20in%20Sacramento%20County. | | | | | | | | | | X | | X |
| Sacramento County Public Health- Black Infant Health Program | Sacramento County | dhs.saccounty.gov/PUB/Pages/Black-Infant-Health-Program/SP-Black-Infant-Health-Program.aspx | | | | | X | | | | | | | |
| Sacramento County Public Health- California Children's Services | Sacramento County | dhs.saccounty.gov/PUB/Pages/California-Childrens-Services/SP-California-Childrens-Services.aspx | | | | | X | | | | | X | | |
| Sacramento County Public Health- Chest Clinic/Tuberculosis Control | Sacramento County | dhs.saccounty.gov/PUB/Pages/Communicable-Disease-Control/GI-TB-Control.aspx | | | | | X | | | | | X | | X |
| Sacramento County Public Health- Child Health and Disability Prevention | Sacramento County | dhs.saccounty.gov/PUB/CHDP/Pages/CHDP-Home.aspx | | | X | | | | | | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | Other Health Needs |
|---|-------------------|---|---|--|--|-------------------------------|--|-------------------------------------|------------------------------------|--|---------------------------------|--|---|--------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Mental/Behavioral Health and Substance Use Services | Access to Quality Primary Care Health Services | Access to Functional Needs | Injury and Disease Prevention and Management | Active Living and Healthy Eating | Increased Community Connections | Safe and Violence- Free Environment | Healthy Physical Environment | Access to Specialty and Extended Care | Access to Dental Care and Preventive Services | System Navigation |
| Sacramento County Public Health- Comprehensive Perinatal Services Program | Sacramento County | dhs.saccounty.gov/PUB/Pages/Comprehensive-Perinatal-Services-Program/SP-Comprehensive-Perinatal-Services-Program-(CPSP).aspx | | x | | | | x | x | | | | x | |
| Sacramento County Public Health- Disease Control and Epidemiology | Sacramento County | dhs.saccounty.gov/PUB/Pages/Epidemiology/SP-Epidemiology.aspx | | | | | | x | | | | | | x |
| Sacramento County Public Health- Emergency Preparedness | Sacramento County | dhs.saccounty.gov/PUB/Emergency-Preparedness/Pages/SP-Emergency-Preparedness.aspx | | | | | | x | | | | | | |
| Sacramento County Public Health- HIV/STD Prevention Program | 95660 | dhs.saccounty.gov/PUB/SexualHealthPromotionUnit/Pages/GI-HIV-STD-Prevention-Program.aspx | | | x | | | x | | | | | x | x |
| Sacramento County Public Health- HIV/STD Surveillance | Sacramento County | dhs.saccounty.gov/PUB/SexualHealthPromotionUnit/Pages/GI-STD-Control.aspx | | | | | | x | | | | | | x |
| Sacramento County Public Health- Immunization Assistance Program | Sacramento County | dhs.saccounty.gov/PUB/Pages/Immunization-Assistance-Program/Immunization-Assistance-Program-(IAP).aspx | | | | | | x | | | | | | |
| Sacramento County- Public Health Laboratory | Sacramento County | dhs.saccounty.gov/PUB/Laboratory/Pages/Laboratory-Home.aspx | | | | | | x | | | | | | |
| Sacramento County Public Health- Lead Poisoning Prevention Program | Sacramento County | dhs.saccounty.gov/PUB/Pages/Childhood-Illness-Injury-Prevention-Program/LeadPoisoningPrevention/SP-Lead-Poisoning-Prevention.aspx | | | | | | x | | | | | | |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | Other Health Needs |
|---|-------------------|--|---|--|--|-------------------------------|--|-------------------------------------|------------------------------------|--|---------------------------------|--|---|--------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Mental/Behavioral Health and Substance Use Services | Access to Quality Primary Care Health Services | Access to Functional Needs | Injury and Disease Prevention and Management | Active Living and Healthy Eating | Increased Community Connections | Safe and Violence- Free Environment | Healthy Physical Environment | Access to Specialty and Extended Care | Access to Dental Care and Preventive Services | System Navigation |
| Sacramento County Public Health- Nurse Family Partnership | Sacramento County | dhs.saccounty.gov/PUB/Pages/Nurse-Family-Partnership/The-Nurse-Family-Partnership-Program.aspx | | | | | X | | | | | X | | X |
| Sacramento County Public Health- Obesity Prevention Program | Sacramento County | www.saccounty.gov/services/Pages/Obesity-Prevention-Program.aspx | | | | | X | X | | | | | | |
| Sacramento County Public Health- Ryan White Program | Sacramento County | dhs.saccounty.gov/PUB/SexualHealthPromotionUnit/Pages/RyanWhiteProgram/Ryan-White-Program.aspx | | X | X | | X | | | | | X | | |
| Sacramento County Public Health- Tobacco Education Program | Sacramento County | dhs.saccounty.gov/PUB/Pages/Tobacco-Education-Program/SP-Tobacco-Education-Program.aspx | | | | | X | | | | X | | | |
| Sacramento County Public Health- Vital Records | Sacramento County | dhs.saccounty.gov/PUB/Pages/Birth-and-Death-Certificates/Sacramento-County-Vital-Records.aspx | | | | | X | | | | | | | |
| Sacramento Works Job Centers | 95842, 95610 | sacramentoworks.org | X | | | | | | | | | | | |
| San Juan Unified School District | 95608 | www.sanjuan.edu | X | X | | | | X | | X | | | X | X |
| Seniors First | 95602 | seniorsfirst.org | X | X | | X | | | | X | | | | |
| SETA Head Start | 95608, 95610 | headstart.seta.net | X | X | | | | X | | X | | | | |
| Shady Creek Outdoor School and Event Center | | www.shadycreek.org | | | | | | | X | X | X | | | |
| Sierra College Foundation | 95677 | www.sierracollege.edu/about-us/sierracollege-foundation/index.php | | | | | | | X | X | | | | |
| Sierra Community Medical Foundation | 95677 | www.scmfoundation.org | | X | X | | | | | | | | | X |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | Other Health Needs |
|--|-------------------|--|---|---|--|----------------------------|--|----------------------------------|---------------------------------|------------------------------------|------------------------------|---------------------------------------|---|--------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Mental/Behavioral Health and Substance Use Services | Access to Quality Primary Care Health Services | Access to Functional Needs | Injury and Disease Prevention and Management | Active Living and Healthy Eating | Increased Community Connections | Safe and Violence-Free Environment | Healthy Physical Environment | Access to Specialty and Extended Care | Access to Dental Care and Preventive Services | System Navigation |
| Sierra Foothills Outpatient Clinic | 95603 | www.va.gov/directory/guide/facility.asp?ID=986 | | X | X | | | | | | | | | X |
| Sierra Health Foundation | 95833 | www.sierrahealth.org | | X | X | | X | X | | X | | | | X |
| Sierra Mental Wellness Group | 95661 | sierramentallowellness.org | | X | | | | | | | | | | X |
| Slavic Assistance Center | 95825 | www.slaviccenter.us/ | X | | | | | | X | | | | | |
| St. Vincent De Paul Society of Roseville | 95678 | www.placersvdp.com | X | | X | | | | X | | | | | |
| Stand Up Placer | 95661 | standupplacer.org | X | X | | | | | X | X | | | | |
| Stanford Sierra Youth and Families *change web | 95603 | www.ssyaf.org | | X | | | | | X | X | | | | |
| Stop Stigma Sacramento Speakers Bureau | Sacramento County | www.stopstigmasacramento.org | | | | | X | | X | | | | | |
| Sutter Medical Center, Sacramento | 95616 | www.sutterhealth.org/smcs | | X | X | | X | | | | | X | | X |
| Sutter Roseville Medical Center | 95661 | www.sutterhealth.org/srhc | | X | X | | X | | | | | | | X |
| Terra Nova Counseling | 95834 | www.terravacounseling.org | | X | | | | | | | | | | X |
| The Gathering Inn | 95678 | www.thegatheringinn.com | X | X | X | | | | | | | | | X |
| The Salt Mine | 95648 | www.thesaltmine.org | X | | | | | | X | | | | | |
| The Salvation Army | 95603, 95746 | auburn.salvationarmy.org/auburn, roseville.salvationarmy.org | X | | | | | | X | | | | | |
| Twin Lakes Food Bank | 95630 | www.twinlakesfoodbank.org | X | | | | | | X | | | | | |
| Twin Rivers Unified School District | 95660 | www.twinriversusd.org | X | X | | | | X | | | | | | X |

| Organization Information | | | Significant Health Needs | | | | | | | | | | | Other Health Needs |
|--|----------------------------|----------------------------|---|---|--|----------------------------|--|----------------------------------|---------------------------------|------------------------------------|------------------------------|---------------------------------------|---|--------------------|
| Name | Primary ZIP Code | Website | Access to Basic Needs Such as Housing, Jobs, and Food | Access to Mental/Behavioral Health and Substance Use Services | Access to Quality Primary Care Health Services | Access to Functional Needs | Injury and Disease Prevention and Management | Active Living and Healthy Eating | Increased Community Connections | Safe and Violence-Free Environment | Healthy Physical Environment | Access to Specialty and Extended Care | Access to Dental Care and Preventive Services | System Navigation |
| U.S Department of Veterans Affairs- Vet Center | 95610 | www.vetcenter.va.gov | x | x | | | | | | | | | | x |
| Volunteers of America-Home Start Inc. | 95678 | www.voa-ncnn.org/homestart | x | x | | | | | x | | | | | |
| WarmLine Family Resource Center | 95818 | www.warmlinefrc.org | x | x | x | | | | x | | | | | |
| WellSpace Health | 95630, 95660, 95621, 95661 | www.wellspacehealth.org | | x | x | | x | | | | | | x | x |
| Western Sierra Medical Clinic | 95603 | wsmcmed.org | | x | x | | x | | | | | x | x | x |
| What Would Jesus Do, Inc. | 95678 | www.wwjdinc.org | x | | | | | | x | | | | | |
| World Relief Sacramento | 95660 | worldrelief.org/sacramento | x | | | | | | x | | | | | x |
| Zafia's Family House | 95678 | zafiasfamilyhouse.org | x | | | | | | x | | | | | |

Limits and Information Gaps

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

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

Finally, though this CHNA was conducted with an equity focus, data that point to differences among population subgroups that are more “upstream” focused are not as available as those data that detail the resulting health disparities. Having a clearer picture of early-in-life opportunity differences experienced among various populations that result in later-in-life disparities can help direct community health improvement efforts for maximum impact.

Appendix A: Evaluation of the Impact of Actions Taken Since 2019 CHNA – Sutter Roseville Medical Center

MENTAL HEALTH

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

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| | <p>educational needs of more than 10,000 students. RJUHSD is in the 4th year of implementing 8 Wellness Centers which focus on: increasing access to mental health, substance use intervention, and overall health and wellness. The Wellness Centers focus on serving the needs of high-risk student populations including homeless, foster, probation, and low socioeconomic disadvantaged students. Wellness Centers are staffed by interns, trainees, mental health associates and we have 3 Licensed Clinical Social Workers that supervise all clinical services throughout the district.</p> |
| Goals | <p>RJUHSD Wellness Centers will increase student and family access to mental health, substance use, attendance support and engaged with community resources. RJUHSD Wellness is aware of the lack of community resources to address the rising needs surrounding the mental health and wellness of students and families. They will address and work through barriers to students school success to increase students overall functioning in academic, social, and emotional aspirations.</p> |
| Outcomes | <p>In 2021, served 842 children and youth. Scheduled 2,435 mental health appointments; provided 10,387 services. As COVID continues to impact the community, RJUHSD increased referral access points to include parents and students direct referrals for services. At each of the school sites RJUHSD have increased classroom presentations, for a total of 224 hours, to students and staff raising awareness of Wellness Center services, community resources, and providing prevention education surrounding mental health and coping skills.</p> |
| Name of program/activity/initiative | <p>Lighthouse Counseling and Family Resource Center Family Wellness Program</p> |
| Description | <p>Our Family Wellness Initiative provides comprehensive counseling services and a wide variety of family wellness classes for children and families who are negatively affected by trauma, anxiety and depression, family attachment issues, domestic violence, child abuse and neglect, crime, poor mental health, and other forms of familial distress. Our goals are to help families heal by establishing long-term safety, self-sufficiency, and positive health outcomes. We accomplish this through an inclusive approach that incorporates case management and referral services, counseling and parental support, and a variety of educational classes.</p> |
| Goals | <p>Programs goals include the following:</p> <ol style="list-style-type: none"> 1) Improve the quality of life for Placer County families and the community as a whole by providing quality evidence-based mental health counseling services (individual and/or group therapy) and educational classes for up to 150 individuals. 2) Reduce the incidences of familial violence, and child abuse and neglect in Placer County. 3) Provide intensive case management for Placer County families we |

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| | serve by connecting them to critical resources such as Medi-Cal, Cal-Fresh, rent and utility assistance, diapers, bus passes, back-to-school supplies, seasonal assistance, Christmas toys, reconditioned bicycles, and gift cards for food, gas, and clothing. |
| | 4) Our primary goal is to build strong families and in turn strong communities. |
| Outcomes | 2021: Served 675 adults, 491 children/youth and 872 families; provided 1,609 counseling sessions; made referrals to 1,121 support services. 2020: Served 1,981 adults, 1,732 children/youth and 1,325 families; provided 2,676 counseling sessions; made referrals to 1,670 support services. |

ACCESS TO QUALITY PRIMARY HEALTHCARE SERVICES

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| Name of program/activity/initiative | Comprehensive Management Team – WellSpace Health |
| Description | The WellSpace Health CMT program provides case management services for people who frequent the emergency departments for non-urgent needs. We support this vulnerable population with vital resources such as income (SSI/GA), primary care, mental and behavioral health services, transportation, substance abuse treatment and other key community resources. By linking these patients to the appropriate care and wraparound services, we see a drastic improvement to the health and overall quality of life for this often undeserved, patient population. |
| Goals | <ol style="list-style-type: none"> 1. Reduce the frequency of individuals utilizing high cost systems of care 2. Coordinate and link clients to a medical and behavioral health home 3. Provide wraparound case management services to the under-served 4. Educate and assist clients with additional community resources. |
| Outcomes | 2020: served 54 adult clients; provided 356 services; 2,259 service referrals; 124 established with mental or primary health care homes. 2021: served 81 adult clients; provided 426 services; 2,332 service referrals; 174 established with mental or primary health care homes. |

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| Name of program/activity/initiative | Promotora Program – Latino Leadership Council |
| Description | The Promotora program is the only program regionally that uses Promotores to help uninsured and underinsured Latinos get access to health, dental, vision and mental health services and to teach them how to effectively navigate the health care system. Promotores conduct home visits during evenings and weekends to help participants learn how to properly and effectively engage the health care system, provide them with important health information and ensure that they find a medical home or other culturally and linguistically appropriate supports such as specialty care, mental health, or family wellness. |
| Goals | Provide access to health, dental, vision and mental health for Latino |

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| | adults through Promotores. |
| Outcomes | 2021: 991 total adults, youth and families served; 3,569 total services provided; 3,891 referrals made; 436 obtained basic needs. 2020: 652 total adults, youth and families served; 2,324 total services provided; 1,830 referrals made; 517 obtained basic needs. 2019: 446 total adults, youth and families served; 177 total services provided; 648 referrals made; 39 obtained basic needs. |

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

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| Name of program/activity/initiative | Placer County Food Bank Senior Mobile Food Distribution |
| Description | Program provided nutritional food boxes to income-challenged/low income seniors. Attempted to cost-effectively "customize" food boxes with food items that are easy to prepare or add to existing food and can be dietary-friendly should a senior have health-related issues |
| Goals | Help overcome seniors' transportation constraints through the mobile distribution model so those we are targeting don't have to worry about self-pickup. |
| Outcomes | 2021: 533 seniors served; 2,250 total services provided. The program allowed to serve 533 seniors of which 150 were added due to this funding opportunity, these reside within nine different sites. These seniors received custom built food boxes that were delivered semi-monthly, these boxes included senior friendly items as many suffer from dietary restrictions. |

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| Name of program/activity/initiative | Seniors First Meals on Wheels Distribution |
| Description | Seniors First has been awarded funding to once again operate the Meals on Wheels program in Placer County. Meals on Wheels is the nation's oldest and largest community-based senior nutrition organization and supports the more than 5,000 senior nutrition programs across the country dedicated to addressing senior hunger and isolation. This network exists in virtually every community in America and delivers the nutritious meals and friendly visits that enable America's seniors to live nourished lives with independence and dignity. |
| Goals | Deliver meals to homebound Placer County seniors (ages 60+). |
| Outcomes | 2021: Served over 1,300 adults with food distribution. Participation in our MOW program has continued at heightened levels; we are currently serving 190% of normal program capacity. Seniors are keenly aware of their vulnerability to the coronavirus and continue to have major concerns about public contact. All our congregate meals remain closed due to the pandemic and will remain closed until deemed safe by public health officials to re-open. |

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| Name of | The Gathering Inn – Interim Care Program |
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| program/activity/initiative | |
| Description | The Gathering Inn's Interim Care Program provides homeless individuals a safe place to rest and recover following hospital discharge. Its housing first model, and low barrier approach, make it a viable option to being discharged to the street and have a positive effect on health and housing outcomes. Guests of the program reside in a 5 bedroom fully furnished home and have access to showers, computers, cable television, laundry services, food, and clothes. In addition to meeting the basic needs of guests, the program provides intensive case management. Case management works with guests daily, helping to connect them to health care providers, income assistance programs, housing opportunities, and more. Since its inception in 2009, the Interim Care Program has served over 600 individuals. |
| Goals | <ol style="list-style-type: none"> 1. To improve the health outcomes of homeless individuals. 2. To break the costly cycle of emergency room as first-line medical care. 3. To reduce recidivism and facilitate healing, recovery, and hope 4. To reduce health inequity by providing appropriate accommodation for recovery. 5. To transition patients to permanent supportive housing after their stay. |

ACCESS AND FUNCTIONAL NEEDS

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| Name of program/activity/initiative | |
| | Health Express/ My Rides Program |
| Description | MyRides provides free transportation services to non-emergency medical appointments and other essential services for eligible Placer County residents. Transportation is provided by volunteer drivers who are approved and scheduled by Seniors First. |
| Goals | Ensure low-income, Placer County seniors have transportation to non-emergency medical care. |
| Outcomes | <p>2021: Provided more than 1,900 rides to medical appointments</p> <p>2020: Provided nearly 4,000 rides to medical appointments.</p> <p>2019: Provided rides to more than 1,500 clients.</p> |

INJURY AND DISEASE PREVENTION AND MANAGEMENT

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| Name of program/activity/initiative | |
| | Keaton's Childhood Cancer Alliance, Family Navigator Program |
| Description | The Family Navigator Program was first launched in 2011 and has evolved from the direct feedback of families and hospital partners. In our region, over 800 children are diagnosed with cancer each year. Keaton's will expand and enhance its proven Family Navigator Program to address the financial, structural, and personal barriers as well as the psychological effects of childhood cancer on the entire family. |

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| Goals | Goal is to ensure child cancer families have access to high-quality healthcare, social services, financial assistance, and other vital resources that promote wellness and increase the quality of life. |
| Outcomes | <p>2021: Total of 1,811 individuals served in 2021 (patients and siblings ages 0-18 + their immediate family members) of which 158 are from Placer County; 241% of goal of 750 individuals. Provided 556 linkages to direct services, mental health support, and community resources; 111% of goal of 500 linkages.</p> <p>The financial strain and burden experienced by the families Keaton's serves continue to be enhanced. To help reduce this burden, Keaton's provided 102 financial grants as well as 408 total meal and/or fuel vouchers in 2021.</p> <p>2020: 653 adults and youth served; 653 who obtained basic needs; 57 total services provided.</p> <p>2019: 348 families served; 228 obtained basic needs.</p> |

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| Name of program/activity/initiative | Telehealth Diabetes Prevention Program – Chapa De Indian Health |
| Description | Chapa-De's Diabetes Prevention Program (DPP) is a year-long program that helps Chapa-De patients to avoid the onset of diabetes and to live healthier. Using CDC teaching materials proven to promote weight loss and lifestyle change, Chapa-De lifestyle coaches teach participants about eating healthy, being physically active and managing stress. Participants attend weekly classes for 10 weeks, then 6 bi-weekly classes, followed by optional monthly sessions to help maintain weight loss and healthy lifestyles. |
| Goals | Utilize a video telehealth platform to engage 40 individuals who have been identified as at-risk for type II diabetes to participate in our Diabetes Prevention Program to receive virtual instruction, support, and assistance along with all necessary equipment and supplies to empower them to live healthier lives, lose weight, prevent diabetes, and heart disease. |
| Outcomes | 2021: 113 total adults served; 486 total services provided. |

ACCESS TO SPECIALTY AND EXTENDED CARE

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| Name of program/activity/initiative | Family Support Project – Placer County Public Health |
| Description | The ongoing collaboration and coordination of Sutter Roseville Medical Center (SRMC) and Placer County Maternal Child Adolescent Health (MCAH) provide the pathway for the medical center to meet the post-discharge needs of the Family Birth Center families (FBC). The program serves the expanded SRMC families in 21 zip codes served by the hospital. The FSP PHN will also serve the perinatal population in the various medical-surgical departments of the hospital, if requested. The FSP PHN is also available to address families directly when requested by FBC staff members. |

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| Goals | The goal of the program is to establish a partnership between the County and Hospital, to improve the health of infants born at Sutter Roseville Medical Center (SRMC), including childhood immunization education, outreach, and promotion of breastfeeding, and to provide outreach for care and services and link families to available services. |
| Outcomes | 2021: 70 total families served; 234 direct services provided; 204 referrals made to support services. 2020: 40 total families served; 44 direct services provided; 53 referrals made to support services. 2019: 72 total families served; 142 direct services provided; 191 referrals made to support services. |

HEALTHY EATING AND ACTIVE LIVING

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| Name of program/activity/initiative | Boys and Girls Club of Placer County – Roseville Site |
| Description | Since opening its doors in 1994, Boys & Girls Club of Placer County has been offering critical services to young people in our community with a wide range of programs in such areas as education, character development, career exploration, sports & recreation, the arts, and community service. Their new clubhouse in Roseville Heights be the first Boys & Girls Club in the south Placer region and will include a teen center, art center, learning lab, and outdoor recreation area for members. |
| Goals | The main objective of the Club will be to serve the Roseville Heights neighborhood. This community has one the lowest median income level, the highest rate of unemployment as well as the highest crime rate in the city of Roseville. These residents and this neighborhood are underserved, making it an ideal location for the Boys & Girls Club to offer high-quality programming to all children, ages 6-18. |
| Outcomes | 2021: Supported the construction of a new play yard at the new Roseville Heights neighborhood clubhouse. It is anticipated this site will serve 150-175 youth each day after school as well as a 6-8 week Summer Camp when school is out for the summer. . |

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| Name of program/activity/initiative | Shady Creek Outdoor Education Foundation: FitQuest |
| Description | The three tenets of Fit Quest are nutrition, physical activity, and mental wellness and the students' overall health. The Fit Quest program serves students in the 5th and 6th grades (ages 9-13 years old in their respective communities) either in the classroom or, if the school permits, by interactive virtual assemblies (at least 2 site visits, if approved by the school) to accommodate current health concerns. In addition, Fit Quest hosts Family Camp once a year allowing the program to share its objectives, tenets, and encouraging families to eat healthier, engage in physical fitness and instill behaviors to improve |

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| | their overall mental health as a family unit. |
| Goals | <p>Reduce the number of children at risk or, by definition, obese with long term effect of reducing community health care costs.</p> <p>Increase mindfulness, individual uniqueness, awareness of emotional triggers and responses, tools, and resources for navigating stressors.</p> <p>Empower students to effect change with inclusion of family in process.</p> <p>Increase overall number of students meeting physical fitness standards; encourage physical activity.</p> <p>Reach as many students as possible and their families to educate them of the tenets of Fit Quest in the counties served.</p> |
| Outcomes | <p>2021: 426 total adults and youth served.</p> <p>2020: 349 total adults and youth served.</p> <p>2019: 711 total adults and youth served; including 24 families.</p> |