2019 Community Health Needs Assessment

Kaiser Foundation Hospital: Sacramento

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KAISER PERMANENTE®

Kaiser Permanente Northern California Region Community Benefit

CHNA Report for KFH-Sacramento

Contents

I. Introduction/background

A. About Kaiser Permanente (KP)

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

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

Kaiser Permanente is an integrated health care delivery system comprised of Kaiser Foundation Hospitals (KFH), Kaiser Foundation Health Plan (KFHP), and physicians in the Permanente Medical Groups. Today we serve more than 12 million members in nine states and the District of Columbia. Our mission is to provide high quality, affordable health care services and to improve the health of our members and the communities we serve.

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

B. About Kaiser Permanente Community Health

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

Better health outcomes begin where health starts, in our communities. Like our approach to medicine, our work in the community takes a prevention-focused, evidence-based approach. We go beyond traditional corporate philanthropy or grantmaking to pair financial resources with medical research, physician expertise, and clinical practices. Our community health strategy focuses on three areas:

- Ensuring health access by providing individuals served at KP or by our safety net partners with integrated clinical and social services;
- Improving conditions for health and equity by engaging members, communities, and Kaiser Permanente's workforce and assets; and
- Advancing the future of community health by innovating with technology and social solutions.

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

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

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

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

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

Kaiser Permanente's innovative approach to CHNAs include the development of a free, web-based CHNA data platform that is available to the public. The data platform provides access to a core set of 130 publicly available indicators to understand health through a framework that includes social and economic factors, health behaviors, physical environment, clinical care, and health outcomes.

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

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

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

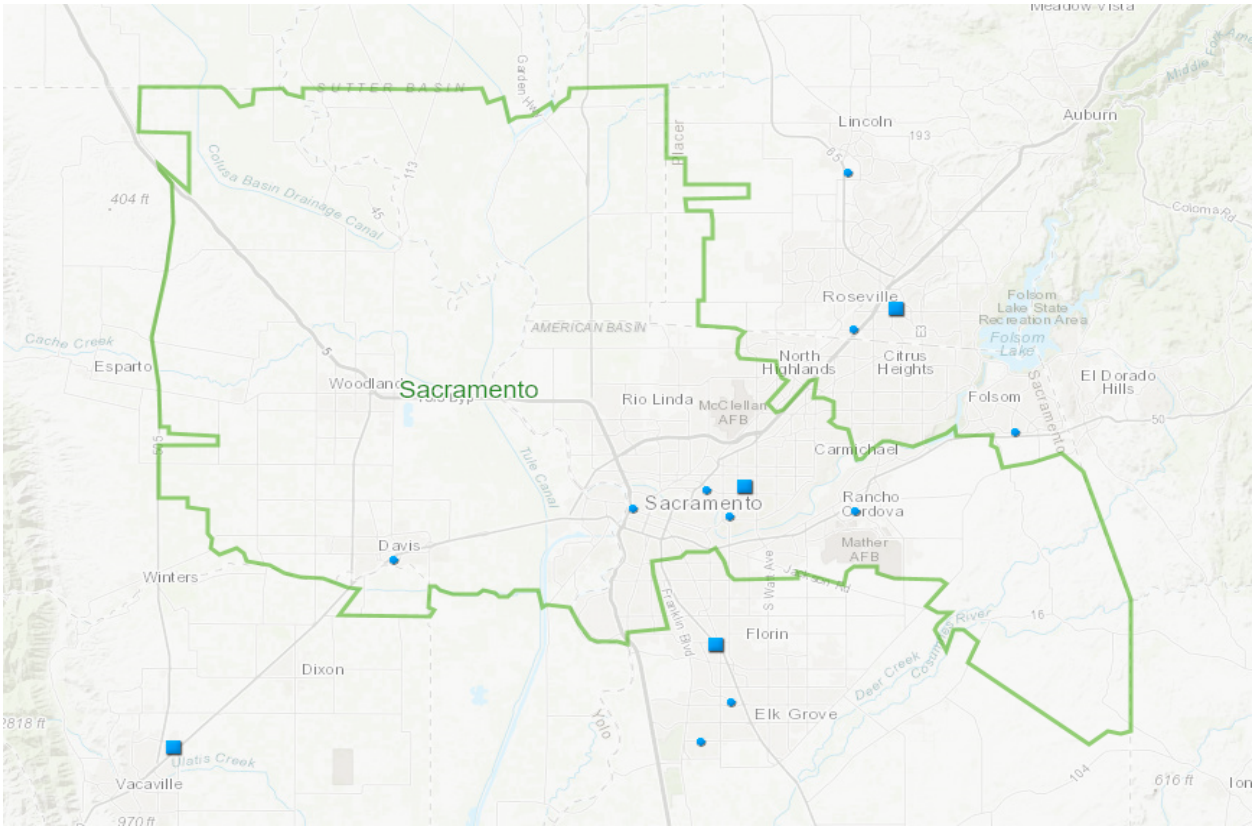
II. Community served

A. Kaiser Permanente's definition of community served

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

B. Map and description of community served

i. Map



KFH-Sacramento Service Area

ii. Geographic description of the community served

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

iii. Demographic profile of the community served

Demographic profile: KFH-Sacramento

Race/ethnicity		**Socioeconomic Data**	
Total Population	897,528	Living in poverty (<100% federal poverty level)	19.4%
Asian	12.8%	Children in poverty	25.1%
Black	8.8%	Unemployment	3.9%
Native American/Alaska Native	0.7%	Uninsured population	10.2%
Pacific Islander/Native Hawaiian	0.7%	Adults with no high school diploma	12.1%
Some other race	8.0%		
Multiple races	6.5%		
White	62.5%		
Hispanic/Latino	24.3%		

III. Who was involved in the assessment?

A. Identity of hospitals and other partner organizations that collaborated on the assessment

KFH-Sacramento coordinated 2019 CHNA efforts with several regional hospital systems– Dignity Health, Sutter Health, and the University of California, Davis Medical Center. These three health systems worked collectively through a contract with Community Health Insights (CHI) to conduct their CHNAs. Monthly joint meetings between Kaiser Permanente and the other health systems provided opportunities to share strategies and coordinate efforts. In particular, Harder+Company Community Research, the consultant for the KFH-Sacramento CHNA process, and CHI partnered on the development of qualitative data collection protocols and data collection workload, and shared transcripts from respective data collection activities. This strategy allowed for parallel CHNA processes and the integration of extensive amounts of qualitative data into their respective CHNA reports while avoiding overtaxing the community with multiple data collection efforts. It also ensured coordination and communication between hospitals with overlapping service areas. The collaboration strategy still allowed for unique CHNA needs to arise given differences in hospital service areas, and for each hospital to use data collection and analysis methods that best aligned with their internal protocol. In addition to coordinating efforts with the other regional hospital systems, Sacramento County Public Health staff participated in the monthly joint hospital meetings to provide insight into the community health needs from a public health perspective. To further incorporate the regional public health expertise, Kaiser Permanente exchanged data with both Sacramento County Public Health and Yolo County Health and Human Services. KFH-Sacramento provided qualitative data findings from the CHNA process to both Sacramento County Public Health and Yolo County Health and Human Services and received quantitative data collected by both departments.

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

Harder+Company Community Research (Harder+Company) is a social research and planning firm with offices in San Francisco, Sacramento, Los Angeles, and San Diego. Harder+Company works with public sector, nonprofit, and philanthropic clients nationwide to reveal new insights about the nature and impact of their work. Through high-quality, culturally-responsive evaluation, planning, and consulting services, Harder+Company helps organizations translate data into meaningful action. Since 1986, Harder+Company has worked with health and human service agencies throughout California and the country to plan, evaluate, and improve services for vulnerable populations. The firm's staff offer deep experience assisting hospitals, health departments, and other health agencies on a variety of efforts—including conducting needs assessments, developing and operationalizing strategic plans, engaging and gathering meaningful input from community members, and using data for program development and implementation. Harder+Company offers considerable expertise in broad community participation, which is essential to both health care reform and the CHNA process in particular. Harder+Company is the consultant on several CHNAs throughout the state, including other Kaiser Foundation Hospital service areas in Roseville, San Bernardino, San Rafael, Santa Rosa, South Sacramento, Vacaville, and Vallejo.

IV. Process and methods used to conduct the CHNA

A. Secondary data

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

KFH-Sacramento used the Kaiser Permanente CHNA Data Platform (http://www.chna.org/kp) to review 130 indicators from publicly available data sources. KFH-Sacramento also used additional data sources beyond those included in the CHNA Data Platform. For details on specific sources and dates of the data used, please see Appendix A. Secondary Data Sources and Dates.

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

Kaiser Permanente's CHNA Data Platform is a web-based resource provided to our communities as a way to support community health needs assessments and community collaboration. This platform includes a focused set of community health indicators that allow users to understand what is driving health outcomes in particular neighborhoods. The platform provides the capacity to view, map and analyze these indicators as well as understand racial/ethnic disparities and compare local indicators with state and national benchmarks.

As described in section IV.A.i above, KFH-Sacramento also leveraged additional data sources beyond those included in the CHNA Data Platform.

CHNA partners (e.g., county health departments, service providers, and other stakeholders) provided additional data (e.g., frequency tables, reports, etc.) to inform both the identification and prioritization of health needs across the service area (see Appendix A. Secondary Data Sources and Dates for a list of additional data sources). This data provided additional context and, in some cases, more up-to-date statistics to the indicators included in the CHNA Data

Platform. The Harder+Company team did not conduct additional analysis on secondary data shared by CHNA partners as the data was already disaggregated across several variables including region, race/ethnicity, and age. Each health need profile includes a reference section with a detailed list of all secondary data sources used in that profile to inform the prioritization of health needs (see Appendix C. Health Need Profiles).

B. Community input

i. Description of who was consulted

Community input was provided by a broad range of community members through key informant interviews, group interviews, and focus groups. Individuals with the knowledge, information, and expertise relevant to the health needs of the community were consulted. These individuals included representatives from health departments, school districts, local non-profits, and other regional public and private organizations as well as community leaders, clients of local service providers, and other individuals representing medically underserved, low-income, and sub-populations that face unique barriers to health (e.g., race/ethnic minority populations, individuals experiencing homelessness). For a complete list of communities and organizations who provided input, see Appendix B. Community Input Tracking Form.

ii. Methodology for collection and interpretation

In an effort to include a wide range of community voices from individuals with diverse perspectives and experiences and those who work with or represent underserved populations and geographic communities within the KFH-Sacramento service area, Harder+Company staff used several methods to identify communities for qualitative data collection activities. First, Harder+Company staff reviewed the participant lists from previous CHNA reports in the same service area. Second, they examined reports published by local organizations and agencies (e.g., county and city plans, community-based organizations) to identify additional high-need communities. Finally, staff researched local news stories to identify emerging health needs and social conditions affecting community health that may not yet be indicated in secondary data. Importantly, the inclusion of service providers (through key informants and provider group interviews) and community members (through focus groups) allowed for the identification of health needs from the perspectives of service delivery groups and beneficiaries. (For a complete list of participating organizations, see Appendix B. Community Input Tracking Form).

Harder+Company collaborated with Community Health Insights (the consulting firm working with the other regional hospitals) on the development of the interview and focus group protocols, which the Kaiser Permanente CHNA team reviewed. Protocols were designed to inquire about health needs in the community, as well as a broad range of social determinants of health (i.e., social, economic, and environmental), behavioral, and clinical care factors. Some of the identified factors represented barriers to care while others identified solutions or resources to improve community health. Participants also described any new or emerging health issues and to prioritize the top health concerns in their community.

Harder+Company also coordinated with Community Health Insights on qualitative data collection. The two consulting firms divided the data collection activities so that Community

Health Insights primarily conducted the key informant interviews, Harder+Company conducted the group interviews, and focus groups were evenly divided between the two firms. All data collection activities occurred in-person. When respondents granted permission, interviews were recorded and transcribed for all interviews and shared across consultants.

All qualitative data were coded and analyzed using ATLAS.ti software (GmbH, Berlin, version 7.5.18). A codebook with robust definitions was developed to code transcripts for information related to each potential health need, as well as to identify comments related to subpopulations or geographic regions disproportionately affected; barriers to care; existing assets or resources; and community-recommended healthcare solutions. At the onset of analysis, three interview transcripts (one from each type of data collection) were coded by all nine Harder+Company team members to ensure inter-coder reliability and minimize bias. Following the inter-coder reliability check, the codebook was finalized to eliminate redundancies and capture all emerging health issues and associated factors. All transcripts were analyzed according to the finalized codebook to identify health issues mentioned by interview respondents.

In comparison to secondary (i.e., quantitative) data sources, primary qualitative (i.e., community input) data was essential for identifying needs that have emerged since the previous CHNA. Health need identification used qualitative data based on the number of interviewees or groups who referenced each health need as a concern, regardless of the number of mentions within each transcript.

For any primary data collection activities conducted in Spanish, bilingual staff from the Harder+Company team facilitated and took notes. All recordings (if granted permission) were then transcribed, but not translated into English. Bilingual staff coded these transcripts and translated any key findings or representative quotes needed for the health need profiles.

C. Written comments

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

As of the time of this CHNA report development, KFH-Sacramento received one instance of written comments related to the previous CHNA Report. These comments referred to the importance of examining the unique needs of seniors and older adults as a vulnerable sub-population in the Sacramento service area. KFH-Sacramento leadership responded in writing to the individual who raised the issue, thanking them for their input, highlighting how the 2016 assessment took into account the perspective of seniors and organizations serving seniors, and committed to continuing to examine carefully the issues facing seniors and other vulnerable populations within our community.

D. Data limitations and information gaps

The KP CHNA data platform includes 130 secondary indicators that provide timely, comprehensive data to identify the broad health needs faced by a community. However, there

are some limitations with regard to these data, as is true with any secondary data. Some data were only available at a county level, making an assessment of health needs at a neighborhood level challenging. Furthermore, disaggregated data around age, ethnicity, race, and gender are not available for all data indicators, which limited the ability to examine disparities of health within the community. Lastly, data are not always collected on a yearly basis, meaning that some data are several years old.

The limitations discussed above have implications for the identification and prioritization of community health needs. Where only countywide data was available or data was unable to be disaggregated, values represent averages across many communities and may not reflect the unique needs of subpopulations. As is standard, the state average is used as a benchmark when available, with health indicators that fall below the state average were flagged as potential health needs. However, whether a hospital service area (HSA) indicator is on par with or better than the state average does not necessarily mean that ideal health outcomes or service quality exists.

Harder+Company also gathered extensive qualitative data across the HSA to complement the quantitative data. Qualitative data is ideal for capturing rich descriptions of lived experiences, but it cannot be treated as representative of any population or community. Despite efforts to speak to a broad range of service providers and community members, several limitations to the qualitative data remain. First, although experts in their fields, some service providers expressed hesitation about speaking beyond their expertise areas, limiting their contribution to overall health needs and social determinants. Second, although likely reflective of workforce demographics, people of color were underrepresented in the service providers who engaged in data collection activities, which may limit perspectives captured. Third, in large part, community-based organizations helped to recruit community members for focus groups. This strategy is necessary for making contact with community members and for securing interview spaces that make participants feel safe. However, it inherently excludes disconnected individuals (i.e., those not engaged in services). To address this, Harder+Company made efforts to collect data at several community events where individuals gather without directly receiving services. Finally, although, focus groups were conducted focus groups in English and Spanish, future CHNA processes should consider strategies to include data collection in additional languages that are prevalent in the service area.

V. Identification and prioritization of the community's health needs

A. Identifying community health needs

i. Definition of "health need"

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

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

Extensive secondary quantitative data (from the Kaiser CHNA Data Portal and other publically available data), as well as primary qualitative data collected from key informant interviews, provider group interviews, and focus groups with community members, were synthesized and analyzed to identify the community health needs.

For the quantitative data, the Harder+Company team identified potential health needs by creating a matrix of health issues and associated secondary data. The Kaiser CHNA Data Platform groups 130 specific health indicators into 14 health need categories (i.e., composites of individual indicators). The health needs are not mutually exclusive, as indicators can appear in more than one need. Individual indicator values are categorized as relatively better, worse, or similar to established benchmark data, in most cases, the California state average estimate. Indicators identified as on average worse than the benchmark were flagged as potential health needs. In addition, regardless of comparison to the benchmark, any indicator with data reflecting racial or ethnic disparities was also marked as a potential health need.

For the qualitative data, the Harder+Company team read and coded transcripts from all primary data collection activities (i.e., key informant interviews, focus groups, and provider group interviews, see Section IV B ii for details). Part of the analysis included grouping individual qualitative themes (e.g., green spaces, safe spaces, food security, obesity, diabetes) into health need categories (e.g., healthy eating and active living) similar to those identified in the Kaiser CHNA Data Platform. Health need categories that were identified in the majority of data collection activities (i.e., the majority of key informant interviews, the majority of group interviews, *and* the majority of focus groups) were considered as potential health needs.

The final process to determine whether each health issue qualified as a CHNA health need drew upon both secondary and primary data, as follows:

1. A health need category was identified as **high need based on secondary data** from the Kaiser CHNA Data Platform if it met *any* of the following conditions:
    - *Overall severity:* at least one indicator Z-score within the health need was much worse or worse than benchmark.
    - *Disparities:* at least one indicator Z-score within the health need was much worse or worse than benchmark for any defined racial/ethnic group.
    - *External benchmark:* indicator value worse than an external goal (e.g., state average, county data, and Healthy People 2020).
2. A health need category was identified as **high need based on primary data** if it was identified as a theme in a majority of key informant interviews, group interview, *and* focus groups.
3. Classification of primary and secondary data was combined into the final health need category using the following criteria:
    - **Yes**: high need indicated in *both* secondary and across *all types* of primary data. Kaiser Permanente and CHNA partners then confirmed these health needs.

- **Maybe**: high need indicated only in secondary data and/or some primary data. These health issues were further discussed with Kaiser Permanente and CHNA partners to determine final status.
    - If a health need was mentioned overwhelmingly in primary data but did not meet the high need criteria for secondary data, the Harder+Company team conducted an additional search for secondary data sources that indicated disparities (e.g., geographic, race/ethnicity, and age) to ensure compliance with both primary and secondary criteria.
    - In some cases, multiple indices were merged into one health need if there were cross-cutting secondary indicators or themes from the qualitative data.
- **No**: high need indicated in only one or fewer sources.

B. Process and criteria used for prioritization of health needs

For each identified community health need, Harder+Company developed a three- to four-page written profile. These health need profiles summarized primary and secondary data, including statistics on sub-indicators, quantitative and qualitative data on regional and demographic disparities, commentary and themes from primary data, contextual information on main drivers and community assets, and suggested solutions. Profiles for all of the identified health needs are included in Appendix C. Health Need Profiles.

Harder+Company then facilitated an in-person prioritization meeting in late 2018 with regional CHNA partners and stakeholders (including service providers and health department representatives) to prioritize the health needs. The meeting began with a brief presentation of each health need profile, highlighting major themes and disparities, followed by small-group discussions of the health needs, including the consideration of the following agreed-upon criteria for prioritization:

- **Severity:** Severity of need demonstrated in data and interviews. Potential to cause death or extreme/lasting harm. Data significantly varies from state benchmarks. Magnitude/scale of the need, where magnitude refers to the number of people affected.
- **Clear Disparities or Inequities:** Health need disproportionately impacts specific geographic, age, or racial/ethnic subpopulations.
- **Impact:** The ability to create positive change around this issue, including potential for prevention, addressing existing health problems, mobilizing community resources, and the ability to affect several health issues simultaneously.

During the small-group discussions, meeting participants referred to the health need profiles as their main source of information while also sharing their individual knowledge and work in that subject area, including additional secondary data.

After small-group discussions, meeting participants discussed key insights for each health need with the larger group and then voted to determine the final ranked list of health needs. Participants voted either individually or as a voting bloc if there were multiple stakeholders from the same organization. Participants ranked the health needs three times, once for each

prioritization criteria (i.e., severity, disparities, impact), on a scale from 1-7 (*1=lowest priority*; *7=highest priority*). Ranking required that no two health needs were scored the same within each criterion. Harder+Company tallied the votes after the prioritization meeting.

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

Summaries of the health needs for the service area follow. The order of the health needs reflects the final prioritization of needs identified by the process described above (see Section V. B. Process and criteria used for prioritization of health needs). For more detailed descriptions of each of the health needs, including additional data, quotes, and themes, refer to [Appendix C. Health Need Profiles].

1. **Mental and Behavioral Health:** Mental and behavioral health are foundations for healthy living, and encompass rates of mental illness, rates of challenging behaviors (e.g., school suspensions), substance abuse, access to social and emotional support, and access to providers for preventive care and treatment. In some cases, mental health is associated with homelessness. The Sacramento service area scores on par with the California state average on many indicators related to mental and behavioral health, including substance use (e.g., excessive drinking, current smokers, and opioid prescription drug claims). However, the service area has lower access to mental health providers than the Northern California region (324 and 353 providers per 100,000 population, respectively).[1] Within the service area, Sacramento County specifically has higher rates of school suspensions, an indicator of mental and behavioral health, than the state (12 percent compared to 6 percent).[2] These rates also reflect racial/ethnic disparities. In Sacramento County, the suspension rates are highest among Black/African American male students (20 percent), with even higher rates among Black/African American youth with the following experiences: foster care (33 percent), homelessness (26 percent), disabilities (25 percent), and low-income (22 percent).[3] Local stakeholders identified several challenges to meeting their mental and behavioral health needs: too few mental and behavioral health providers, lack of trust in health systems, experiences of stigma accessing services, and financial constraints. Public health experts who participated in the prioritization meeting also discussed that opioid deaths are the leading cause of injury-related deaths in the region (61 deaths in 2017), and the high rates of opioid prescriptions in children under the age of 5 (rate 10.6 per 1,000 residents).[4]

2. **Economic Security:** Economic security means having the financial resources, public supports, career and educational opportunities, and housing accommodations necessary to live your fullest life. The Sacramento service area scores worse than the California state average on many indicators measuring economic security. The service area has a

[1] Area Health Resource File. (2016). Retrieved from https://datawarehouse.hrsa.gov/topics/ahrf.aspx
[2] California Department of Education. (2016-2017). Retrieved from https://www.cde.ca.gov/ds/
[3] The Five Critical Facts Series. (2018). Retrieved from https://cceal.org/wp-content/uploads/2018/06/sacramento.pdf
[4] California Department of Public Health (2017). Retrieved from https://discovery.cdph.ca.gov/CDIC/ODdash/

higher percent of individuals living below the federal poverty level (19 percent versus 16 percent),[5] and more individuals who are food insecure (16 percent versus 13 percent).[6] Significant disparities remain across the region by race/ethnicity and geography. For example, Hispanic/Latino/a (29 percent) and Black/African American adults (11 percent) are more likely than White adults (6 percent) to not have a high school diploma,[7] and Black/African American (23 percent) and Hispanic/Latino/a households (18 percent) were more likely to receive Supplemental Nutrition Assistant Program (SNAP) benefits than White households (8 percent).[8] Further, unemployment and housing problems (including lacking complete kitchens and plumbing facilities, overcrowding, or housing costs that represent over 30 percent of monthly income) vary by geographic region. Highest rates of unemployment were found in Sutter County[9] and highest rates of housing problems were found in parts Sacramento (Arden Arcade, Downtown Sacramento, Natomas, Oak Park, and South Sacramento) and Yolo (Davis, Woodland, and West Sacramento) Counties.[10] In addition, local stakeholders identified the following barriers to economic security: a lack of awareness of local systems and supports, affordable food, accessible housing, accessible transportation, consistent funding for services, and high cost of living. These barriers disproportionately affect low-income individuals and people of color.

3. **Women and Children's Well-Being:** Women and children's well-being reflects not only health outcomes, but also access to services, such as reproductive health, pre-natal medical care, childcare, and education. On average, within the Sacramento service area, women and children fare worse than the state benchmarks. For example, the Sacramento service area has higher rates of breast cancer among women, and higher rates of hospitalizations due to domestic violence and adolescent mental health issues than the state overall. Disparities within the region also exist, with higher rates of teen pregnancies, smoking during pregnancies, low birth weights, and infant mortality for women of color. For example, per 1,000 population, Black/African American (23) and Hispanic/Latina (18) teenage women (ages 15-18) are more likely than White (10) and Asian (7) teens to have a child.[11] In Sacramento County, Black/African American infants are more likely to be born with a low birth weight (11 percent) than Hispanic/Latino/a and White infants (both 6 percent).[12] In addition, infants of color have higher rates of mortality (6.3 per 1,000 births) than White infants (4.5 per 1,000 births) in the Sacramento service area[13] (although infant mortality rates have decreased by 45 percent for African Americans in Sacramento County in recent years).[14] Further, low rates of preschool

[5] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/
[6] Feeding America. (2014). Retrieved from http://map.feedingamerica.org/
[7] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/
[8] Ibid.
[9] Bureau of Labor Statistics. (2017). Retrieved from https://www.bls.gov/
[10] Consolidated Planning CHAS Data. (2011-2015). Retrieved from https://www.huduser.gov/portal/datasets/cp.html
[11] Community Status Report Sacramento County. (2014). Retrieved from http://www.dhs.saccounty.net/PUB/Documents/Epidemiology/RT-HealthStatusReport2014.pdf
[12] Sacramento County Birth Fact Sheet. (2016). Retrieved from http://www.dhs.saccounty.net/PUB/Documents/Epidemiology/RT-BirthFactSheet2016.pdf
[13] National Vital Statistics System. (2008-2014). Retrieved from https://www.cdc.gov/nchs/nvss/index.htm
[14] First 5 Sacramento Reduction of African American Perinatal and Infant Deaths. (2018). Retrieved from http://www.first5sacramento.net/Results/Documents/3-yr_RAACD_EvalReport.PDF

enrollment were found throughout the HSA, with some of the lowest rates found in parts of Sacramento (Arden Arcade, Natomas, east of Rancho Cordova, South Sacramento) and Yolo (South Davis, West Sacramento, Woodland) Counties, and all of Sutter County.[15] Local stakeholders identified lack of childcare, affordable and healthy food, and housing as barriers to women and children's well-being.

4. **Violence and Injury:** Direct and indirect exposure to violence and injury, such as domestic and community violence, have significant effects on well-being and health. On average, residents of the Sacramento service area have higher rates of violence compared to the California state average, including higher rates of domestic violence hospitalizations, suicide deaths, and violent crimes. For example, per 100,000 population, the Sacramento service area has higher rates of violent crimes reported (479) than the California average (403).[16] Although already higher than the state average, disparities exist within these indicators as well, such that Sacramento and Sutter Counties had higher rates of domestic violence hospitalizations.[17] Sacramento County also had high rates of violent crimes exposure compared to the other counties in the service area.[18] In addition, local stakeholders identified, several additional factors as contributing to the effects of violence and injury, including existing trauma in the community, competing priorities with other basic needs, mistrust of law enforcement, and lack of affordable housing and safe spaces—and these barriers disproportionately affect low-income individuals and people of color.

5. **Access to Care:** Access to quality health care includes affordable health insurance and utilization of preventive care, with the ultimate goal of reducing the risk of unnecessary disability and premature death. Importantly, it is also one of the key drivers in achieving health equity. The Sacramento service area scores better than the California state average on some of the indicators measuring health access, such as a lower percentage of uninsured individuals and higher rates of first trimester prenatal care. However, there are higher rates of breast and lung cancer in the area, and significant disparities remain within indicators in which the area exceeded state averages. For example, Native American and Alaskan Native (19 percent), Hispanic/Latino/a (16 percent), and Native Hawaiian and Pacific Islander (13 percent) individuals are more likely than Asian (10 percent), Black/African American (9 percent), multi-racial (9 percent), and White (7 percent) individuals to be uninsured.[19] Further, Black/African American residents are more likely than White residents to experience a preventable hospital event (48 versus 26 out of 1,000 residents).[20] Within the service area, the highest rates of uninsured populations were found in Sacramento (Rancho Cordova, South Natomas, and South Sacramento), and Yolo (West Sacramento, and Woodland) Counties.[21] In addition, local stakeholders identified that lack of knowledge, access to mental and behavioral health

[15] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/
[16] FBI Uniform Crime Reports. (2012-2014). Retrieved from https://www.fbi.gov/services/cjis/ucr
[17] California EpiCenter. (2013-2014). Retrieved from http://epicenter.cdph.ca.gov/
[18] FBI Uniform Crime Reports. (2012-2014). Retrieved from https://www.fbi.gov/services/cjis/ucr
[19] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/
[20] Dartmouth Atlas of Healthcare. (2014). Retrieved from https://www.dartmouthatlas.org/
[21] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/

providers, and trust in the system inhibit the ability of individuals to navigate existing systems of care, and these barriers disproportionally affect low-income individuals and people of color.

6. **Health Eating and Active Living (HEAL):** Healthy eating and active living (HEAL) relates to the ability of residents to positively shape their health outcomes by focusing on nutrition and exercise. Many factors outside of individuals' control also shape these behaviors, such as access to safe parks and affordable vegetables. Further, HEAL impacts the rates of many chronic conditions like cardiovascular disease (CVD), stroke, and cancer. The Sacramento service area scores worse than the California state average on many indicators measuring HEAL. Adults are more likely to experience obesity and residents have less access to affordable and nutritious food compared to the California state average. Significant disparities exist by race/ethnicity and geography, specifically related to youth obesity, inactivity, and receipt of SNAP benefits. For example, although the Sacramento service area is just below the state average for the percent of youth experiencing obesity (19 percent versus 20 percent),[22] Native Hawaiian and Pacific Islander (28 percent), Hispanic/Latino/a (26 percent), Native American and Alaskan Native (24 percent), and Black/African American (21 percent) youth all exceed the state average.[23] Further, compared to other counties within the service area, Sutter County had lower access to areas with exercise opportunities[24] including parks, playgrounds, or other recreational facilities, and the lowest Food Environment Index Score, a measure of affordable, close, and nutritious food retailers.[25] Local stakeholders identified violence in the community, inaccessible transportation, unaffordable healthy food options, and lack of knowledge about how to navigate systems as barriers to HEAL.

7. **Environmental Health:** Environmental health indicators include respiratory hazards, tree canopy, and access to public transportation, as well as related health outcomes such as asthma and lung cancer. On average, the Sacramento Service Area performs worse than benchmarks on many factors related to environmental health, including having a worse Respiratory Hazard Index score (i.e., more respiratory hazards), lower tree canopy cover, and higher rates of asthma prevalence and lung cancer incidence. For example, the Sacramento service area performs worse on the Respiratory Hazard Index,[26] has higher percentage of asthma prevalence (15% vs. 19 percent),[27] and higher rates of lung cancer (53 vs. 45 per 100,000 population)[28] compared to the state. In addition, geographic disparities exist with highest rates of asthma prevalence in the

[22] National Survey of Children's Health. (2016). Retrieved from http://childhealthdata.org/learn-about-the-nsch/NSCH
[23] Ibid.
[24] County Health Rankings. (2010; 2014). Retrieved from http://www.countyhealthrankings.org/
[25] Food Environment Atlas (USDA) and Map the Meal Gap (Feeding America). (2014). Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-factors/health-behaviors/diet-exercise/food-environment-index
[26] EPA National Air Toxics Assessment. (2011). Retrieved from https://www.epa.gov/national-air-toxics-assessment
[27] California Department of Public Health California Asthma Data Tool. (2015-2016). https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/EHIB/CPE/Pages/CaliforniaBreathingCountyAsthmaProfiles.aspx
[28] State Cancer Profiles. (2010-2014). Retrieved from https://statecancerprofiles.cancer.gov/

Sutter County portion of the service area.[29] Local stakeholders identified lack of consistent access to public transportation, and lack of access to clean and safe green spaces as barriers associated with environmental health.

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

The service area for KFH-Sacramento contains community-based organizations, government departments and agencies, hospital and clinic partners, and other community members and organizations engaged in addressing many of the health needs identified by this assessment. Examples of resources available to respond to each community-identified health need, as found in qualitative data, are indicated in each health need brief found in Appendix C. Health Need Profiles. In addition, a list of community-based organizations and agencies that participated in the CHNA process can be found in Appendix B. Community Input Tracking Form. For a more comprehensive list of community assets and resources, please call 2-1-1 OR 800-273-6222, or reference https://www.211ca.org/ and enter the topic and/or city of interest.

VI. KFH-Sacramento 2016 Implementation Strategy evaluation of impact

A. Purpose of 2016 Implementation Strategy evaluation of impact

KFH-Sacramento's 2016 Implementation Strategy Report was developed to identify activities to address health needs identified in the 2016 CHNA. This section of the CHNA Report describes and assesses the impact of these activities. For more information on KFH-Sacramento's Implementation Strategy Report, including the health needs identified in the facility's 2016 service area, the health needs the facility chose to address, and the process and criteria used for developing Implementation Strategies, please visit (https://www.kp.org/chna). For reference, the list below includes the 2016 CHNA health needs that were prioritized to be addressed by KFH-Sacramento in the 2016 Implementation Strategy Report:

1. Access to Care
2. Healthy Eating and Active Living (HEAL)
3. Behavioral Health
4. Community and Family Safety

KFH-Sacramento is monitoring and evaluating progress to date on its 2016 Implementation Strategies for the purpose of tracking the implementation and documenting the impact of those strategies in addressing selected CHNA health needs. Tracking metrics for each prioritized health need include the number of grants made, the number of dollars spent, the number of people reached/served, collaborations and partnerships, and KFH in-kind resources. In addition, KFH-Sacramento tracks outcomes, including behavior and health outcomes, as appropriate and where available.

[29] California Department of Public Health California Asthma Data Tool. (2015-2016). https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/EHIB/CPE/Pages/CaliforniaBreathingCountyAsthmaProfiles.aspx

The impacts detailed below are part of a comprehensive measurement strategy for Community Health. KP's measurement framework provides a way to 1) represent our collective work, 2) monitor the health status of our communities and track the impact of our work, and 3) facilitate shared accountability. We seek to empirically understand two questions 1) how healthy are Kaiser Permanente communities, and 2) how does Kaiser Permanente contribute to community health? The Community Health Needs Assessment can help inform our comprehensive community health strategy and can help highlight areas where a particular focus is needed and support discussions about strategies aimed at addressing those health needs.

As of the documentation of this CHNA Report in March 2019, KFH-Sacramento had evaluation of impact information on activities from 2017 and 2018. These data help us monitor progress toward improving the health of the communities we serve. While not reflected in this report, KFH-Sacramento will continue to monitor impact for strategies implemented in 2019.

B. 2016 Implementation Strategy evaluation of impact overview

In the 2016 IS process, all KFH hospital facilities planned for and drew on a broad array of resources and strategies to improve the health of our communities and vulnerable populations, such as grantmaking, in-kind resources, collaborations and partnerships, as well as several internal KFH programs including, charitable health coverage programs, future health professional training programs, and research. Based on years 2017 and 2018, an overall summary of these strategies is below, followed by tables highlighting a subset of activities used to address each prioritized health need.

KFH programs: From 2017-2018, KFH supported several health care and coverage, workforce training, and research programs to increase access to appropriate and effective health care services and address a wide range of specific community health needs, particularly impacting vulnerable populations. These programs included:

- Medicaid: Medicaid is a federal and state health coverage program for families and individuals with low-incomes and limited financial resources. KFH provided services for Medicaid beneficiaries, both members and non-members.
- Medical Financial Assistance: The Medical Financial Assistance (MFA) program provides financial assistance for emergency and medically necessary services, medications, and supplies to patients with a demonstrated financial need. Eligibility is based on prescribed levels of income and expenses.
- Charitable Health Coverage: Charitable Health Coverage (CHC) programs provide health care coverage to low-income individuals and families who have no access to public or private health coverage programs.
- Workforce Training: Supporting a well-trained, culturally competent, and diverse health care workforce helps ensure access to high-quality care. This activity is also essential to making progress in the reduction of health care disparities that persist in most of our communities.

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

Grantmaking: For 70 years, Kaiser Permanente has shown its commitment to improving community health through a variety of grants for charitable and community-based organizations. Successful grant applicants fit within funding priorities with work that examines social determinants of health and/or addresses the elimination of health disparities and inequities. From 2017-2018, KFH-Sacramento awarded 269 number of grants amounting to a total of $7,713,587.94 in service of 2016 health needs. Additionally, KFH Northern California Region has funded significant contributions to the East Bay Community Foundation in the interest of funding effective long-term, strategic community benefit initiatives within the KFH-Sacramento service area. During 2017-2018, a portion of money managed by this foundation was used to award 5 grants totaling $1,644,852.20 in service of 2016 health needs.

In-kind resources: In addition to our significant community health investments, Kaiser Permanente is aware of the significant impact that our organization has on the economic vitality of our communities as a consequence of our business practices including hiring, purchasing, building or improving facilities, and environmental stewardship. We will continue to explore opportunities to align our hiring practices, our purchasing, our building design and services and our environmental stewardship efforts with the goal of improving the conditions that contribute to health in our communities. From 2017-2018, KFH-Sacramento leveraged significant organizational assets in service of 2016 Implementation Strategies and health needs. Examples of in-kind resources are included in the section of the report below.

Collaborations and partnerships: Kaiser Permanente has a long legacy of sharing its most valuable resources: its knowledge and talented professionals. By working together with partners (including nonprofit organizations, government entities, and academic institutions), these collaborations and partnerships can make a difference in promoting thriving communities that produce healthier, happier, more productive people. From 2017-2018, KFH-Sacramento engaged in several partnerships and collaborations in service of 2016 Implementation Strategies and health needs. Examples of collaborations and partnerships are included in the section of the report below.

C. 2016 Implementation Strategy evaluation of impact by health need

KFH-Sacramento Priority Health Needs

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
Access to Care	*During 2017 and 2018, KFH-Sacramento awarded 103 grants totaling $5,116,983.94 that address Access to Care in the KFH-Sacramento service area*	KP Medicaid and Charity Care: In 2017 and 2018 KP served 37,216 and 43,326 Medi-Cal members respectively totaling $108,416,917.67 worth of care. KP also provided a total of $18,196,621.58 of Medical Financial Assistance (MFA) to 9,238 individuals in 2017 and 6,669 individuals in 2018.
		211: Community Link Capital Region received a $50,000 grant to support 211's business operations and partnership efforts with local health care systems in order to improve access to healthcare and social non-medical services. It is expected that 300,000 individuals will be reached through calls, website searches and outreach.
		PHASE: Over the course of three years (2017-2019), Sacramento Native American Health Center, Inc. (SNAHC) is the recipient of a $150K grant to support the successful use of PHASE among clinic sites. Strategies include SMPB and individual case management of high risk patients by an LVN. SNAHC is reaching over 1,500 patients through PHASE. 66% of their patients with diabetes and 93% of those with hypertension have their blood pressure controlled.
		Respite care: WellSpace Health Interim Care Program (ICP) was awarded a $46,000 grant (evenly split between KFH-Sacramento and KFH-South Sacramento) to provide lay-in respite care shelter for 54 post-hospitalization homeless patients. All clients had the opportunity to attend at least one medical follow-up appointment with a primary care provider and or specialist prior to program completion. Clients who were living with behavioral health needs were linked with community behavioral resources while in ICP and supported with follow-up care that included assistance with completing required documents and transportation to and from appointments.
		Access to care and coverage: Yolo Healthy Aging Alliance received $10,000 to connect diverse populations to services. The program will increase access to care and coverage in Yolo County for older adults and persons with disabilities through a printed and online resource guide in multiple languages and three community outreach events that will increase and systematize access to needed medical and social non-medical services. By April 1, 2018, 500 copies of *Yolo Senior Resource Guide* were distributed to the Woodland, Davis, and West Sacramento senior centers; in the rural communities of Winters, Esparto, Clarksburg and Knights Landing; through Senior Link; and at the Kaiser Permanente medical offices in Davis. And 1,189 unique users accessed the digital version of the guide and the Yolo Healthy Aging Alliance Resource page.
Healthy Eating, Active Living	*During 2017 and 2018, KFH-Sacramento awarded 45 grants totaling $749,968.81 that*	Physical activity program: Roberts Family Development Center was awarded a $30,000 grant for its Youth Development and Health & Fitness initiatives, which increased health among 491 vulnerable children through access to physical activity opportunities during out-of-school time year-round. The initiatives also improve community health and safety by providing educational support, job readiness training, and life skills enrichments to 63 at-risk and high-risk teens.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
	address Healthy Eating Active Living in the KFH-Sacramento service area	Urban farm: Soil Born Farms received $34,889 for its Urban Agriculture & Education Eat Your Veggies project, which focuses on engaging 35,500 Rancho Cordova youth and adults in healthy food activities through direct hands-on experiences and classes at American River Ranch to increase knowledge and abilities related to growing, purchasing, preparing, preserving, and eating healthy, locally grown produce. Based on surveys, 100% of participants increased their knowledge of healthy food, walked away with recipes, and enjoyed samples, and 92% expressed a willingness to prepare recipes they sampled at the farm at home. In addition, all class participants said they learned new ways to prepare fresh produce, 91% said they learned something new about nutrition, and 91% said they learned helpful information for eating healthy.
		CalFresh: Sacramento Food Bank & Family Services (SFBFS) received a $95,000 grant (evenly split between KFH-Sacramento and KFH-South Sacramento) to increase enrollment in and use of CalFresh, by convening stakeholders, training partner agencies, and targeting outreach in zip codes with low CalFresh participation. To date, SFBFS has trained three new partners to help with outreach and application assistance. SFBFS has screened 211 individuals and submitted 173 CalFresh applications, of which 75 were approved.
		Parks: City of Sacramento received a $75,000 grant to build and activate an outdoor fitness court in downtown Sacramento's Roosevelt Park. This project is projected to serve 10,000 residents and employees in the surrounding neighborhood, many of whom reside in low-income housing units. To date, over 250 people have participated in lunch time bootcamps and local groups have been using the courts during lunch hours, after work and on the weekend.
Mental & Behavioral Health	*During 2017 and 2018, KFH-Sacramento awarded 56 grants totaling $820,001.23 that address Mental and Behavioral Health in the KFH-Sacramento service area*	Stigma: San Juan Unified School District (SJUSD) received a $90,000 grant to address mental health stigma among youth at SJUSD by providing outreach and education to 1,000 students, parents, families and educators to increase their understanding of mental health issues and decrease the stigma associated with accessing mental health services. As a result of this effort, they hope to see an increase in utilization of the White House counseling center.
		Mental health services: Loaves & Fishes was awarded a $25,000 grant for its onsite Genesis Mental Health project, which served 910 homeless guests and provided 4,511 unique and significant encounters, including counseling sessions, crisis intervention, mental health assessments, and resource referrals to on-campus and outside community services. Services are free, lack restrictive criteria, and accommodate any homeless person on a walk-in basis or if they choose through ongoing, unlimited weekly sessions.
		Support group: Women’s Empowerment received $15,000 to help 118 homeless and formerly homeless women in Sacramento to understand the link between substance abuse and domestic violence (DV), and to reduce or stop misuse of drugs and alcohol so they could find a safe home, acquire a steady job, and create a healthy lifestyle for themselves and their children. Among participants, 77% secured employment and 92% regained a safe home. Of the Wellness & Recovery Support Group participants, 100% reported understanding the effects of substance abuse in their lives and their children’s lives and where to get help; and 86% reported feeling healthier and more empowered in their newfound support networks and/or experienced decreased distorted cognitive behavioral thinking. Among DV support group participants, 83% improved their DV situation.

Need	Summary of impact	Top 3-5 Examples of most impactful efforts.
Community & Family Safety	*During 2017 and 2018, KFH-Sacramento awarded 39 grants totaling $708,271.05 that address Community and Family Safety in the KFH-Sacramento service area*	Violence Prevention: WellSpace Health received a $200,000 grant (evenly split between KFH-South Sacramento and KFH-Sacramento) to implement the Sacramento Violence Intervention Program (SVIP). Youth ages 15-26 who are admitted to Kaiser Permanente's South Sacramento Trauma Center with injuries related to violence receive case management and linkage to services. The goal of SVIP is to reduce the number of re-injuries due to violence. To date, SVIP has mentored and provided after-care services for over 75 patients and families affected by violence.
		Firearms: Over four years (2017-2021), Safe Passages received a $400,000 grant (evenly split between KFH-Sacramento and KFH-South Sacramento) to implement the Advance Peace Sacramento project to reduce firearm assaults in three Sacramento California communities by providing resources to firearm offenders. The expected outcome includes a 50% reduction in firearm assault over five years. To date, 75 fellows have been enrolled in the Peacemaker Fellowship, which provides fellows with support to develop a life plan and work towards educational, professional, and personal goals.
		College preparation: Mutual Assistance Network was awarded a $40,000 grant for its College Sports Academy (CSA), which prepared 411 youth for college with a combination of academics, enrichment, and physical health. Targeting diverse, low-income elementary students in Del Paso Heights and North Sacramento, CSA provides a structured, healthy environment that supports a violent-free life. Of the 122 participants who completed the post-fitness assessment, 99 (81%) showed an improvement in their fitness level.
		Crisis nursery: Sacramento Children's Home received $20,000 (evenly split between KFH-Sacramento and KFH-South Sacramento) for its Crisis Nursery, which served a total of 2,012 children and 1,342 families through an innovative family strengthening program wherein parents can bring their children 0 to 5 for emergency child care or overnight care during a crisis. Outcomes include 98% of caregivers received a crisis assessment and case plan at intake, and upon exit, 95% of caregivers indicated a reduction of stress and either agreed or strongly agreed with the following statement, “I feel my children were safe and secure at the Crisis Nursery during their stay that is ending today.” Lastly 89% of caregivers agreed or strongly agreed that they were better able to work on solving their crisis situations with the support of the Crisis Nursery.

VII. Appendices

A. Secondary Data Sources and Dates
    i. Secondary sources from the KP CHNA Data Platform
    ii. Additional sources
B. Community Input Tracking Form
C. Health Need Profiles

Appendix A. Secondary Data Sources and Dates

i. Secondary sources from the KP CHNA Data Platform

	Source	Dates
1.	American Community Survey	2012-2016
2.	American Housing Survey	2011-2013
3.	Area Health Resource File	2006-2016
4.	Behavioral Risk Factor Surveillance System	2006-2015
5.	Bureau of Labor Statistics	2016
6.	California Department of Education	2014-2017
7.	California EpiCenter	2013-2014
8.	California Health Interview Survey	2014-2016
9.	Center for Applied Research and Environmental Systems	2012-2015
10.	Centers for Medicare and Medicaid Services	2015
11.	Climate Impact Lab	2016
12.	County Business Patterns	2015
13.	County Health Rankings	2012-2014
14.	Dartmouth Atlas of Health Care	2012-2014
15.	Decennial Census	2010
16.	EPA National Air Toxics Assessment	2011
17.	EPA Smart Location Database	2011-2013
18.	Fatality Analysis Reporting System	2011-2015
19.	FBI Uniform Crime Reports	2012-14
20.	FCC Fixed Broadband Deployment Data	2016
21.	Feeding America	2014
22.	FITNESSGRAM® Physical Fitness Testing	2016-2017
23.	Food Environment Atlas (USDA) & Map the Meal Gap (Feeding America)	2014
24.	Health Resources and Services Administration	2016
25.	Institute for Health Metrics and Evaluation	2014
26.	Interactive Atlas of Heart Disease and Stroke	2012-2014
27.	Mapping Medicare Disparities Tool	2015
28.	National Center for Chronic Disease Prevention and Health Promotion	2013
29.	National Center for Education Statistics-Common Core of Data	2015-2016
30.	National Center for Education Statistics-EDFacts	2014-2015
31.	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2013-2014
32.	National Environmental Public Health Tracking Network	2014
33.	National Flood Hazard Layer	2011
34.	National Land Cover Database 2011	2011
35.	National Survey of Children's Health	2016
36.	National Vital Statistics System	2004-2015
37.	Nielsen Demographic Data (PopFacts)	2014
38.	North America Land Data Assimilation System	2006-2013
39.	Opportunity Nation	2017
40.	Safe Drinking Water Information System	2015
41.	State Cancer Profiles	2010-2014
42.	US Drought Monitor	2012-2014
43.	USDA - Food Access Research Atlas	2014

ii. Additional sources

	Source	Dates
1.	Bureau of Labor Statistics.	2017
2.	California Office of Statewide Health Planning and Development	2000-2016
3.	Consolidated Planning CHAS Data	2011-2015
4.	First 5 Sacramento Reduction of African American Perinatal and Infant Deaths	2018
5.	Homelessness in Sacramento County: Results from the 2017 Point-in-Time Count	2017
6.	Sacramento County Birth Fact Sheet	2016
7.	Sacramento County Community Health Status Report	2014
8.	The Five Critical Facts Series	2018
9.	Yolo County Health and Human Services Health Status Survey	2018

Appendix B. Community Input Tracking Form

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
Organizations						
1	Key Informant Interview	Legal Services of Northern California (Deputy Director)	1	Low-income; racial or ethnic minorities	Service Provider	6/13/18
2	Key Informant Interview	WellSpace Health (CEO)	1	Low-income; medically underserved; racial or ethnic minorities	Service Provider	6/18/18
3	Key Informant Interview	Sacramento Covered (Executive Director, Director of Behavioral Health Integration, and Director of Programs)	3	All residents of Sacramento County	Service Provider	6/20/18
4	Key Informant Interview	Sacramento County Public Health (Public Health Officer)	1	All residents of Sacramento County	Service Provider	6/26/18
5	Key Informant Interview	Mutual Assistance Network (Executive Director)	1	Low-income; medically underserved; racial or ethnic minorities	Service Provider	6/27/18
7	Group Interview	WellSpace Health, Sacramento Violence Intervention Program(Staff: Therapist; Program Manager; Volunteer and Steering Committee Member; and 2 Violence Intervention Specialists)	5	Low-income; medically underserved; racial or ethnic minorities	Service Providers	7/06/18
8	Group Interview	Learn for Life Marconi Learning Academy (Counselor; Student Relations and Site Utility)	7	Low-income; medically underserved; racial or ethnic minorities	Service Providers	7/12/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
		Sacramento City Unified School District (Director of Student Support and Health Services) San Juan Unified School District (Program Manager; Student Support Services; and Program Specialist Health Care Services)				
9	Group Interview	City of Sacramento (Program Manager) Downtown Sacramento Partnership (Executive Director) Franklin Property-Based Business Improvement District (Executive Director) Midtown Associates (Executive Director) Roseville area Chamber of Commerce (Executive Director) Sacramento Hispanic Chamber (Executive Director)	6	Low-income; medically underserved; racial or ethnic minorities	Service Providers	7/16/18
10	Group Interview	All participants were Steering Committee Members of Resilient Sacramento and represent the following organizations: Breaking The Cycles.com (Speaker and Consultant) California Behavioral Health Planning Council (Volunteer Council Member)	7	Low-income; medically underserved; racial or ethnic minorities	Service Providers	7/19/18

	Data collection method	Title/name	Number	Target group(s) represented*	Role in target group	Date input was gathered
		Creative Behavior Systems (Executive Director) Kaleidoschool (Executive Director) Mutual Assistance Network (Program Manager) ACEs Connection (Community Facilitator)				
11	Group Interview	Anti-Recidivism Coalition (Director; Administrator; Program Manager; and Member)	4	Low-income; medically underserved; racial or ethnic minorities	3 Service Providers and 1 Community Member	7/19/18
12	Group Interview	Women's Empowerment (Executive Director; Program Manager; Direct Service Provider; Social Worker; and 4 Clients)	8	Low-income; racial or ethnic minorities	4 Service Providers and 4 Community Members	10/18/18
Community residents						
13	Focus group	La Familia Counseling Center (Spanish-speaking clients from South Sacramento and North Highlands)	6	Racial or ethnic minorities	Community Members	9/6/18
14	Focus group	Yolo Family Resource Center (families and clients served in West Sacramento)	14	Low-income; medically underserved; racial or ethnic minorities	Community Members	9/12/18
15	Focus group	Lao Family Community Development Center Seniors (Seniors from the Mien Community)	19	Racial or ethnic minorities	Community Members	9/14/18

16	Focus group	Mutual Housing at Spring Lake (Spanish-speaking Latino/a agricultural workers in Woodland)	14	Low-income; racial or ethnic minorities	Community Members	9/20/18
17	Focus group	Sacramento ACT (Sacramento faith leaders and community members)	5	Low-income; racial or ethnic minorities	Community Members	9/24/18
18	Focus group	My Sister's House (Domestic violence survivors)	12	Low-income; racial or ethnic minorities	Community Members	9/26/18
19	Focus group	Roberts Family Development Center (Del Paso Heights residents)	8	Low-income; racial or ethnic minorities	Community Members	9/26/18
20	Focus group	Marconi Learning Academy (Foster youth and homeless youth)	8	Low-income; racial or ethnic minorities	Community Members	9/27/18
21	Focus group	North and South Oak Park Neighborhood Association (Oak Park residents)	11	Low-income; racial or ethnic minorities	Community Members	10/03/18
22	Focus group	South Natomas Community Center Seniors (Seniors from South Natomas)	6	Low-income; racial or ethnic minorities	Community Members	10/03/18
23	Focus group	Sacramento Native American Health Center (Native American community members)	5	Low-income; medically underserved; racial or ethnic minorities	Community Members	10/22/18
24	Focus group	Sacramento Food Bank and Family Health Services (Individuals and families experiencing food Insecurity)	5	Low-income; medically underserved; racial or ethnic minorities	Community Members	11/2/18
25	Focus group	Sacramento LGBT Community Center (LGBT community members)	9	Medically underserved; racial or ethnic minority	Community Members	11/8/18

*Focus Group and Group Interview participants completed an optional survey. These data were used to capture the representation of the four target groups during data collection events:

Health department representative: One or more participant indicated they identify as a leader, representative, or member of any of a health department or the health care sector

Low-income: One or more participant indicated they received government assistance and/or their family earned less than $30,000, or worked with a low-income community

Medically underserved: One or more participants indicated they either had “No Insurance” or identified as from traditionally medically underserved communities (e.g., LGBTQ, homeless), or worked with a medically underserved community

Minority: One or more participant indicated their race/ethnicity as non-White, or that they worked with a minority community

Appendix C. Health Need Profiles

Health need profiles include primary data (i.e. qualitative findings from focus groups, key informant interviews, and group interviews) and secondary data (regional statistics), and were developed prior to the prioritization meeting. The profiles do not reflect additional knowledge shared by individual stakeholders during that meeting. Additionally, statistics presented in the health need profiles were not analyzed for statistical significance and should be interpreted in conjunction with qualitative findings.

Kaiser Foundation Hospital – Sacramento Service Area
Community Health Needs Assessment

Access to Care

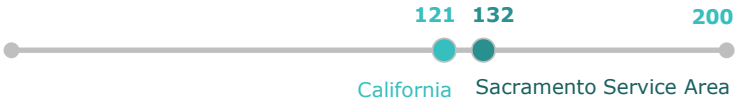
Access to quality health care includes affordable health insurance, utilization of preventive care, and ultimately reduced risk of unnecessary disability and premature death. Importantly, it is also one of the key drivers in achieving health equity. The Kaiser Permanente Sacramento Service Area scores better than the California state average on some of the indicators measuring health access, such as a lower percentage of uninsured individuals and higher rates of first trimester prenatal care. However, there are higher rates of breast and lung cancer in the area, and significant disparities remain within indicators in which the area exceeded state averages. For example, some communities are at greater risk of being uninsured, and going to the hospital for preventative causes. In addition, lack of knowledge, access to mental and behavioral health providers, and trust in the system inhibit the ability of individuals to navigate existing systems of care, and these barriers disproportionally affect low-income individuals and people of color.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Breast cancer incidence (rate is per 100,000 females)[1]



First trimester prenatal care[2]

Lung cancer incidence (rate is per 100,000 population)[3]

Uninsured population[4]

Community Identified Barriers

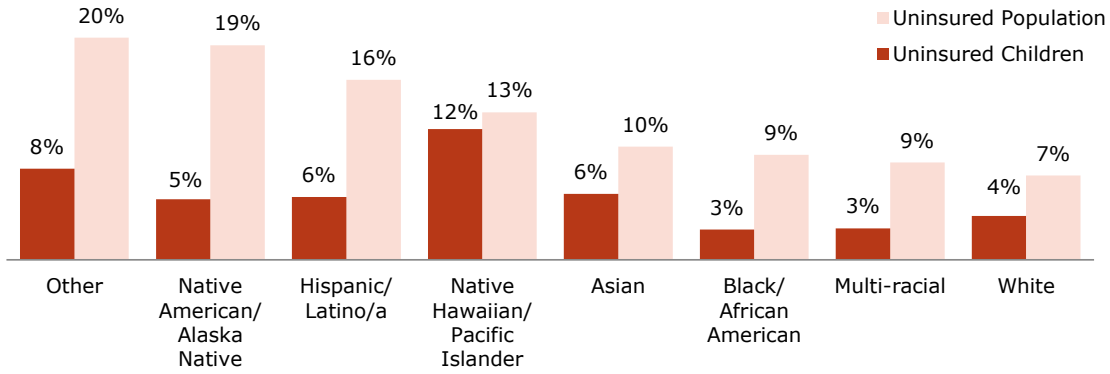
- Lack of resources available with cultural competency and multiple languages
- Fear and mistrust in the community
- Lack of access to mental and behavioral health services and providers
- Lack of knowledge of systems
- Technological barriers for the elderly population
- Lack of transportation
- Long waitlists for services
- Affordability of services
- Lack of oral health and vision coverage

> For me personally, I have issues because they do not speak Spanish. I had surgery last year… they were going to run some tests on me and they never spoke to me in Spanish. They sent me to get another test and I was unable to get it done.
> - Focus Group participant (translated from Spanish)

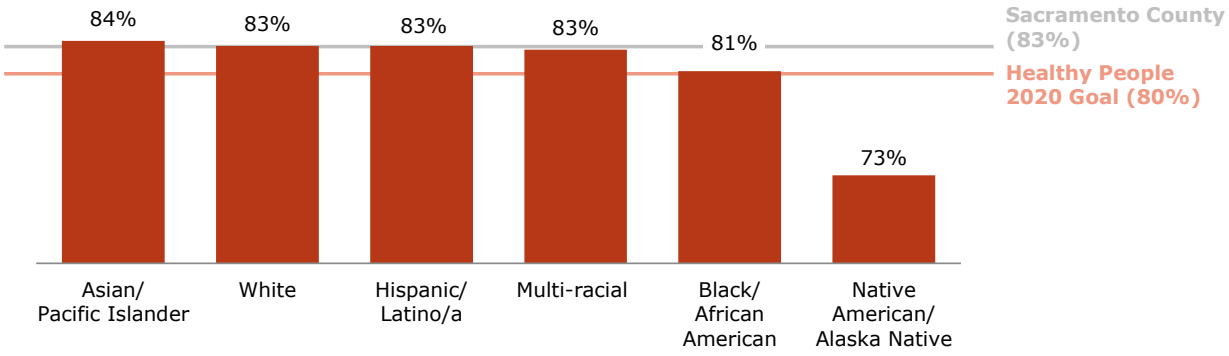
Updated March 2019

Populations with Greatest Risk

Uninsured population and children in the Sacramento Service Area[5]



Sacramento County first trimester prenatal care[6]



Preventable hospital events (rate is per 1,000 population)[7]

48 out of 1,000 Black/African American residents experienced a preventable hospital event

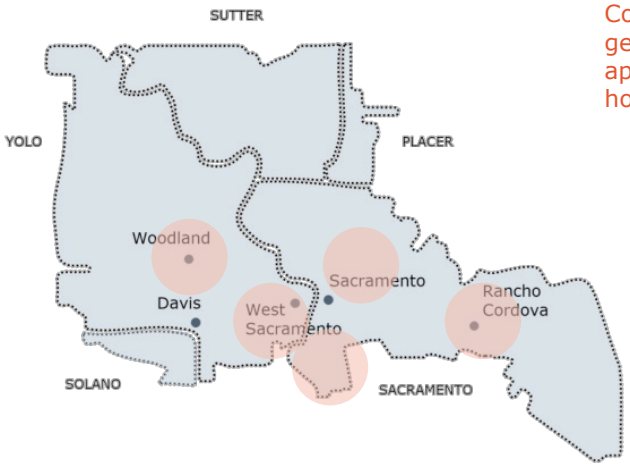
whereas

26 out of 1,000 White residents experienced a preventable hospital event

> I think people feel like they're being forgotten and not talking about it and sharing it. For every really great place that we have down here in downtown, there's multiple places that are taking five hours to get to a doctor's office on the transportation part of it. So it kind of hits everything.
> - Service provider

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Common barriers for accessing care varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area (HSA).

Highest rates of uninsured populations[8] were found in Sacramento (Rancho Cordova, South Natomas, and South Sacramento city), and Yolo (West Sacramento, and Woodland) Counties.

Highest rates of uninsured children[9] were found in Natomas, Rancho Cordova, and the eastern most areas of the HSA, as well as West Sacramento and Woodland.

Emerging Needs

Sacramento Service Area residents and providers reported the following emerging community needs:

- Fear of accessing resources for undocumented community members
- Access to adequate services, including mental health services for the formerly incarcerated population
- Insurance barriers for community members with preexisting conditions
- Increase in suicide risk amongst youth in the community
- Cultural stigma to reach out for services
- Lack of affordable housing

> But the undocumented are afraid to reach out. You know, obviously fear deportation. You have African American families who, quite frankly, just ... they've gone through so much that stress is an everyday thing for them. So when they admit that they have some kind of mental depression, it's frowned upon... So now you're having a larger, diverse group of population that are afraid to reach out for health services.
> - Service provider

> The other striking thing we saw this year, when we looked at our data, is we had a 76% increase in suicide risk assessments.
> - Service provider

Assets and Ideas

Examples of Existing Community Assets

The Sacramento Service Area has many strengths. The following are assets identified by residents and providers.

Access to health services in multiple languages

Access to multiple hospitals

Community organizations that provide holistic care

Wellness programs sponsored by Kaiser Permanente

Ideas from Focus Groups and Interview Participants

Sacramento Service Area residents and providers shared their ideas for how best to meet the needs in the community.

- Integrate currently fragmented channels of care (primary, dental, mental health, substance abuse, social services), perhaps using schools as community hubs
- Increase place-based health delivery, such as mobile health clinics and home-based care
- Continue to provide specialized referrals to services that connect people to the proper organizations
- Increase number of bilingual and bicultural service providers
- Confront stigma around accessing mental health care services
- Increase knowledge of systems of care within the community
- Improve access to public transportation, especially for seniors

References

[1] State Cancer Profiles. (2010-2014). Retrieved from http://statecancerprofiles.cancer.gov/
[2] Sacramento County Community Health Status Report. (2014). Retrieved from http://www.dhs.saccounty.net/PUB/Documents/Epidemiology/RT-HealthStatusReport2014.pdf
[3] State Cancer Profiles. (2010-2014). Retrieved from https://statecancerprofiles.cancer.gov/
[4] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/
[5] Ibid.
[6] Sacramento County Community Health Status Report. (2014). Retrieved from http://www.dhs.saccounty.net/PUB/Documents/Epidemiology/RT-HealthStatusReport2014.pdf
[7] Dartmouth Atlas of Healthcare. (2014). Retrieved from https://www.dartmouthatlas.org/
[8] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/
[9] Ibid.

Economic Security

Economic security means having the financial resources, public supports, career and educational opportunities, and housing necessary to be able to live your fullest life. The Kaiser Permanente Sacramento Service Area scores worse than the California state average on many of the indicators measuring economic security, including more children and adults living below the federal poverty level, and more individuals who are food insecure. Significant disparities remain across the region both by race/ethnicity and geography. For example, people of color are more likely to surpass the state average on each of these indicators, and the extent to which food insecurity, unemployment, and housing problems are prevalent varies by geographic region. In addition, through interviews and focus groups with local stakeholders, a lack of awareness of local systems and supports, affordable food, accessible housing, cost of living, accessible transportation, and a lack of consistent funding for services all emerged as common barriers to economic security. These barriers disproportionally affect low-income individuals and people of color.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Adults with no high school diploma[1]

Individuals experiencing food insecurity[2]

Percent of population below 100% Federal Poverty Line (FPL)[3]

Severe housing problems[4]

Community Identified Barriers

- Fluctuating resources and services (due to funding changes)
- Increased cost of living
- Lack of livable wages
- Lack of access to affordable transportation
- Low vacancy rate
- Lack of access to affordable and healthy foods
- Lack of knowledge of systems and resources

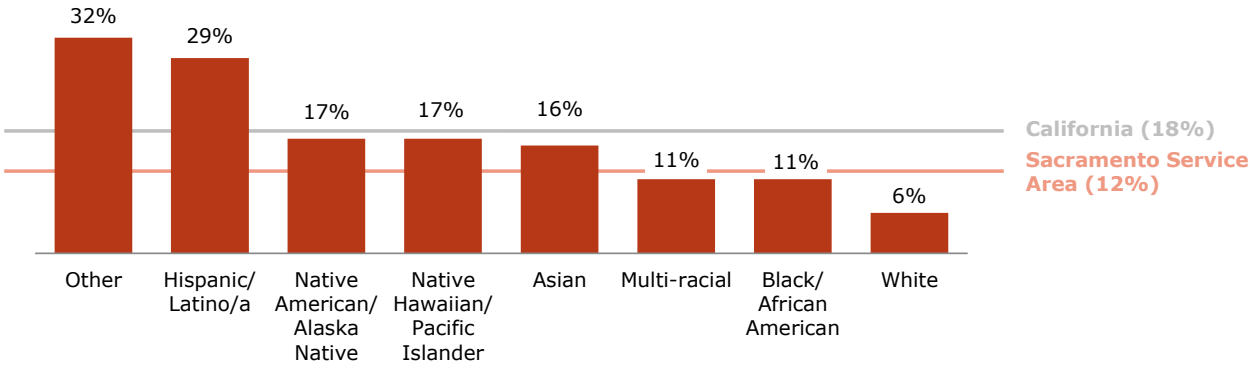
> There is income inequality for Latinos in Sacramento. They don't have a problem getting a job, it's about the wages that they get. In the African American community, what we're seeing and experiencing in Sacramento is this anti-blackness that keeps them from even getting a job.
> - Service provider

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk

Adults with no high school diploma[5]



Children living below the Federal Poverty Line (FPL)[6]

40% of Black/African American children were living in households with incomes below the FPL

17% of White children were living in households with incomes below the FPL

Receipt of Supplemental Nutrition Assistance Program (SNAP) benefits[7]

23% of Black/African American households in the Sacramento Service Area received SNAP benefits

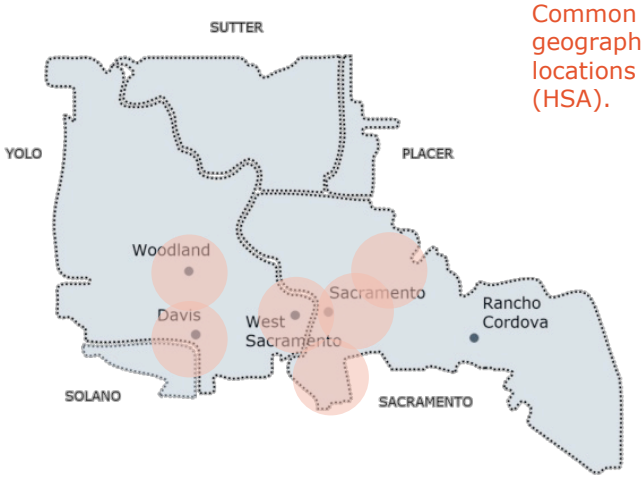
whereas

8% of White households in the Sacramento Service Area received SNAP benefits

> If you are working and you go over just a little bit, you do not get the same help from the government and we are still poor… the waitlists are too long, I cannot afford to wait months to see if my kid can go to daycare… They prioritize some people but we need it too.
> - Focus Group participant (translated from Spanish)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Common barriers to economic security varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area (HSA).

High rates of housing problems,[8] which include lacking complete kitchens and plumbing facilities, overcrowding, or housing costs represent over 30% of monthly income, were present in parts Sacramento (Arden Arcade, Downtown Sacramento, Natomas, Oak Park, and South Sacramento city) and Yolo (Davis, Woodland, and West Sacramento) Counties.

**Not shown on map:*
High rates of unemployment[9] were present in the portions of Sutter County within the HSA.

Emerging Needs

Sacramento Service Area residents and providers reported the following emerging community needs:

- Rise in the cost of housing and lack of affordable housing
- Increase in the prevalence of homelessness especially amongst the formerly incarcerated population
- Rise in need for services to refugees and immigrant families in an appropriate language

> So now we're seeing the impact …[of not] building more affordable housing, right?… Some of the numbers that we have heard in the community is that Sacramento County has a four percent vacancy rate, which means that having money in pockets doesn't guarantee me that I would get housing. So if you have a voucher for Section 8 housing or affordable housing you're like out of luck.
> - Focus Group participant

In recent years, Sacramento County has experienced an increase in homeless individuals and families, with an estimated 30 percent more homeless individuals each night in 2017, compared to 2015.

Thirty-one percent of individuals were chronically homeless, and thus more likely to have mental health conditions, such as PTSD, than others in the homeless community.[10]

Assets and Ideas

Examples of Existing Community Assets

The Sacramento Service Area has many strengths. The following are assets identified by residents and providers.

Strong community-based organizations

Connections to organizations on shelter and housing

Youth and children programs during the summer months

Local food banks and food assistance programs

Ideas from Focus Groups and Interview Participants

Sacramento Service Area residents and providers shared their ideas for how best to meet the needs in the community.

- Integrate a culturally competent approach to educating the community about the resources that exist in the community
- Increase access to affordable housing in the area
- Create rent control policies in the city of Sacramento
- Provide more jobs that pay a living wage along with more job training
- Increase access to affordable clothing at second hand stores

References

[1] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/
[2] Feeding America. (2014). Retrieved from http://map.feedingamerica.org/
[3] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/
[4] Consolidated Planning CHAS Data. (2011-2015). Retrieved from https://www.huduser.gov/portal/datasets/cp.html
[5] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/
[6] Ibid.
[7] Ibid.
[8] Consolidated Planning CHAS Data. (2011-2015). Retrieved from https://www.huduser.gov/portal/datasets/cp.html
[9] Bureau of Labor Statistics. (2017). Retrieved from https://www.bls.gov/
[10] Homelessness in Sacramento County: Results from the 2017 Point-in-Time Count. (2017). Retrieved from http://www.saccounty.net/Homelessness/Documents/2017_SacPIT_Final.pdf

Environmental Health

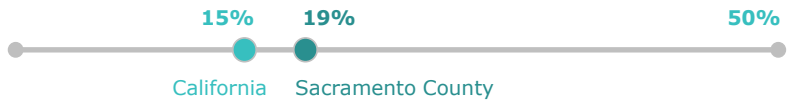
Environmental health indicators include respiratory hazards, tree canopy, and access to public transportation, as well as related health outcomes such as asthma and lung cancer. On average, the Sacramento Service Area performs worse than benchmarks on many factors related to environmental health, including having a worse Respiratory Hazard Index score (i.e., more respiratory hazards), lower tree canopy cover, and higher rates of asthma prevalence and lung cancer incidence. In addition, geographic disparities exist across indicators. Local stakeholders also identified lack of consistent access to public transportation and lack of access to clean and safe green spaces as barriers associated with environmental health.

Key Data

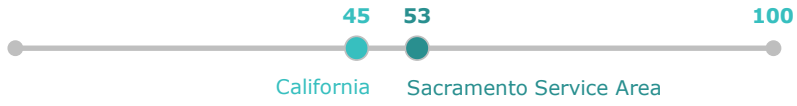
Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Asthma Prevalence[1]

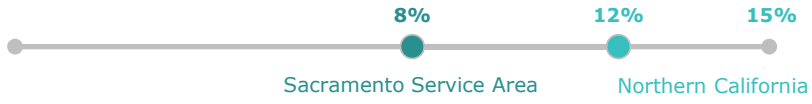


Lung cancer incidence (rate is per 100,000 population)[2]



Respiratory Hazard Index: Scores greater than 1 indicates increased risk of health effects[3]

Tree canopy cover (percentage of land covered by trees)[4]



Community Identified Barriers

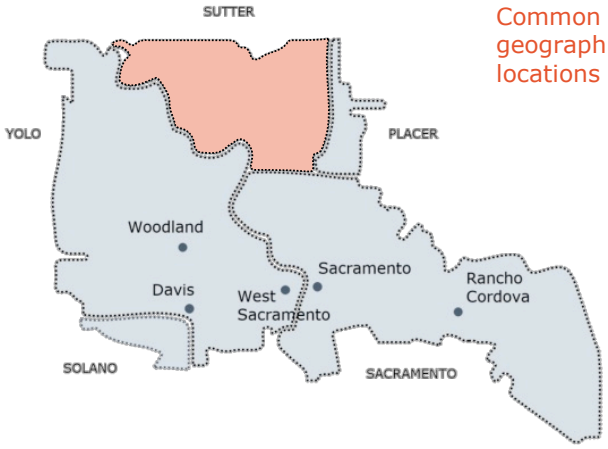
- Lack of access to clean water
- Lack of consistent access to public transportation
- Lack of access to clean and safe green spaces

> The other thing that we are seeing is an increase in health issues, so students requiring emergency care plans for some type of severe health concern. We have like 14,000 students with an identified health issue in our district. I mean, that's just the ones we know where a parent actually put it on a form, and we actually put it in. Lots of asthma, continues to just go up and up. - Service provider

Updated March 2019

Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Common factors related to environmental health varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area (HSA).

Highest rates of **asthma prevalence**[5] were found in Sutter County.

**Not shown on map:*
Almost the entire HSA has high levels of respiratory pollutants, indicated by a high **respiratory hazard index**[6] score. Only the areas east of Rancho Cordova and the far southwestern portion of the HSA are at non-hazardous levels.

Emerging Needs

Sacramento Service Area residents and providers reported the following emerging community needs:

- Rise in extremely hot temperatures during the summer months
- Need for clean streets that are free of drug contamination and trash

> Health is tied to good access to healthy housing. So we have some housing developments in our community where we've noticed those students have 30% more asthma than any other school. And all of the students that go to that school come from that housing development.
> - Service provider

Ideas from Focus Groups and Interview Participants

Sacramento Service Area residents and providers shared their ideas for how best to meet the needs in the community.

- Expand access to public transportation
- Dedicate outreach to homeless community members, through park visitation, for example

References

[1] California Department of Public Health California Asthma Data Tool. (2015-2016). https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/EHIB/CPE/Pages/CaliforniaBreathingCountyAsthmaProfiles.aspx
[2] State Cancer Profiles. (2010-2014). Retrieved from https://statecancerprofiles.cancer.gov/
[3] EPA National Air Toxics Assessment. (2011). Retrieved from https://www.epa.gov/national-air-toxics-assessment
[4] National Land Cover Database. (2011). Retrieved from https://www.mrlc.gov/nlcd2011.php
[5] California Healthy Interview Survey. (2014). Retrieved from http://ask.chis.ucla.edu/
[6] EPA National Air Toxics Assessment. (2011). Retrieved from https://www.epa.gov/national-air-toxics-assessment

Healthy Eating and Active Living

Healthy eating and active living (HEAL) relates to the ability of residents to positively shape their health outcomes by focusing on nutrition and exercise. These behaviors, however, are impacted by many factors that are outside of individuals' control, such as access to safe parks and affordable vegetables. Further, HEAL impacts the rates of many chronic conditions like cardiovascular disease (CVD) and stroke. The Kaiser Permanente Sacramento Service Area scores worse than the California state average on many of the indicators measuring HEAL. For example, adults are more likely to experience obesity and residents have less access to affordable and nutritious food. Significant disparities exist by race/ethnicity and geography, specifically related to youth obesity, inactivity, and receipt of Supplemental Nutrition Assistance Program (SNAP) benefits. Local stakeholders identified violence in the community, accessible transportation, affordable and healthy food options, and lack of knowledge how to navigate systems as barriers to HEAL.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Adult obesity[1]

Food Environment Index: 0 indicating a worse score of affordability and nutritious food accessibility[2]

Food insecurity[3]

Youth obesity[4]

Community Identified Barriers

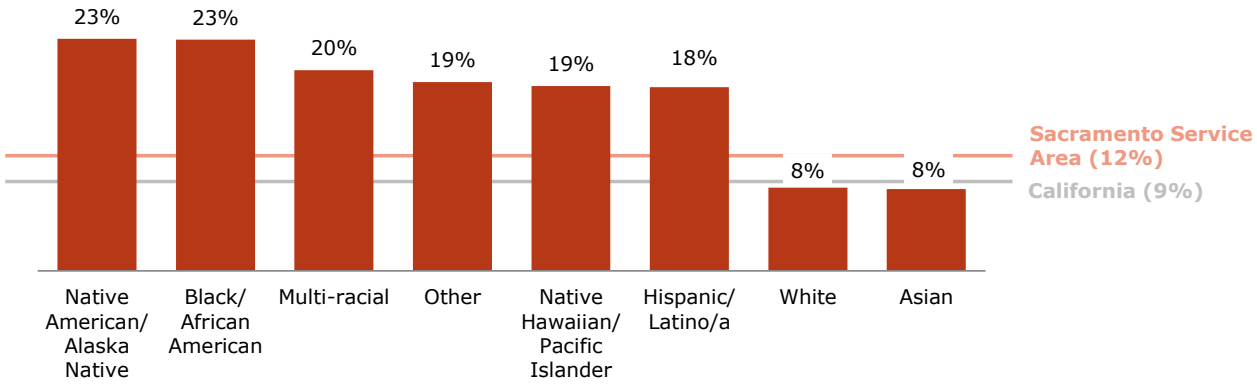
- Violence in the community
- Lack of access to affordable grocery stores with culturally sensitive and healthy foods
- Lack of access to affordable and reliable transportation
- Lack of knowledge of systems
- Lack of oral health care

> I think it is built environment, and it's no accident that low-income communities have built environment barriers that keep folks from being out in their neighborhoods and being active, and hide the connection between obesity and violence for example. I think the access to healthy food, access to fresh fruits and vegetables, those same communities that don't have grocery stores and don't have parks where they feel safe, they have high rates of obesity.
> - Service provider

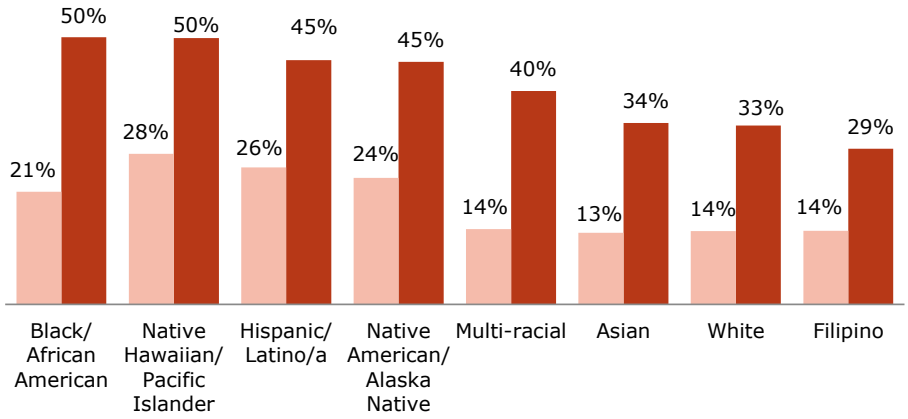
Updated March 2019

Populations with Greatest Risk

Receipt of Supplemental Nutrition Assistance (SNAP) benefits[5]



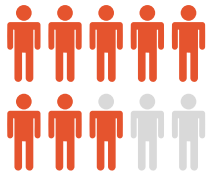
Youth obesity and inactivity[6]



On average, youth inactivity and youth obesity in Sacramento were similar to the California benchmarks.

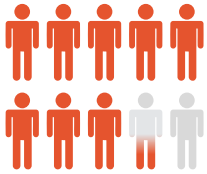
Adult obesity rates also varied by race and ethnicity.

Diabetes Management[7]



78% of Black/African American individuals with diabetes had their blood sugar levels monitored by a health care professional in the past year

whereas



83% of White individuals with diabetes had their blood sugar levels monitored by a health care professional in the past year

> They are all agricultural workers. How sad is it that the very people growing the vegetables that end up on our kitchen tables are not able to purchase the food that they are harvesting because it is too expensive.
> - Focus Group participant (translated from Spanish)

Populations Disproportionately Affected

Geographic Areas with Greatest Risk

Common barriers to healthy eating and active living varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area (HSA).

Compared to other counties in the HSA, Sutter County had **lower access to areas with exercise opportunities**[8] including parks, playgrounds, or other recreational facilities, and the **lowest Food Environment Index Score**,[9] a measure of affordable, close, and nutritious food retailers.

**Not shown on map:*
Sacramento County had **higher prevalence of violent crimes**,[10] which many community members identified as a barrier to engaging in physical activity.

Emerging Needs

Sacramento Service Area residents and providers reported the following emerging community needs:

- Increase in the prevalence of homelessness in the community and homeless individuals in neighborhood parks, which reduces the use of parks by community members
- Lack of transportation as a barrier to access foods and grocery stores
- Fear of accessing resources, such as SNAP benefits, for undocumented population in the community

> People are very concerned about CPS, or ICE. There are a lot of challenges to build that trust. But once you can build it, and connect with it, oftentimes then families will come to us, and then we can leverage our trust to connect them to a community partner. And the barrier to that is, there's not enough of us. There's only so much of us that we can spread around. I'm not hitting everybody.
> - Service provider

Assets and Ideas

Examples of Existing Community Assets

The Sacramento Service Area has many strengths. The following are assets identified by residents and providers.

Stationary and mobile food banks

Summer programs offering free food for children

Wellness programs that offer education on diabetes

Ideas from Focus Groups and Interview Participants

Sacramento Service Area residents and providers shared their ideas for how best to meet the needs in the community.

- Use schools to educate young children and families on healthy eating practices and active living
- Increase nutrition education especially for people with diabetes or other similar conditions
- Connect families to food assistance programs like CalFresh through schools
- Create a community garden or community kitchen that is accessible to all
- Increase access to healthy affordable grocery stores that offer culturally sensitive food
- Increase access to fresh, healthy, local foods through farmers markets
- Increase access to affordable transportation
- Increase knowledge of bike lanes to encourage safe use of them
- Educate public around proper use of protective bike lanes
- Provide cleaner parks and green spaces

References

[1] National Center of Chronic Disease Prevention and Health Promotion. (2013). Retrieved from https://www.cdc.gov/nccdphp/dnpao/index.html
[2] Food Environment Atlas (USDA) and Map the Meal Gap (Feeding America). (2014). Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-factors/health-behaviors/diet-exercise/food-environment-index
[3] Feeding America. (2014). Retrieved from http://map.feedingamerica.org/
[4] National Survey of Children's Health. (2016). Retrieved from http://childhealthdata.org/learn-about-the-nsch/NSCH
[5] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/
[6] National Survey of Children's Health. (2016). Retrieved from http://childhealthdata.org/learn-about-the-nsch/NSCH
[7] Dartmouth Atlas of Healthcare. (2014). Retrieved from https://www.dartmouthatlas.org/
[8] County Health Rankings. (2010; 2014). Retrieved from http://www.countyhealthrankings.org/
[9] Food Environment Atlas (USDA) and Map the Meal Gap (Feeding America). (2014). Retrieved from http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank/health-factors/health-behaviors/diet-exercise/food-environment-index
[10] FBI Uniform Crime Reports. (2012-2014). Retrieved from http://www.fbi.gov/about-us/cjis/ucr/ucr

Mental and Behavioral Health

Mental and behavioral health are foundations for healthy living, and encompass rates of mental illness, rates of challenging behaviors (e.g., school suspensions), substance abuse, access to social and emotional support, and access to providers for preventive care and treatment. In some cases, mental health is associated with homelessness. The Kaiser Permanente Sacramento Service Area scores on par with the California state average on many indicators related to mental and behavioral health, including substance use – excessive drinking, current smokers, and opioid prescription drug claims. However, the region also has higher rates of school suspensions and reduced access to mental health providers compared to the state and region, respectively. In addition, racial/ethnic and geographic disparities exist related to these indicators. Local stakeholders also identified too few mental and behavioral health providers, lack of trust in health systems, experiences of stigma accessing services, and financial challenges to meeting their mental and behavioral health needs.

Key Data

Indicators

Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Mental health providers (rate is per 100,000 population)[1]

Suspensions (rate is per 100 enrolled students)[2]

Adults likely experiencing serious psychological distress in past year[3]

Suicide deaths (rate is per 100,000 population)[4]

Community Identified Barriers

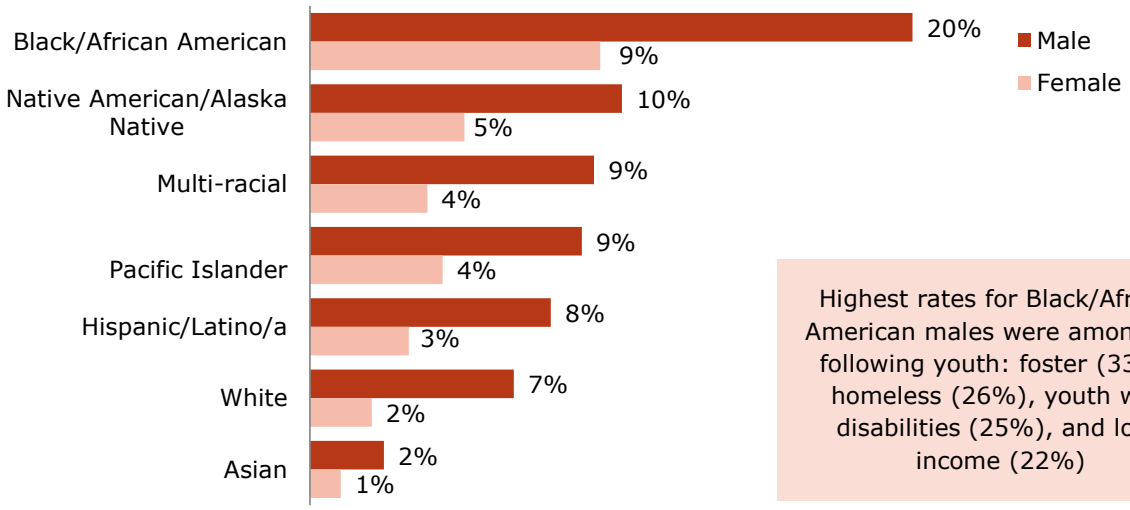
- Not enough resources to meet mental and behavioral health needs
- Stigma to accessing resources
- Fluctuating resources and services (due to funding changes)
- Long waitlists for resources
- Lack of affordable services
- Lack of trust in the community

> I think there needs to be more counseling for children in schools so that those being bullied are less affected. My daughter was so affected to the point where she was contemplating suicide and the schools didn't do anything.
> - Focus Group participant (translated from Spanish)

Updated March 2019

Populations with Greatest Risk

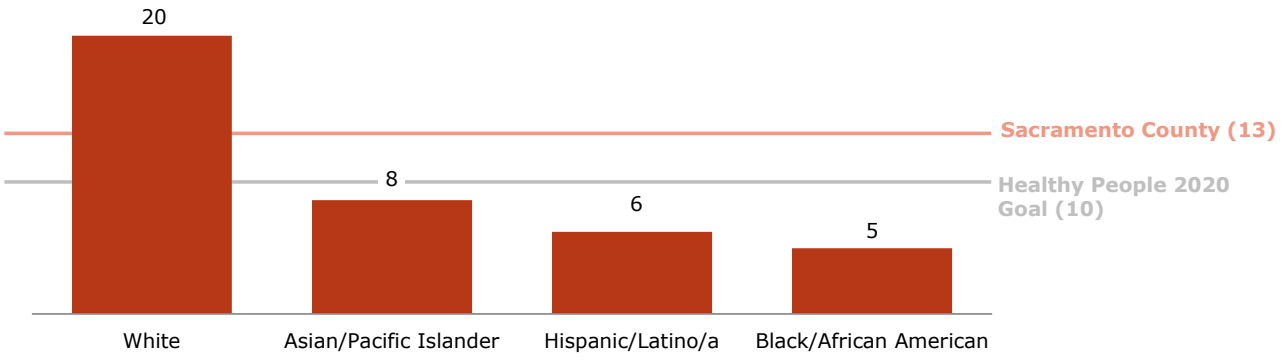
School suspension rates in Sacramento County[5]



Highest rates for Black/African American males were among the following youth: foster (33%), homeless (26%), youth with disabilities (25%), and low-income (22%)

> What they have found with some of the policies that have been put in place, for example, zero tolerance to children misbehaving, has had unfortunate consequences, where I think you may have heard the report where they said that Sacramento County has higher rates of expulsion and this is not high school children, these are people in elementary and kindergarten and it's...there's a disparate proportion of minorities, especially African Americans in that group.
> - Service provider

Suicide rates in Sacramento County per 100,000 population[6]



Populations Disproportionately Affected

Geographic Areas with Greatest Risk

Common barriers to mental and behavioral health varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area (HSA).

Portions of Placer and Sutter Counties had the **lowest number of mental health providers**[7] within the HSA.

**Not shown on map:*
Sacramento had the **highest suspension rates**[8] in the state of California. Sacramento City Unified, Twin Rivers Unified, and San Juan Unified were among the districts with the highest suspension rates for Black males in the state of California.

Emerging Needs

Sacramento Service Area residents and providers reported the following emerging community needs:

- Lack of access to affordable housing
- Lack of support for formerly incarcerated community members
- Increase in homelessness in the community
- Increase fear and mistrust by the undocumented community of the greater community
- Increase in stigma for accessing resources

> The undocumented [individuals] are afraid to reach out. You know, obviously fear deportation. You have African American families who, quite frankly, just ... they've gone through so much that stress is an everyday thing for them. So when they admit that they have some kind of mental depression, it's frowned upon. Then you also have in a Middle Eastern family who, again, in their culture they don't believe in mental health services. So now you're having a larger, diverse group of population that are afraid to reach out for health services.
> - Service provider

In recent years, Sacramento County has experienced an increase in homeless individuals and families, with an estimated 30% more homeless individuals each night in 2017, compared to 2015. Thirty-one percent of individuals were chronically homeless, and thus more likely to have mental health conditions, such as PTSD, than others in the homeless community.[9]

Assets and Ideas

Examples of Existing Community Assets

The Sacramento Service Area has many strengths. The following are assets identified by residents and providers.

Youth programs that offer mentorship and support

Mental health clinics and resources offered by Kaiser Permanente

Community organizations that offer holistic support

Resources and support for homeless community members

Ideas from Focus Groups and Interview Participants

Sacramento Service Area residents and providers shared their ideas for how best to meet the needs in the community.

- Increase community knowledge of resources available in the community and how to navigate the system in a culturally sensitive way
- Increase mentorship opportunities that pair community members with one another
- Increase specialized referrals within community organizations to connect people to the right services
- Increase mental health awareness and training in law enforcement especially through encouraging de-escalation practices
- Reach out to community members who need housing support
- Increase support for youth through more events and programs
- Incorporate trauma informed approaches to education

References

[1] Area Health Resource File. (2016). Retrieved from https://datawarehouse.hrsa.gov/topics/ahrf.aspx
[2] California Department of Education. (2016-2017). Retrieved from https://www.cde.ca.gov/ds/
[3] California Health Interview Survey (2017). Retrieved from http://ask.chis.ucla.edu
[4] National Vital Statistics System. (2011-2015). Retrieved from https://www.cdc.gov/nchs/nvss/index.htm
[5] The Five Critical Facts Series. (2018). Retrieved from https://cceal.org/wp-content/uploads/2018/06/sacramento.pdf
[6] Sacramento County Public Health (2015). Retrieved from http://www.dhs.saccounty.net/PUB/Documents/Epidemiology/RT-SuicideFactSheet2015.pdf
[7] Area Health Resource File. Health Resources & Services Administration. (2016). Retrieved from https://datawarehouse.hrsa.gov/topics/ahrf.aspx
[8] The Five Critical Facts Series. (2018). Retrieved from https://cceal.org/wp-content/uploads/2018/06/sacramento.pdf
[9] Homelessness in Sacramento County: Results from the 2017 Point-in-Time Count. (2017). Retrieved from http://www.saccounty.net/Homelessness/Documents/2017_SacPIT_Final.pdf

Kaiser Foundation Hospital – Sacramento Service Area
Community Health Needs Assessment

Violence and Injury

Direct and indirect exposure to violence and injury, such as domestic and community violence, have significant effects on well-being and health. On average, residents of the Kaiser Permanente Sacramento Service Area have higher rates of violence exposure compared to the California state average, including higher rates of domestic violence hospitalizations, suicide deaths, and violent crimes. Although already higher than the state average, disparities exist within these indicators as well, such that some communities have higher rates of domestic violence hospitalizations and violent crimes exposure than others. In addition, through interviews and focus groups with local stakeholders, several additional factors were identified as contributing to the effects of violence and injury, including existing trauma in the community, competing priorities with other basic needs, mistrust in law enforcement, and lack of affordable housing and safe spaces—and these barriers disproportionally affect low-income individuals and people of color.

Key Data

Indicators

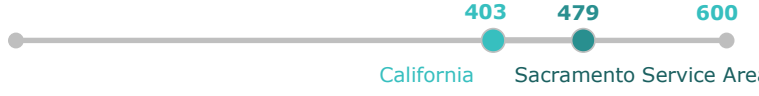
Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Domestic violence hospitalizations (rate is per 100,000 females)[1]

Pedestrian accident deaths (rate is per 100,000 population)[2]

Suicide deaths (rate is per 100,000 population)[3]

Violent crimes reported (rate is per 100,000 population)[4]



Community Identified Barriers

- Existing trauma in the community
- Competing priorities with other basic needs
- Mistrust in law enforcement and other public servants
- Stress in the community
- Lack of affordable housing
- Lack of safe, walkable spaces
- Lack of safety in public transportation

> A lot of the population that we serve hasn't had ... They've had horrible upbringings. They've had complex traumas that they're dealing with. They've never really had a healthy outlet and have never really had a stable support system where they can just feel safe. Even if there's not violence or trauma in the home, as soon as they walk out there's quite a bit of community violence.
> - Service provider

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

Motor vehicle crash deaths (rate is per 100,000 population)[5]

On average, Sacramento Service Area residents had similar rates of motor vehicle crash deaths to the California state average (9)

10

for Asian, Hispanic/Latino/a, and White individuals

6

for Black/African American individuals

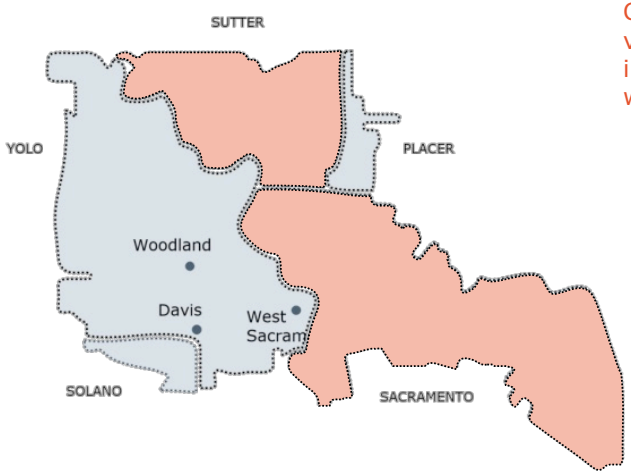
Suicide deaths (rate is per 100,000 population)[6]

17 — The suicide rate for White individuals is **17** per 100,000 population

whereas

6 — The average suicide rate for Hispanic/Latino/a is **6** per 100,000 population

Geographic Areas with Greatest Risk



Common factors related to violence and injury varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area (HSA).

The **number of non-fatal emergency department visits for domestic violence**[7] **among females were highest** in the HSA within Sutter County, followed by Sacramento County.

**Not shown on map:*
Data also showed that the Sacramento County portion of the HSA had the highest rate of **violent crimes**[8] in the service area.

Emerging Needs

> We're seeing quite a bit of students at risk, or actively trafficked in our communities, in Sacramento… Sacramento's a hub, so we're a really high trafficking area. Particularly with our foster youth and our homeless youth… because they're so much more vulnerable.
> - Service provider

Sacramento residents and providers reported the following emerging community needs:

- Police violence and related deaths have increased, causing community fear and mistrust
- Violence and crime in the community
- Higher risk of violence including human trafficking for foster youth and homeless community members
- Bullying in schools with social media playing a role

Assets and Ideas

Examples of Existing Community Assets

The Sacramento Service Area has many strengths. The following are assets identified by residents and providers.

Access to hospitals with a trauma center

Resources for women and survivors of domestic violence

Ideas from Focus Groups and Interview Participants

Sacramento Service Area residents and providers shared their ideas for how best to meet the needs in the community.

- Increase education around the prevalence of trauma in the community and ways to manage and overcome it
- Increase safety in public transportation for example, including a security guard on the bus
- Reduce the prevalence of over policing low-income and communities of color
- Increase education around how to help those experiencing abuse especially among medical care and other services providers
- Empower foster youth and other at risk youth by providing safe spaces for them
- Provide more employment training and job placement assistance

References

[1] California EpiCenter. (2013-2014). Retrieved from http://epicenter.cdph.ca.gov/
[2] Fatality Analysis Report System. (2011-2015). Retrieved from https://www.nhtsa.gov/research-data/fatality-analysis-reporting-system-fars
[3] National Vital Statistics System. (2011-2015). Retrieved from https://www.cdc.gov/nchs/nvss/index.htm
[4] FBI Uniform Crime Reports. (2012-2014). Retrieved from https://www.fbi.gov/services/cjis/ucr
[5] National Vital Statistics System. (2011-2015). Retrieved from https://www.cdc.gov/nchs/nvss/index.htm
[6] Ibid.
[7] California EpiCenter. (2013-2014). Retrieved from http://epicenter.cdph.ca.gov/
[8] FBI Uniform Crime Reports. (2012-2014). Retrieved from https://www.fbi.gov/services/cjis/ucr

Kaiser Foundation Hospital – Sacramento Service Area
Community Health Needs Assessment

Women and Children's Well-Being

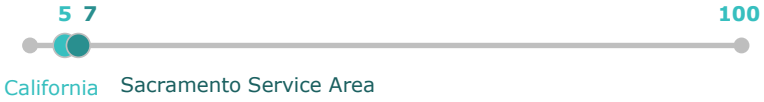
Women and children's well-being reflects not only health outcomes, but also access to services, such as reproductive health, pre-natal medical care, child care, and education. On average, within the Kaiser Permanent Sacramento Service Area, women and children fare worse than the state benchmarks. For example, there are higher rates of breast cancer among women, and higher rates of hospitalizations due to domestic violence and adolescent mental health issues. Disparities within the region also exist, with higher rates of teen pregnancies, smoking during pregnancies, and low-birth rates and infant mortality for women of color. Further, within the Sacramento Service Area, geographic disparities are prevalent regarding rates of preschool enrollment and single parent households. Local stakeholders identified lack of child care, affordable and healthy food, and housing as barriers to women and children's well-being.

Key Data

Indicators

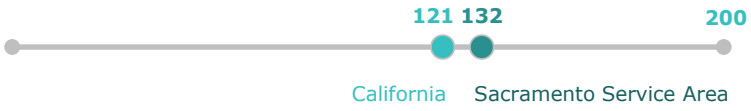
Data presented below represent how the service area performs relative to the identified benchmark. Indicators performing *better* than the benchmark may still reflect a health need since the benchmark may also be low, indicating a widespread need for improvement, or disparities may exist within the indicator, reflected in the following sections.

Domestic violence hospitalizations (rate is per 100,000 population)[1]



Hospitalizations for mental health issues in children ages 15-19 (rate is per 1,000 youth ages 15-19)[2]

Rate of breast cancer incidents (rate is per 100,000 females)[3]



Teen (ages 15-19) birth rates (rate is per 1,000 females ages 15-19)[4]

Community Identified Barriers

- Long waitlists for resources
- Lack of transportation
- Lack of access to child care
- Safety issues that prohibit women and children to walk or use public transportation
- Affordable healthy food for children
- Affordable stable consistent housing

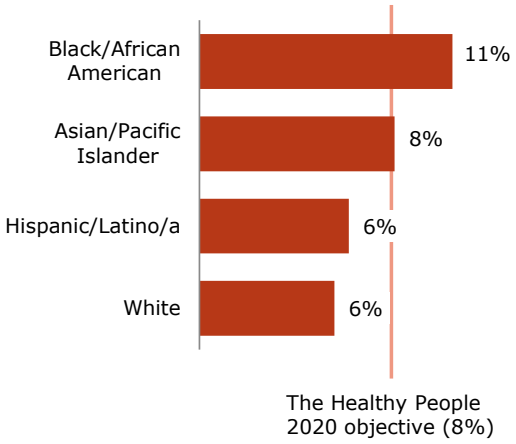
> So many of the women will go back to a domestic violence relationship because of lack of housing. Women who do not have a shelter are vulnerable to everything that can happen. That's huge.
> -Focus Group participant

Updated March 2019

Populations Disproportionately Affected

Populations with Greatest Risk by Race and Ethnicity

Infant low-birth weight in Sacramento County[5]



Infant deaths (rate is per 1,000 births)[6]

6.3 The mortality rate for minority infants is **6.3** per 1,000 births in the Sacramento Service Area*

whereas

4.5 The infant mortality rate for White infants is **4.5** per 1,000 births in the Sacramento Service Area

*Infant mortality rate for Black/African Americans decreased 45% from 2013-2016 in Sacramento County[7]

Teen birth rates (rate is per 1,000 females ages 15-19) in Sacramento County[8]

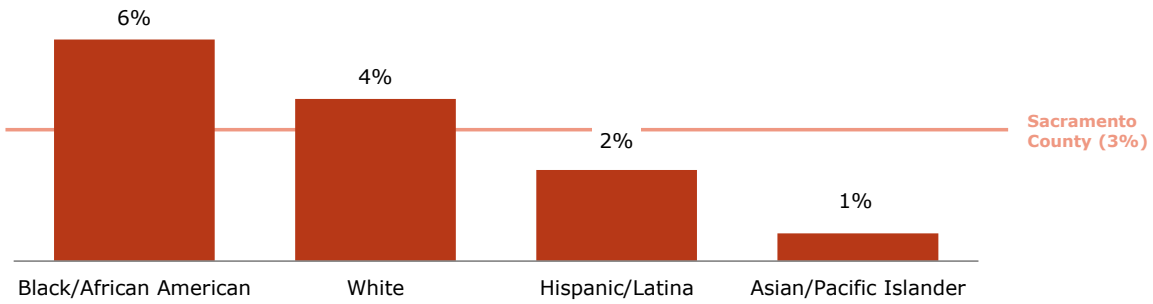
23 Birth rate for Black/African American teens

18 Birth rate for Hispanic/Latina teens

10 Birth rate for White teens

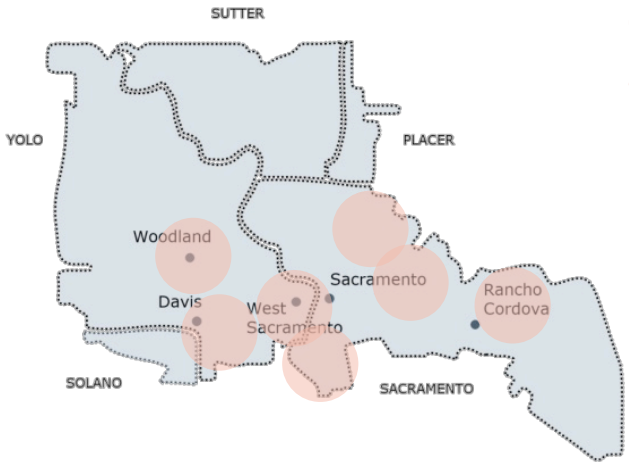
7 Birth rate for Asian teens

Tobacco use during pregnancy in Sacramento County[9]



Populations Disproportionately Affected

Geographic Areas with Greatest Risk



Common barriers to women and children's well-being varied by geographic communities. Pink areas indicate approximate locations of highest need within the hospital service area (HSA).

Low rates of preschool enrollment[10] were found throughout the HSA, with some of the lowest rates found in parts of Sacramento (Arden Arcade, Natomas, east of Rancho Cordova, South Sacramento city) and Yolo (South Davis, West Sacramento, Woodland) Counties, and all of Sutter County.

Emerging Needs

Sacramento Service Area residents and providers reported the following emerging community needs:

- Increase in Autism Spectrum Disorder diagnoses
- Fear of reaching out for needed services amongst the undocumented population and populations where there is stigma surrounding mental health
- Increase in child welfare referrals
- Social media impacting children's mental health
- More dangerous for women to walk on the street

> "Yolo County has seen a pretty dramatic rise in child welfare cases. I don't think we've solved it yet, but we're talking about some different programs." - Service provider

In recent years, Sacramento County has experienced an increase in homeless individuals and families, with an estimated 30% more homeless individuals each night in 2017, compared to 2015. Thirty-one percent of individuals were chronically homeless, and thus more likely to have mental health conditions, such as PTSD, than others in the homeless community.[11]

Assets and Ideas

Examples of Existing Community Assets

The Sacramento Service Area has many strengths. The following are assets identified by residents and providers.

Strong engagement programs for youth

Bilingual resources for parents

Summer programs that provide food for children

Walk-in clinics for women's health screenings for Kaiser Permanente members

Strong community initiatives to reduce deaths amongst African American children

Ideas from Focus Groups and Interview Participants

Sacramento Service Area residents and providers shared their ideas for how best to meet the needs in the community.

- Provide more preventative screenings for women's health at an affordable cost
- Invest more in schools and use them as community hubs that provide resources to children and their families
- Provide mentorship and peer support for young children and youth
- Increase education on healthier food choices for children
- Increase sexual education and resources in schools

References

[1] California EpiCenter. (2013-2014). Retrieved from http://epicenter.cdph.ca.gov/
[2] California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates by Race/Ethnicity with Age and Gender Detail 2000-2009; Population Reference Bureau, Population Estimates 2010-2016. (Aug. 2017). Retrieved from https://www.kidsdata.org
[3] State Cancer Profiles. (2010-2014). Retrieved from https://statecancerprofiles.cancer.gov/
[4] National Vital Statistics System. (2008-2014). Retrieved from https://www.cdc.gov/nchs/nvss/index.htm
[5] Sacramento County Birth Fact Sheet. (2016). Retrieved from http://www.dhs.saccounty.net/PUB/Documents/Epidemiology/RT-BirthFactSheet2016.pdf
[6] National Vital Statistics System. (2008-2014). Retrieved from https://www.cdc.gov/nchs/nvss/index.htm
[7] First 5 Sacramento Reduction of African American Perinatal and Infant Deaths. (2018). Retrieved from http://www.first5sacramento.net/Results/Documents/3-yr_RAACD_EvalReport.PDF
[8] Community Status Report Sacramento County. (2014). Retrieved from http://www.dhs.saccounty.net/PUB/Documents/Epidemiology/RT-HealthStatusReport2014.pdf
[9] Sacramento County Birth Fact Sheet. (2016). Retrieved from http://www.dhs.saccounty.net/PUB/Documents/Epidemiology/RT-BirthFactSheet2016.pdf
[10] American Community Survey. (2012-2016). Retrieved from https://www.census.gov/programs-surveys/acs/
[11] Homelessness in Sacramento County: Results from the 2017 Point-in-Time Count. (2017). Retrieved from http://www.saccounty.net/Homelessness/Documents/2017_SacPIT_Final.pdf