Dignity Health – Sacramento County

2022 Community Health Needs Assessment – Main Report

Acknowledgements

We are deeply grateful to all those who contributed to this community health needs assessment. Many dedicated healthcare practitioners, community health experts and members of various social service organizations serving the most vulnerable members of the Sacramento County community gave their time and expertise as key informants and survey respondents to help guide and inform the findings of the assessment. Specific survey respondents that expressed a desire to be recognized in the report are listed in the technical section of the report in the Community Service Provider Survey section. Many community residents also participated and volunteered their time to tell us what it is like to live in the community and shared the challenges they face trying to achieve better health. We also appreciate the collaborative spirit of Kaiser Permanente and their willingness to share the information they gathered while conducting a similar health assessment in the Sacramento area. Last, we especially acknowledge the sponsors of this assessment, Dignity Health, Sutter Health, and UC Davis Health, who, using the results of these assessments, continuously work to improve the health of the communities they serve. To everyone who supported this important work, we extend our heartfelt gratitude.

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

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Data and Technical Section of the report can be found online at https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment.

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Report Summary

Purpose

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

Dignity Health Commitment and Mission Statement

The hospitals' dedication to engagement with the community, assessing priority needs, and helping to address them with community health program activities is in keeping with our mission. As part of CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Community Definition

The definition of the community served included most portions of Sacramento County, and a small portion of western El Dorado County, California. Regarded as a highly diverse community, Sacramento County covers 994 square miles and is home to approximately 1.5 million residents. The CHNA uses this definition of the community served, as this is the primary geographic area served by the seven nonprofit hospitals that collaborated on this CHNA. Zip codes represented in the report include: 95608, 95610, 95621, 95624, 95626, 95628, 95630, 95632, 95638, 95652, 95655, 95660, 95662, 95670, 95673, 95683, 95693, 95742, 95757, 95758, 95762, 95811, 95814, 95815, 95816, 95817, 95818, 95819, 95820, 95821, 95822, 95823, 95824, 95825, 95826, 95827, 95828, 95829, 95830, 95831, 95832, 95833, 95834, 95835, 95837, 95838, 95841, 95842, 95843, and 95864.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[1] This model of population health includes many factors that impact and account for individual health and well-being. Further, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included interviews with 121 community health experts, members of the county's department of public health, social-service providers that represented medically underserved populations, and medical personnel in one-on-one and group interviews as well as one town hall meeting. Further, 154 community residents participated in 15 focus groups across the county.

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

[1] See: County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

At the time that this CHNA was conducted, the COVID-19 pandemic was impacting communities across the United States, including Sacramento County. The process for conducting the CHNA remained fundamentally the same. However, adjustments were made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the quantitative data analysis and COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs (SHNs). This began by identifying 12 potential health needs (PHNs). These PHNs were compiled from previous CHNAs conducted across Northern California over a period of approximately six years. Data were analyzed to discover which, if any, of the PHNs were present in the service area. After identifying those PHNs that were present as significant health needs, they were prioritized based on rankings provided by primary data sources described above. Qualitative data were also analyzed to detect *emerging health needs*; that is, a health need that emerged from data analysis beyond those 12 PHNs identified in previous CHNAs. (For detailed accounting of how health needs were identified and ranked see the Technical Section of the 2022 CHNA).

Because of the dynamic and evolving nature of health needs, identified significant health needs change over time and new needs may appear. For this assessment, one new emergent health need was identified: Health Equity: Equal Access to Opportunities to be Healthy (#6). Furthermore, data analysis identified three potential health needs (PHNs) that met the threshold of significance to be included in this assessment that were not identified in the previous assessment conducted in 2019. These were: Increased Community Connections (#9), Access to Dental Care and Preventative Services (#12), and Healthy Physical Environment (#13).

List of Prioritized Significant Health Needs

The following significant health needs identified for Sacramento County are listed below in prioritized order.

1. Access to Mental/Behavioral Health and Substance-Use Services
2. Access to Basic Needs Such as Housing, Jobs, and Food
3. Access to Quality Primary Care Health Services
4. System Navigation
5. Injury and Disease Prevention and Management
6. Health Equity: Equal Access to Opportunities to be Healthy (new, emergent)
7. Active Living and Healthy Eating
8. Safe and Violence-Free Environment
9. Increased Community Connections (new from PHNs)
10. Access to Specialty and Extended Care
11. Access to Functional Needs (transportation and physical mobility)
12. Access to Dental Care and Preventive Services
13. Healthy Physical Environment

Communities of Concern

Communities of Concern are geographic areas in Sacramento County, defined by ZIP Code boundaries, that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. For this assessment, 50 ZIP Codes in total were included across all of Sacramento County; of these, 19 met the requirements to be included as a Community of Concern. The total population within these

communities was approximately 700,000 residents, representing 44% of the total population in the service area.

Conclusion

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

Report Adoption, Availability, and Comments

The Dignity Health Community Board for Sacramento County voted, approved and adopted the Community Health Needs Assessment for Mercy Hospital of Folsom, Mercy General Hospital, Mercy San Juan Medical Center and Methodist Hospital of Sacramento on May 26th, 2022.

This main report and the data and technical section is widely available to the public on the hospital's web site (https://www.dignityhealth.org/sacramento/about-us/community-health-and-outreach/health-needs-assessment), and a paper copy is available for inspection upon request at Dignity Health, Community Health and Outreach Department, 3400 Data Drive, Rancho Cordova, CA 95670.

Written comments on this report can be submitted by email to DignityHealthGSSA_CHNA@dignityhealth.org.

Introduction and Purpose

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

This report documents the processes, methods, and findings of a CHNA conducted on behalf of the nonprofit hospitals listed below. Collectively, these nonprofit hospitals serve Sacramento County, California, located in the north-central part of the state. The total population of the service area was 1,564,555 in 2020. The CHNA was conducted over a period of 10 months, beginning in March 2021 and concluding in December 2021. This CHNA report meets requirements of the Patient Protection and Affordable Care Act (and in California, of Senate Bill 697) that nonprofit hospitals conduct a CHNA at least once every three years.

<table>
<tr><th>Dignity Health Affiliates</th><th>Sutter Health Affiliates</th><th>UC Davis Health System</th></tr>
<tr><td>Mercy Hospital of Folsom
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Sacramento, CA 95823</td></tr>
</table>

Community Health Insights (www.communityhealthinsights.com) conducted the CHNA. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. Community Health Insights has conducted health assessments for healthcare systems and local health departments over the previous decade. For this assessment Community Health Insights collaborated with Harder+Company, a consulting firm working on behalf of Kaiser Permanente to conduct a CHNA in the Sacramento region, by sharing primary data.

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

Method Overview

Conceptual and Process Models

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[3] This model of population health includes the many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. For a detailed review of methods, see the technical section.

Public Comments from Previously Conducted CHNAs

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted implementation strategies. The 2019 CHNA was made public for Dignity Health hospitals in Sacramento County. The community was invited to provide written comments on the CHNA reports and Implementation Strategies both within the documents and on the web site where they are widely available to the public. The email address of DignityHealthGSSA_CHNA@dignityhealth.org was created to ensure comments were received and responded to. No written comments have been received.

Data Used in the CHNA

Data collected and analyzed included both primary (or qualitative data) and secondary (or quantitative data). Primary data included 42 interviews with 87 community health experts, 11 focus groups conducted with a total of 57 community residents or community-facing service providers, and 31 responses to the Community Service Provider survey. (A full listing of all participants can be seen in the technical section of this report.)

Secondary data included multiple datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at subcounty levels was used to identify portions of the hospital service area with greater concentrations of disadvantaged populations and poor health outcomes. A set of county-level indicators was collected from various sources to help identify and prioritize significant health needs. Additionally, socioeconomic indicators were collected to help describe the overall social conditions within the service area. Health outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health factor indicators included measures of 1) health behaviors, such as diet and exercise and tobacco, alcohol, and drug use; 2) clinical care, including access to quality care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, and neighborhood safety; and 4) physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 68 different health outcome and health factor indicators were collected for the CHNA.

Data Analysis

Health Need Identification and Prioritization

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

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[3] See: County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

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

Findings – Sacramento County

Prioritized Significant Health Needs – Sacramento County

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the service area. In all, 13 significant health needs were identified. After these were identified, they were prioritized based on an analysis of primary data. The findings are displayed in Figure **Error! Reference ource not found.**.

Because of the dynamic and evolving nature of health needs, identified significant health needs change over time. For this assessment, an emergent health need was identified: Health Equity: Equal Access to Opportunities to be Healthy (#6). Furthermore, data analysis identified three significant health needs that were not identified in the previous assessment conducted in 2019. These were: Increased Community Connections (#9), Access to Dental Care and Preventative Services (#12), and Healthy Physical Environment (#13).

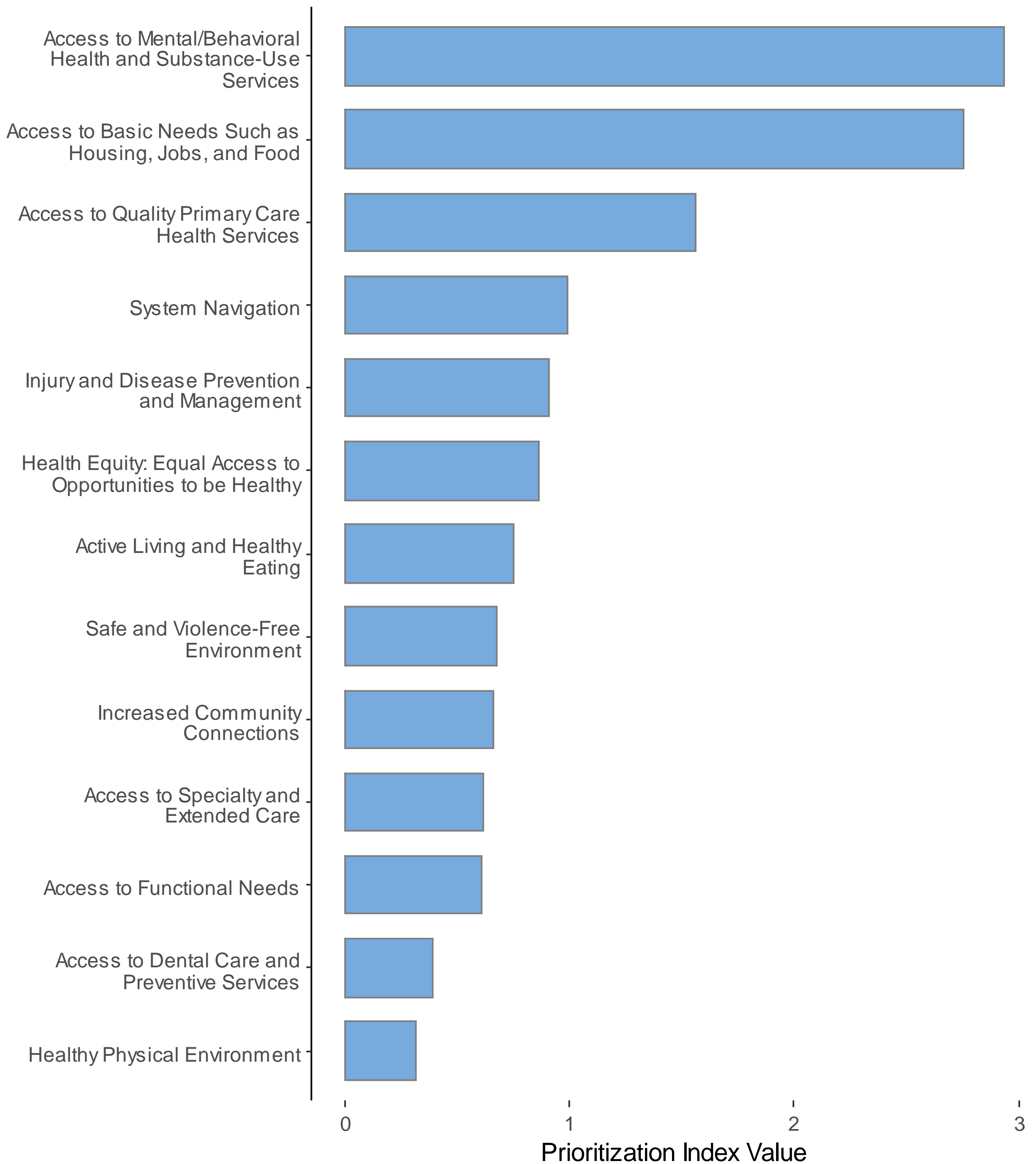

Figure 1: Prioritized, Significant Health Needs for Sacramento County

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

Table 1: Health need prioritization inputs for Sacramento County

Prioritized Health Needs	Percentage of Key Informants and Focus Groups Identifying Health Need	Percentage of Times Key Informants and Focus Groups Identified Health Need as a Top Priority	Percentage of Community Survey Respondents that Identified Health Need as a Top Priority
Access to Mental/Behavioral Health and Substance-Use Services	88%	33%	77%
Access to Basic Needs Such as Housing, Jobs, and Food	94%	26%	74%
Access to Quality Primary Care Health Services	72%	12%	32%
System Navigation	53%	4%	23%
Injury and Disease Prevention and Management	69%	4%	3%
Health Equity: Equal Access to Opportunities to be Healthy	69%	4%	~
Active Living and Healthy Eating	50%	4%	6%
Safe and Violence-Free Environment	28%	1%	26%
Increased Community Connections	44%	4%	6%
Access to Specialty and Extended Care	34%	1%	16%
Access to Functional Needs	53%	1%	0%
Access to Dental Care and Preventive Services	19%	2%	10%
Healthy Physical Environment	6%	1%	16%

~ Because this was an emergent health need it was not included as a potential health need; therefore, the Community Service Provider survey did not list this health need as an option for respondents to select.

These measures were then combined to create a health need prioritization index. The highest priority was given to health needs that were more frequently mentioned and were more frequently identified among the top priority needs.[4] The prioritization index values are shown in Figure 1, where health needs are ordered from highest priority at the top of the figure to lowest priority at the bottom.

Health Need Tables Description

The significant health needs are described below, in prioritized order. The secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health need. (Each indicator is listed in the order it appears in the data set listed in the technical report). Qualitative themes that emerged during analysis are also provided in each table. A full listing of all quantitative indicators can be found in the technical section of this report. Secondary indicators that were

[4] Additional details regarding the creation of the prioritization index can be found in the technical report.

associated with a health need were assigned to that health need based on expert review. Furthermore, some indictors were assigned to multiple health needs.

1. Access to Mental/Behavioral Health and Substance-Use Services

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

Primary Data Analysis		**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- There are not enough mental health and substance-use services (treatment centers, detox centers, crisis stabilization units, etc.) in the community. - Additional mental health services are needed specifically for youth, including trauma informed care. - It is difficult to enter and navigate the mental health system. - The stigma and around seeking mental health services prevents some from seeking care. - The cost of mental health services is prohibitive; treatment options for those on Medi-Cal are severely limited. - The mental health system is siloed from the healthcare system. Need better integration between these two. - There has been a notable increase in mental health issues in the community due to the pandemic.	- It's difficult for people to navigate for mental, behavioral, and substance-use services. - Additional services for those who are homeless and experiencing mental, behavioral, and/or substance use services are needed. - There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).	- Life Expectancy - Premature Age-Adjusted Mortality - Premature Death - Suicide Mortality - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Poor or Fair Health - Excessive Drinking - Drug Induced Death - Adult Smoking - Primary Care Shortage Area - Mental Health Care Shortage Area - Medically Underserved Area - Firearm Fatalities Rate - Disconnected Youth

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

Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs[5] suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.[6]

Primary Data Analysis		**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- Housing access and affordability is a critical issue in the area; subsidies and rent control are needed. - Housing vouchers are stigmatized; many landlords will not accept them. - Housing costs continue to escalate; barriers to secure housing continue to rise. - The number of people experiencing homelessness has significantly increase. - The community must address income inequality. - The working poor do not qualify for many services; they are unable to access needed healthcare and mental health services. - More investment is needed in poorer communities. - Many jobs do not pay a living wage, nor do they offer employees health insurance. - Food insecurity is a critical issue for many in the area.	- Lack of affordable housing is a significant issue in the area. - The area needs additional low-income housing options. - Services for homeless residents in the area are insufficient.	- Infant Mortality - Child Mortality - Life Expectancy - Premature Age-Adjusted Mortality - Premature Death - Hypertension Mortality - Diabetes Prevalence - Low Birthweight - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Poor or Fair Health - Asthma ED Rates - Asthma ED Rates for Children - Drug Induced Death - Adult Obesity - Limited Access to Healthy Foods - Food Environment Index - Medically Underserved Area - COVID-19 Cumulative Full Vaccination Rate - Disconnected Youth - Third Grade Reading Level - Third Grade Math Level - Children in Single-Parent Households

[5] McLeod, S. 2014. Maslow's Hierarchy of Needs. Retrieved from: http://www.simplypsychology.org/maslow.html

[6] See: http://www.countyhealthrankings.org/learn-others/research-articles#Rankingsrationale

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
		- Children Eligible for Free Lunch - Children in Poverty - Median Household Income

3. Access to Quality Primary Care Health Services

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- The community needs more providers that accept Medi-Cal. - Community members with high-deductible health plans avoid care as they cannot afford the out-of-pocket costs. - Having health insurance does not guarantee one can access the healthcare system. - The cost of medications creates a barrier for many. - The healthcare system seems to be built to serve more affluent populations; it is difficult for lower income residents to access quality healthcare. - Physicians cannot afford to care for those on Medi-Cal; reimbursement must increase.	- Patients have difficulty obtaining appointments outside of regular business hours. - Wait times for appointments are excessively long. - Quality health insurance is unaffordable.	- Infant Mortality - Child Mortality - Life Expectancy - Premature Age-Adjusted Mortality - Premature Death - Stroke Mortality - Chronic Lower Respiratory Disease Mortality - Diabetes Mortality - Heart Disease Mortality - Hypertension Mortality - Cancer Mortality - Alzheimer's Disease Mortality - Influenza and Pneumonia Mortality - Diabetes Prevalence - Low Birthweight - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- A single-payer system is needed to improve access and quality healthcare for all. - There is no comprehensive health plan for the undocumented.		- Poor or Fair Health - Colorectal Cancer Prevalence - Breast Cancer Prevalence - Lung Cancer Prevalence - Asthma ED Rates - Asthma ED Rates for Children Primary Care Shortage Area - Medically Underserved Area - Preventable Hospitalization - COVID-19 Cumulative Full Vaccination Rate

4. System Navigation

System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems in order to receive the necessary benefits and supports to improve health outcomes. Research has demonstrated that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities.[7] Furthermore, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- There is too much "red tape" when trying to access social services. - Many community members struggle with how to access and navigate the healthcare system. - The healthcare system is fragmented, making navigation a challenge for many. - System navigation challenges are compounded by language barriers.	- People may not be aware of the services they are eligible for. - It is difficult for people to navigate multiple, different healthcare systems. - Dealing with medical and insurance paperwork can be overwhelming.	- No quantitative indicators were used in analysis for this health need. Currently, there are no indicators available that describe the degree of navigation difficulty for Sacramento County residents.

[7] Natale-Pereira, A. et. al .2011. *The Role of Patient Navigators in Eliminating Health Disparities*. US National Library of Medicine, National Institutes of Health, 117:15, 3543-3552.

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- There needs to be better linkages between primary and specialty care. - More culturally informed and linguistically appropriate navigators, social workers, and case managers are needed to meet the demand for services. - Systems are particularly challenging for those with mental health and development challenges.		

5. Injury and Disease Prevention and Management

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- Preventative services have been avoided due to the pandemic. - Health education is critical to prevention, and its relatively inexpensive. - Community health education must be expanded; move away from reactive care and into prevention. - Health information needs to be linguistically appropriate.	- There isn't really a focus on prevention around here. - There should be greater focus on chronic disease prevention (e.g., diabetes, heart disease). - Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision).	- Infant Mortality - Child Mortality - Stroke Mortality - Chronic Lower Respiratory Disease Mortality - Diabetes Mortality - Heart Disease Mortality - Hypertension Mortality - Suicide Mortality - Unintentional Injuries Mortality - Alzheimer's Disease Mortality

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- The community must increase access to preventative healthcare screenings.	- Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, elderly, LGBTQ individuals, and immigrants).	- Diabetes Prevalence - Low Birthweight - Poor Mental Health Days - Frequent Mental Distress - Frequent Physical Distress - Poor or Fair Health - Asthma ED Rates - Asthma ED Rates for Children - Excessive Drinking - Drug Induced Death - Adult Obesity - Physical Inactivity - Chlamydia Incidence - Adult Smoking - COVID-19 Cumulative Full Vaccination Rate - Firearm Fatalities Rate - Motor Vehicle Crash Death - Disconnected Youth - Third Grade Reading Level - Third Grade Math Level

6. Health Equity: Equal Access to Opportunities to be Healthy

Health equity is defined as everyone having the same opportunity to be as healthy as possible.[8] Health is largely determined by social factors. Some communities have resources needed to be healthy readily available to them, while others do not. Many people experience barriers as the result of policies, practices, systems, and structures that discriminate against certain groups. Individual and community health can be improved by removing or mitigating practices that result in health inequity. While health equity is described as a specific health need in this assessment, it is recognized that equity plays a role in each health need in a community.

[8] Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. *What is Health Equity?* (May 1, 2017). The Robert Wood Johnson Foundation. Retrieved: https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html.

Primary Data Analysis		**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- Healthcare services including mental health and specialty care are unaffordable to low-income populations. - There is prejudice and limited cultural competence in the healthcare system. - The pandemic has shined a light on structural inequities that lead to health disparities. - Language barriers lead to health inequities. - Structured racism is a public health crisis. - Over-policing is an issue in some communities. - Income and education inequity are pervasive in the community. - There is little to no investment in communities of color. - Hate crimes against the Asian American Pacific Islander (AAPI) community have continued to increase. - Representation is important; the community needs individuals of color in healthcare provider and administration roles.	- This health need was not a previously identified health need and emerged during data analysis. Therefore, the Community Service Provider survey did refer to this health need.	- This health need was not previously identified; therefore, no quantitative indicators were associated with this health need during data analysis.

7. Active Living and Healthy Eating

Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes are often overloaded with fast food and other establishments where unhealthy food is sold. They are often challenged with food insecurity, lacking the means to consistently secure food for themselves or their families. When families rely on food pantries and school meals alone, these may not always provide sufficient nutrition for maintaining health.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>- Healthy foods are not as affordable as less healthy foods.
- Many parts of the community are not built to support a healthy lifestyle—no sidewalks or bike paths.
- Our communities are “car-centric,” and result in less physical activity
- Food deserts are found throughout the Sacramento area.</td><td>- There are food deserts where fresh, unprocessed foods are not available.
- Food insecurity is an issue here.
- Students need healthier food options in school.
- The built environment doesn’t support physical activity (e.g., neighborhoods aren’t walkable, roads aren’t bike friendly, or parks are inaccessible.
- The community needs nutrition education programs.
- Homelessness in parks or other public spaces deters their use.
- Grocery store options in the area are limited.</td><td>- Life Expectancy
- Premature Age-Adjusted Mortality
- Premature Death
- Stroke Mortality
- Diabetes Mortality
- Heart Disease Mortality
- Hypertension Mortality
- Cancer Mortality
- Diabetes Prevalence
- Poor Mental Health Days
- Frequent Mental Distress
- Poor Physical Health Days
- Frequent Physical Distress
- Poor or Fair Health
- Colorectal Cancer Prevalence
- Breast Cancer Prevalence
- Asthma ED Rates
- Asthma ED Rates for Children
- Adult Obesity
- Physical Inactivity
- Limited Access to Healthy Foods
- Food Environment Index</td></tr>
</table>

8. Safe and Violence-Free Environment

Feeling safe in one’s home and community is fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) physical safety is essential. Feeling unsafe affects the way people act and react to everyday life occurrences. Furthermore, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.[9]

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

<table>
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<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.</td><td rowspan="2">The following indicators performed worse in Sacramento County when compared to state averages.</td></tr>
<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>- There are not enough safe places for youth to play outdoors.
- Some women stay in abusive marriages due to the stigma of being divorced.
- There is growing violence and gang activity in parts of the community.
- More investment needed in violence prevention, including teams that respond to gang violence.
- Lack of affordable housing forces many to move into unsafe environments.
- Hate crimes against the Asian American Pacific Islander (AAPI) community continue to rise; many go unreported due to fear of retaliation.
- Pedestrian safety continues to be an issue; the Stockton and Fruitridge intersection is known for being dangerous for pedestrians.</td><td>- People feel unsafe because of crime.
- There are not enough resources to address domestic violence and sexual assault.
- Human trafficking is an issue in the area.</td><td>- Life Expectancy
- Premature Death
- Hypertension Mortality
- Poor Mental Health Days
- Frequent Mental Distress
- Frequent Physical Distress
- Poor or Fair Health
- Physical Inactivity
- Homicide Rate
- Firearm Fatalities Rate
- Violent Crime Rate
- Motor Vehicle Crash Death
- Disconnected Youth</td></tr>
</table>

9. Increased Community Connections

As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all."[10] Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

[10] Robert Wood Johnson Foundation. 2016. *Building a Culture of Health: Sense of Community*. See: https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- Community engagement is needed to rebuild trust between communities and the medical and scientific community. - Healthcare, mental health, and social services are siloed; these need more integration. - The community needs more grassroots efforts to build support for disenfranchised groups. - The community needs to embed social workers in the police department. - Substance-use organizations need to be more integrated in local emergency departments. - Isolation has increased during the pandemic, especially for certain groups, e.g., seniors. - The loss of trust in government and sense of fragmentation among communities has grown during the pandemic. - "People heal better when they can come together." - Federally Qualified Health Centers (FQHCs) can be hubs to link patients to other services, but often fall short.	- Health and social service providers operate in silos; cross-sector connections are needed. - Building community connections doesn't seem like a focus in the area. - Relations between law enforcement and the community need to improve. - City and County leaders need to work together.	- Infant Mortality - Child Mortality - Life Expectancy - Premature Age-Adjusted Mortality - Premature Death - Stroke Mortality - Diabetes Mortality - Heart Disease Mortality - Hypertension Mortality - Suicide Mortality - Unintentional Injuries Mortality - Diabetes Prevalence - Low Birthweight - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Poor or Fair Health - Excessive Drinking - Drug Induced Death - Physical Inactivity - Primary Care Shortage Area - Mental Health Care Shortage Area Medically Underserved Area - Preventable Hospitalization - COVID-19 Cumulative Full Vaccination Rate - Homicide Rate - Firearm Fatalities Rate - Violent Crime Rate - Disconnected Youth Children in Single-Parent Households

10. Access to Specialty and Extended Care

Extended care services, which include specialty care, are services provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and

high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

Primary Data Analysis		**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- More dialysis services are needed in the community; existing services cannot keep up with demand. - There are excessive wait-times for appointments to see specialists. - The community needs more specialists willing to serve low-income residents. - Specialty services are unaffordable to the low-income community. - Long-term care is expensive and unavailable for many low-wage earners. - Many have to travel outside of the community to see specialists. - Medi-Cal insurance plans have a narrow set of services available, with high out-of-pocket costs. - For those without insurance that need specialty care, it can take months to get enrolled in Medi-Cal. - Hospice care is needed for the homeless community.	- Wait times for specialists' appointments are excessively long. - The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care). - People have to travel to reach specialists. - Too few specialty and extended care providers accept Medi-Cal.	- Infant Mortality - Life Expectancy Premature Age-Adjusted Mortality - Premature Death - Stroke Mortality - Chronic Lower Respiratory Disease Mortality - Diabetes Mortality - Heart Disease Mortality - Hypertension Mortality - Cancer Mortality - Alzheimer's Disease Mortality - Diabetes Prevalence - Poor Mental Health Days - Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Poor or Fair Health - Lung Cancer Prevalence - Asthma ED Rates - Asthma ED Rates for Children - Drug Induced Death - Preventable Hospitalization

11. Access to Functional Needs – Transportation and Physical Disability

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

Primary Data Analysis		**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse in Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- Access to transportation to receive medical services is a challenge for many. - Public transportation is a challenge as it does not serve many parts of the community. - Public transportation shuts down in the evenings leaving many without transportation after business hours. - There are limited transportation options for lower-income populations that cannot afford a car. - There are limited public transportation options for those living with disabilities.	- There were no responses by those who participated in the survey to the question of how this health need expressed itself in the Sacramento County community.	- Disability - Frequent Mental Distress - Frequent Physical Distress - Poor or Fair Health - Adult Obesity - COVID-19 Cumulative Full Vaccination Rate

12. Access to Dental Care and Preventive Services

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

Primary Data Analysis		**Secondary Data Analysis**
The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.		The following indicators performed worse Sacramento County when compared to state averages.
Key Informant and Focus Group Data	Community Service Provider Survey Data	
- Dental providers offer minimal services to Medi-Cal enrollees. - Many Medi-Cal enrollees are treated in emergency departments for dental issues because they cannot access a dentist.	- There aren't enough providers in the area that accept Medi-Cal. - Dental care is unaffordable, even if you have insurance. - There aren't enough dental providers in the area. - The lack of access to dental care leads to overuse of emergency departments.	- Frequent Mental Distress - Poor Physical Health Days - Frequent Physical Distress - Poor or Fair Health - Dentists per 100K of population

<table>
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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>- There are excessive wait times for children to see a dentist.</td><td>- Quality dental services for kids are limited.</td><td></td></tr>
</table>

13. Healthy Physical Environment

Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one's living environment, including the physical (natural and built) and sociocultural environment, has more impact on individual health than other factors such as one's lifestyle, heredity, or access to medical services.[11]

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>- Illegal dumping is an issue in parts of the community.
- Landlords that do not maintain properties should be held legally accountable.</td><td>- Low-income housing is substandard.
- The air quality contributes to high rates of asthma.
- Wildfires in the region harm the air quality.</td><td>- Infant Mortality
- Life Expectancy
- Premature Age-Adjusted Mortality
- Premature Death
- Chronic Lower Respiratory Disease Mortality
- Hypertension Mortality
- Cancer Mortality
- Frequent Mental Distress
- Frequent Physical Distress
- Poor or Fair Health
- Colorectal Cancer Prevalence
- Breast Cancer Prevalence
- Lung Cancer Prevalence
- Asthma ED Rates
- Asthma ED Rates for Children
- Adult Smoking
- Air Pollution - Particulate Matter
- Drinking Water Violations</td></tr>
</table>

[11] See Blum, H. L. 1983. *Planning for Health*. New York: Human Sciences Press

Description of Community Served – Sacramento County

Sacramento County was the designated area served by the participating hospitals for the 2022 CHNA. This definition of the community served was used because this is the primary geographic area served by the seven nonprofit hospitals that collaborated on this CHNA.

Sacramento County was incorporated in 1850, and much of its rich history was influenced by the discovery of gold in the area in 1848. The county is home to California's capital city, Sacramento. The county includes seven incorporated cities, with the City of Sacramento being the largest. Covering a geographic area of 994 square miles and home to approximately 1.56 million residents, Sacramento County sits at the northern portion of California's Central Valley, situated along the Interstate 5 corridor. The area consists of both urban and rural communities and includes the Sacramento–San Joaquin Delta that connects the Sacramento River to the San Francisco Bay through some 700 miles of winding waterways. Sacramento is a diverse community, and a report ranked the city the fourth most racially and ethnically diverse large city in the US.[12]

Sacramento County has over 30 cities, census-designated places, and unincorporated communities that include neighborhoods with rich heritages such as Oak Park, known as Sacramento's first suburb, to newer communities such as the City of Rancho Cordova, incorporated in 2003. Sacramento County ranks as California's 26th most overall healthy county among the 58 in the state.[13] The area is served by a number of healthcare organizations, including those that collaborated on this assessment.
In this CHNA, two additional ZIP Codes from El Dorado County, a neighboring county east of Sacramento, were included to capture the portion of the community served by Mercy Hospital of Folsom, located near the border of these two counties. With some exceptions, findings described in this report are organized both at the county level and, as detailed later in this report, by designated regions within the county.

Regions of Sacramento County

Sacramento County has a population of over 1.5 million residents and is comprised of many communities, each with unique attributes and characteristics that influence community health. In an effort to capture these unique attributes for this CHNA, the county was subdivided into four distinct regions to allow for more detailed data collection and analysis. These regions are shown in Figure 2. Primary data collection included interviews with community health experts and community residents that lived and worked in the communities within these regions, thus providing a richer and more robust understanding of each community's unique features. When available, secondary data were collected and analyzed within each region as well.

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[12] McCann, A. (May 3, 2018). *2018's Most Diverse Cities in the U.S.* Washington DC: WalletHub. (Retrieved: https://wallethub.com/edu/most-diverse-cities/12690/#methodology).
[13] See: https://www.countyhealthrankings.org/app/california/2021/rankings/outcomes/overall

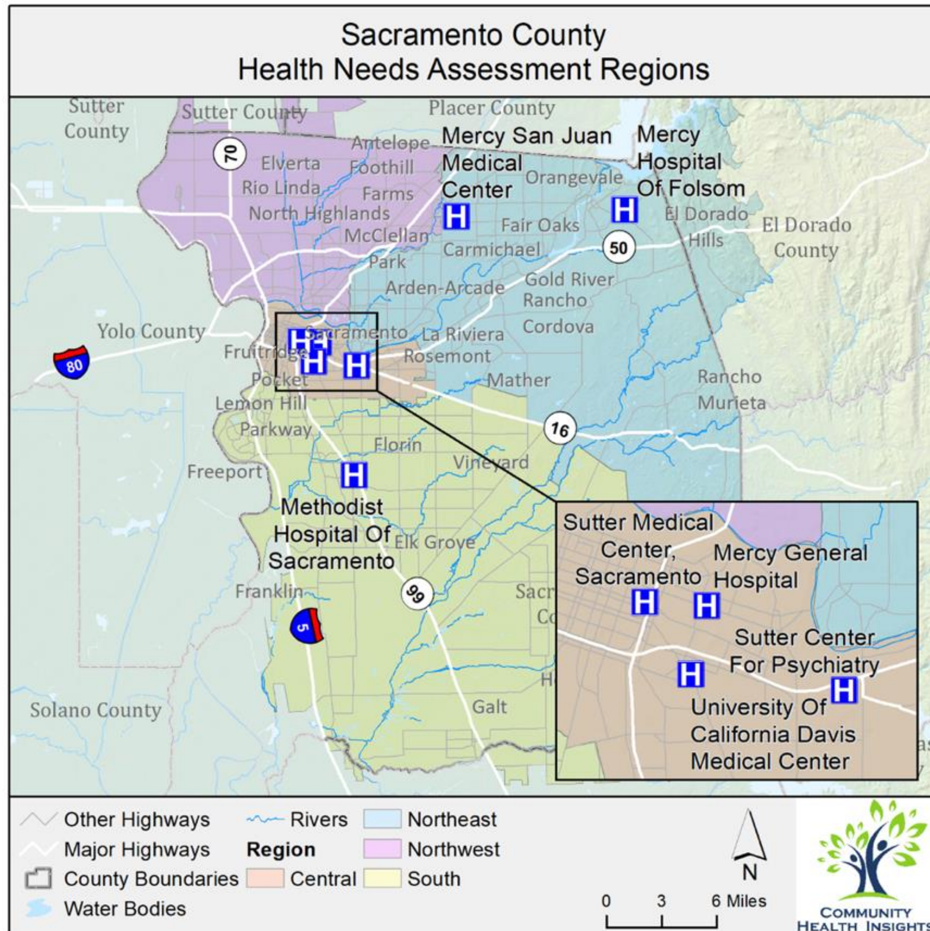

Figure 2: Map of Sacramento County regions

The following sections give more detailed information and findings that are unique to each region. To begin, a description of each community is presented, followed by sociodemographic information for each ZIP Code in the region. These are followed by displays of two informative findings of the CHNA: 1) the California Healthy Places Index, and 2) Communities of Concern within each region.

California Healthy Places Index

The California Healthy Places Index (HPI) is an index based on 25 health-related measures for communities across California .[14] Measures included in the HPI were selected based on their known relationship to life expectancy and other health outcomes. These values are combined into a final score representing the overall health and well-being of the community, which can then be used to compare the factors influencing health between communities. Higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present.

Communities of Concern

Communities of Concern are geographic areas in Sacramento County that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse

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

populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA methodology because, after the service area has been assessed more broadly, they allow for a focus on those portions of the region likely experiencing the greatest health disparities. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the technical section of this report for an in-depth description of how these are identified). For this assessment, a total of 50 ZIP Codes were included across all of Sacramento County; of these, 19 met the requirements to be included as a Community of Concern. The total population within these communities was approximately 700,000 residents, representing 44% of the total population in the service area.

Findings for Each Region

Prioritized Significant Health Needs by Region

While a goal of the assessment was to identify the health needs of Sacramento County as a whole, it was also important to identify and prioritize health needs for the multiple communities within the county. To accomplish this data were collected and analyzed at two levels. Health need identification and prioritization for the county overall was based on all qualitative data collected across the county. However, health need identification and prioritization for each region was based on qualitative data collected only within that particular region. This resulted in differences between the health needs identified and prioritized for the entire county and those identified and prioritized for each region.

After each region's health needs were identified, they were prioritized based on an analysis of primary data sources that mentioned the health need as a priority. The findings are displayed in Table 2.

Table 2: Ranking of prioritized significant health needs for each region and Sacramento County

Significant Health Need	North-east	North-west	Central	South	*County*
Access to Mental/Behavioral/ Substance-use Services	1	1	2	2	*1*
Access to Basic Needs Such as Housing, Jobs, and Food	2	2	1	1	*2*
Access to Quality Primary Care Health Services	3	3	3	3	*3*
System Navigation	4	7	4	4	*4*
Injury and Disease Prevention and Management	5	5	6	7	*5*
Health Equity: Equal Access to Opportunities to be Healthy	7	9	5	5	*6*
Active Living and Healthy Eating	9	6	11	9	*7*
Safe and Violence-Free Environment	11	11	7	6	*8*
Increased Community Connections	6	4	8	8	*9*
Access to Specialty and Extended Care	10	10	10	10	*10*
Access to Functional Needs	8	8	9	11	*11*
Access to Dental Care and Preventive Services	13	12	12	13	*12*
Healthy Physical Environment	12	13	13	12	*13*

Northeast Region

Description of the Community Served

The Northeast Region is comprised of 15 ZIP Codes and is home to 540,637 residents. Table 3 displays population characteristics for each ZIP Code. Data are compared to the state and county rates, and ZIP

Codes that negatively varied or performed poorly when compared to either the county or state benchmark are highlighted.

Table 3: Population characteristics for each ZIP Code located in Northeast Region

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95608	62,539	30.8	41.7	$64,059	14.7	6.5	6.0	6.7	38.7	15.4
95610	46,305	31.8	36.5	$61,461	12.1	6.2	6.8	10.0	41.6	15.9
95621	41,740	29.0	39.7	$63,214	10.8	6.2	4.7	9.3	36.5	15.5
95628	40,855	25.7	45.4	$86,181	8.4	4.7	4.7	5.5	31.6	11.1
95630	78,159	38.2	40.7	$114,405	5.6	3.1	2.5	6.2	28.2	7.6
95655	4,156	44.8	36.4	$86,486	13.5	8.6	2.7	6.7	33.9	7.5
95662	32,172	23.6	41.2	$80,434	7.9	5.4	5.2	6.6	34.9	13.7
95670	55,558	46.8	36.7	$67,015	13.1	7.3	6.3	10.0	37.2	13.7
95683	6,326	24.2	50.1	$108,338	4.5	3.5	0.6	3.1	25.5	12.7
95742	12,472	55.7	34.5	$132,636	6.2	6.4	3.5	3.6	25.8	9.1
95762	43,052	25.7	44.4	$142,453	3.2	4.4	1.7	3.7	30.0	7.6
95821	35,812	45.4	37.4	$42,456	24.3	8.9	5.7	10.5	48.7	12.1
95825	37,473	54.4	32.1	$40,515	31.4	10.7	8.2	13.8	51.6	11.4
95827	20,666	57.1	35.2	$59,115	12.6	7.7	5.9	13.7	39.0	15.5
95864	23,352	29.2	46.4	$105,849	7.4	4.4	3.1	3.9	27.6	12.0
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

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

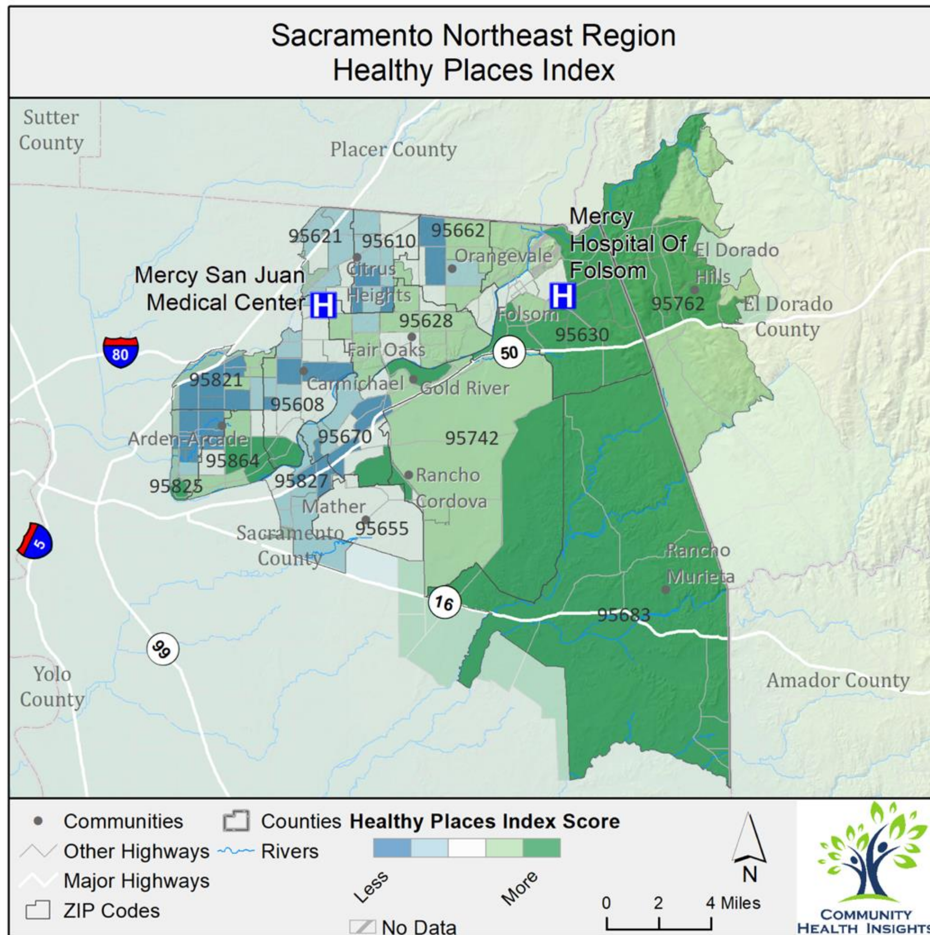

Figure 3: Healthy Places Index for Northeast Region

Healthy Places Index- Northeast Region

Figure 3 displays the HPI for the Northeast Region. As described earlier, higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present. In the map, those communities with lower values are designated "less healthy" and are shaded in blue.

Communities of Concern

Six ZIP Codes in the Northeast Region met the criteria to be classified as Communities of Concern. These are shown in Figure 4 and described in Table 4 with the census population provided for each.

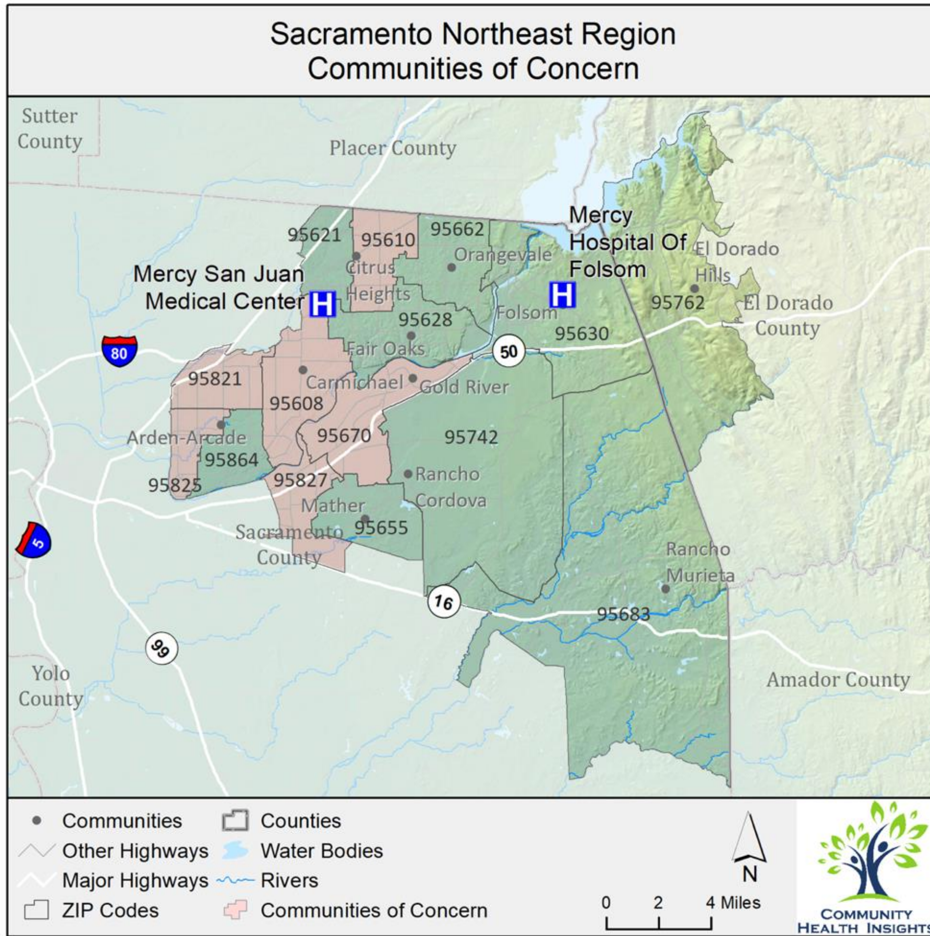

Figure 4: Communities of Concern for the Northeast Region

Table 4: Identified Communities of Concern for the Northeast Region

ZIP Code	*Community\Area*	*Population*
95608	Carmichael	62,539
95610	Citrus Heights	46,305
95670	Rancho Cordova	55,558
95821	Arden Arcade, North Highlands	35,812
95825	Arden Arcade, North Highlands	37,473
95827	Rancho Cordova, Rosemont	20,666
	Total Population in Communities of Concern	*258,353*
	Total Population in Northeast Region	*540,637*
	Percentage of Northeast Region Population in Communities of Concern	*47.8%*

Northwest Region

Description of the Community Served

The Northwest Region is comprised of 13 ZIP Codes. The area is home to 336,702 residents. Table 5 displays population characteristics for each ZIP Code. Data are compared to the state and county rates, and ZIP Codes that negatively varied or performed poorly when compared to either the county or state benchmark are highlighted.

Table 5: Population characteristics for each ZIP Code located in the Northwest Region

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95626	6,065	28.2	41.4	$75,481	11.4	4.4	7.5	12.2	35.9	10.1
95652	789	51.3	30.7	$33,000	61.3	10.7	2.9	15.1	62.8	27.0
95660	35,461	54.4	31.1	$45,845	25.1	4.6	7.2	18.2	44.6	11.6
95673	16,636	35.2	36.8	$70,876	15.2	5.0	6.0	13.4	33.6	12.9
95815	25,673	70.7	32.3	$34,583	29.8	11.9	10.3	24.2	54.5	12.4
95833	39,905	71.9	31.5	$63,418	11.7	6.1	5.8	12.3	37.4	9.1
95834	30,076	75.7	32.2	$64,996	15.6	6.6	4.1	11.8	42.1	8.7
95835	40,170	65.7	38.2	$102,895	4.7	3.5	4.9	7.4	32.0	6.9
95837	300	16.3	47.3	$219,063	11.0	9.0	7.3	5.0	17.7	11.0
95838	39,053	78.4	31.0	$48,416	22.7	6.9	7.5	25.7	49.5	11.1
95841	21,229	44.4	34.5	$50,295	19.1	4.1	7.7	8.2	43.7	11.2
95842	33,522	48.6	32.9	$53,458	19.7	8.3	7.2	13.3	45.8	12.9
95843	47,823	41.3	32.9	$81,028	11.2	3.5	5.8	7.2	35.8	8.5
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

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

Healthy Places Index- Northwest Region

Figure 5 displays the HPI for the Northwest Region. As described earlier, higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present. In the map, those communities with lower values are designated “less healthy” and are shaded in blue.

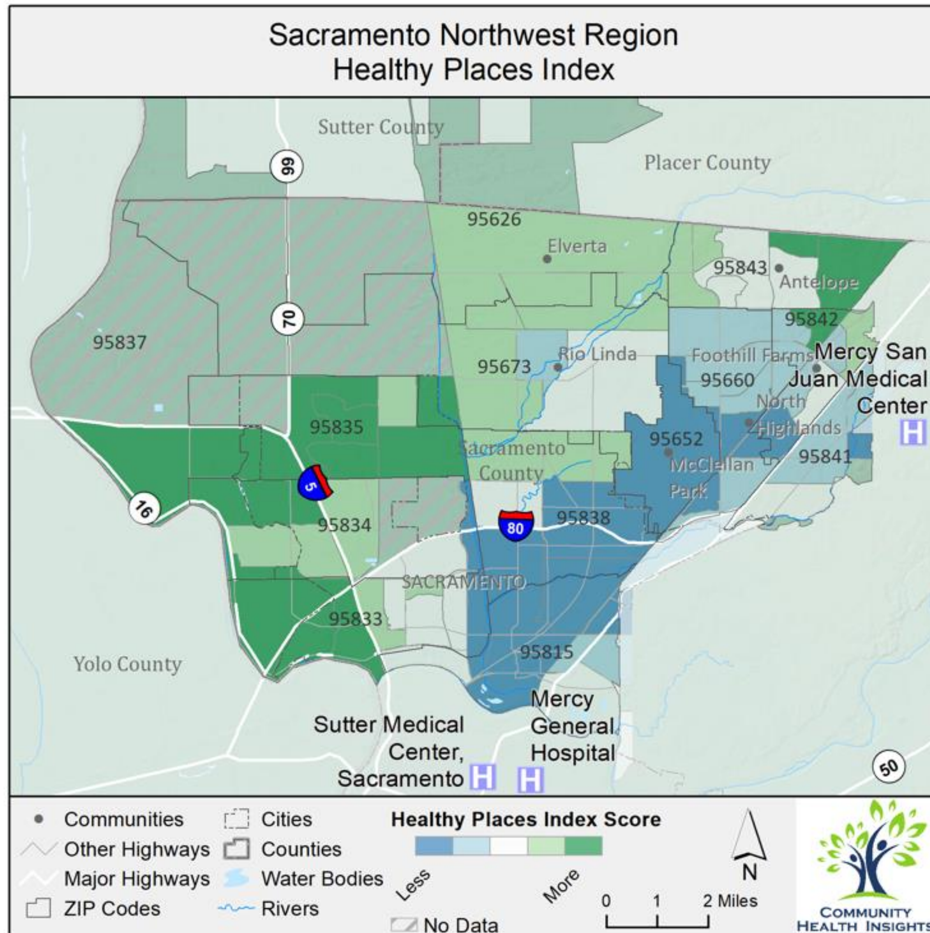

Figure 5: Healthy Place Index for Northwest Region

Communities of Concern

Five ZIP Codes in the Northwest Region met the criteria to be classified as Communities of Concern. These are shown in Figure 6 and described in Table 6 with the census population provided for each.

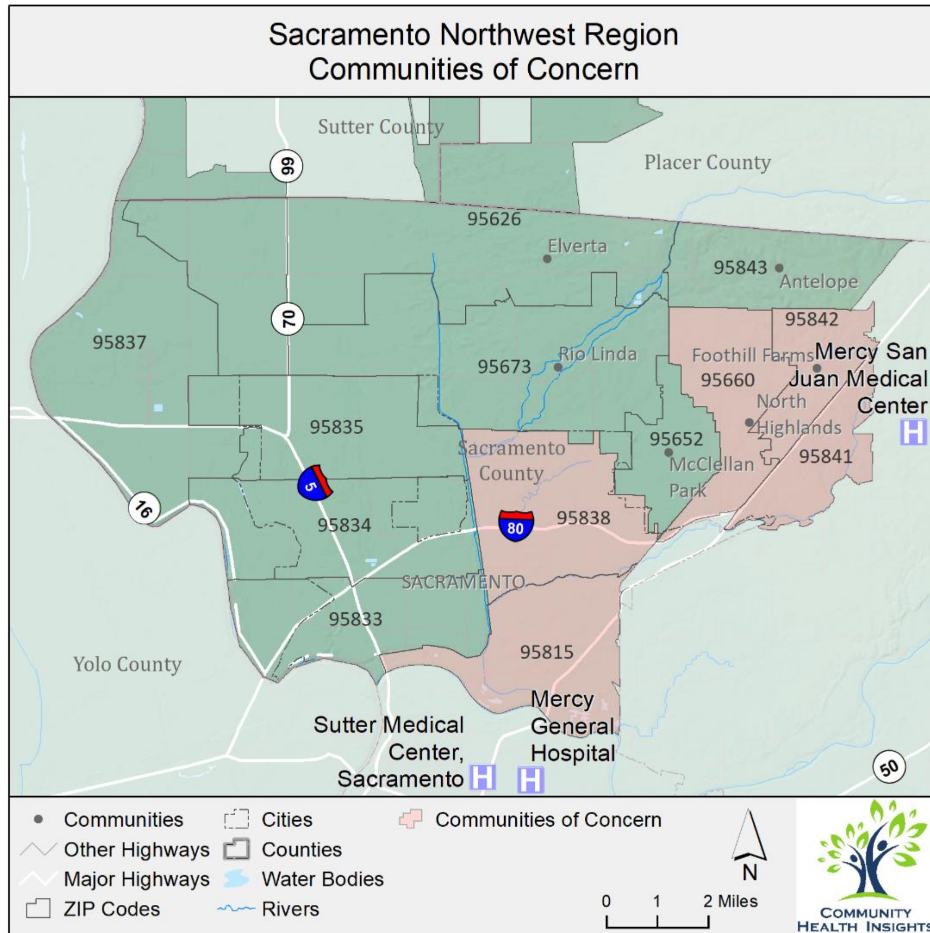

Figure 6: Communities of Concern for Northwest Region

Table 6: Identified Communities of Concern for the Northwest Region

ZIP Code	***Community/Area***	***Population***
95660	North Highlands	35,461
95815	North Sacramento	25,673
95838	Del Paso Heights	39,053
95841	Arden Arcade, North Highlands	21,229
95842	Arden Arcade, North Highlands, Foothill Farms	33,522
	Total Population in Communities of Concern	154,938
	Total Population in Northwest Region	336,702
	Percentage of Northwest Region Population in Communities of Concern	46.0%

Central Region

Description of the Community Served

The Central Region is comprised of eight ZIP Codes. The area is home to 166,256 residents. Table 7 displays population characteristics for each ZIP Code. Data provided are compared to the state and county rates, and ZIP Codes that negatively varied or performed poorly when compared to either the county or state benchmark are highlighted.

Table 7: Population characteristics for each ZIP Code located in the Central Region

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95811	6,294	48.2	32.0	$59,254	26.2	5.2	4.9	9.4	35.4	13.9
95814	11,908	49.7	34.0	$33,938	27.8	6.8	4.8	13.4	47.5	18.5
95816	17,199	31.5	34.6	$72,270	9.7	4.2	5.6	4.7	29.9	11.9
95817	13,758	54.0	35.5	$50,925	21.9	6.3	7.1	15.7	37.8	14.0
95818	21,625	44.2	39.2	$84,908	15.0	6.2	2.6	6.1	27.5	10.6
95819	19,890	30.5	36.4	$106,514	6.8	4.2	2.1	1.6	23.5	7.6
95820	36,437	67.5	35.1	$51,068	21.6	9.9	9.5	20.2	41.3	14.5
95826	39,145	52.2	33.5	$64,241	17.7	6.3	5.0	8.1	36.4	13.3
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

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

Healthy Places Index- Central Region

Figure 7 displays the HPI for the Central Region. As described earlier, higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present. In the map, those communities with lower values are designated "less healthy" and are shaded in blue.

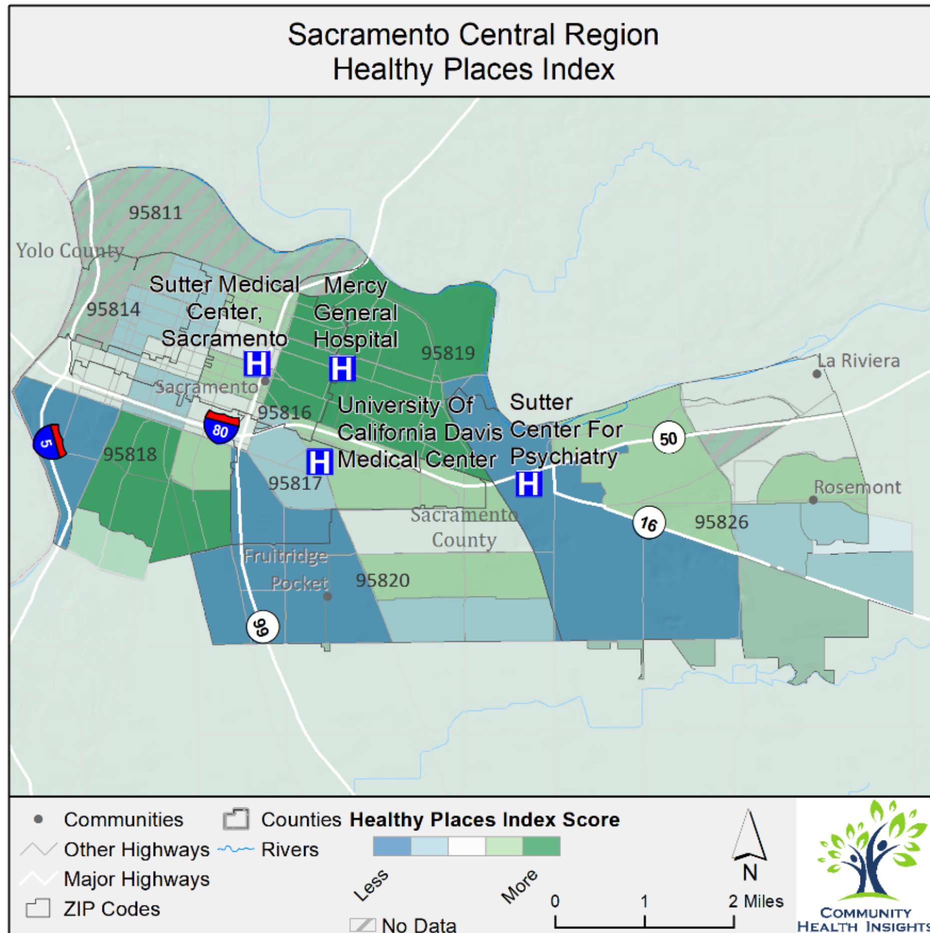

Figure 7: Healthy Places Index for Central Region

Communities of Concern

Four ZIP Codes in the Central Region met the criteria to be classified as Communities of Concern. These are shown in Figure 8 and described in Table 8 with the census population provided for each.

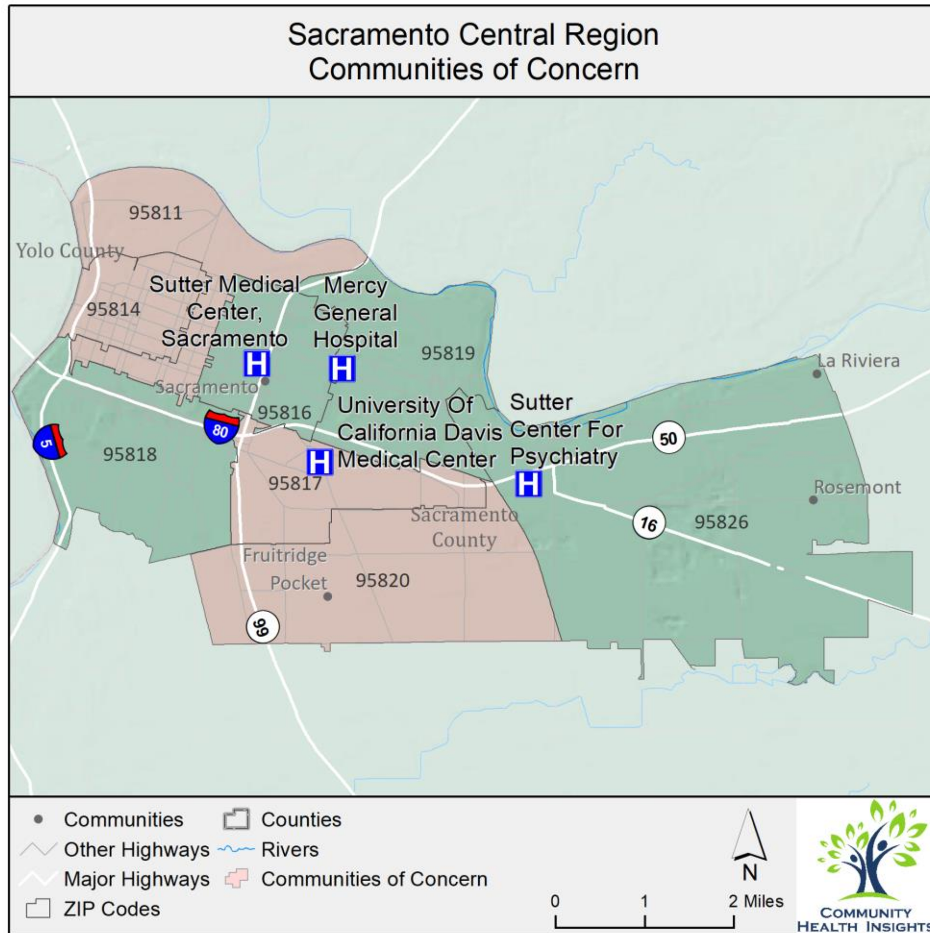

Figure 8: Communities of Concern for the Central Region

Table 8: Identified Communities of Concern for the Central Region

ZIP Code	*Community/Area*	*Population*
95811	Downtown Sacramento	6,294
95814	Downtown Sacramento	11,908
95817	Oak Park	13,758
95820	Oak Park, Tahoe Park	36,437
	Total Population in Communities of Concern	68,397
	Total Population in Central Region	166,256
	Percentage of Central Region Population in Community of Concern	41.14%

South Region

Description of the Community Served

The Southern Region is comprised of 14 ZIP Codes and is home to 520,960 residents. Table 9 displays population characteristics for each ZIP Code. Data provided are compared to the state and county rates, and ZIP Codes that negatively varied or performed poorly when compared to the either the state or county benchmark are highlighted.

Table 9: Population characteristics for each ZIP Code located in the Southern Region.

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95624	65,948	60.0	37.9	$93,090	8.4	6.1	2.9	10.3	34.3	11.2
95632	31,911	52.9	36.5	$76,334	9.5	6.0	6.5	18.1	30.9	11.6
95638	2,126	30.6	49.6	$92,708	8.2	3.4	3.9	9.1	25.1	13.2
95693	7,037	36.5	47.7	$100,265	7.9	4.6	1.6	9.4	26.4	9.3
95757	50,727	72.3	36.1	$105,390	7.7	3.8	2.0	9.7	34.6	8.9
95758	65,811	68.2	37.4	$85,221	9.4	6.6	3.2	10.3	32.5	9.7
95822	44,741	74.1	38.1	$57,535	15.8	8.3	6.0	17.0	37.3	14.4
95823	79,440	84.8	31.4	$47,553	22.2	10.0	7.7	22.7	48.1	12.4
95824	30,296	85.7	32.7	$38,985	30.8	9.6	9.7	37.7	47.8	14.4
95828	58,717	81.4	36.4	$53,229	20.6	11.1	6.9	24.1	42.9	13.8
95829	28,264	67.7	35.5	$93,377	9.2	4.7	4.2	11.1	32.3	9.4
95830	734	36.1	54.6	$101,786	9.5	2.1	0.4	5.5	27.5	30.0
95831	43,094	63.9	43.8	$79,368	7.4	4.6	3.4	6.7	32.0	11.7
95832	12,114	91.3	29.7	$47,341	22.1	12.7	5.1	26.2	48.7	14.6
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

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

Healthy Places Index- South Region

Figure 9 displays the HPI for the Southern Region. As described earlier, higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present. In the map, those communities with lower values are designated “less healthy” and are shaded in blue.

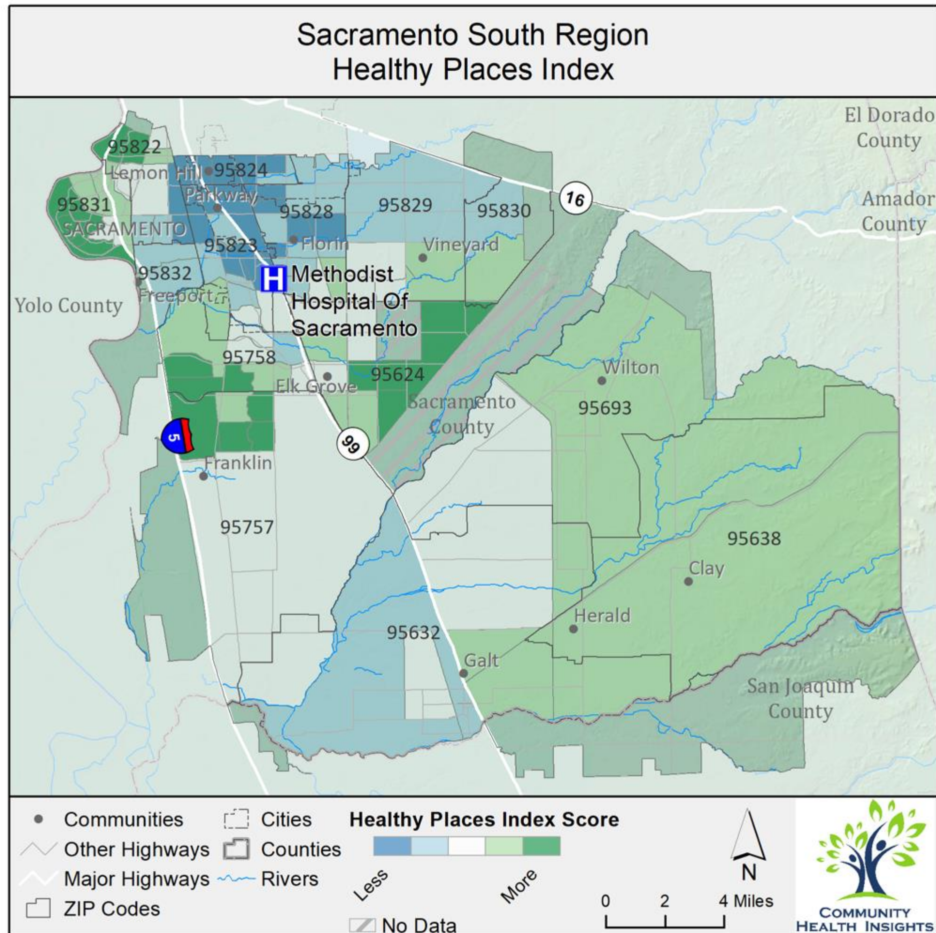

Figure 9: Healthy Place Index for the South Region

Communities of Concern

Five ZIP Codes in the Southern Region met the criteria to be classified as Communities of Concern. These are shown in Figure 10 and described in Table 10 with the census population provided for each.

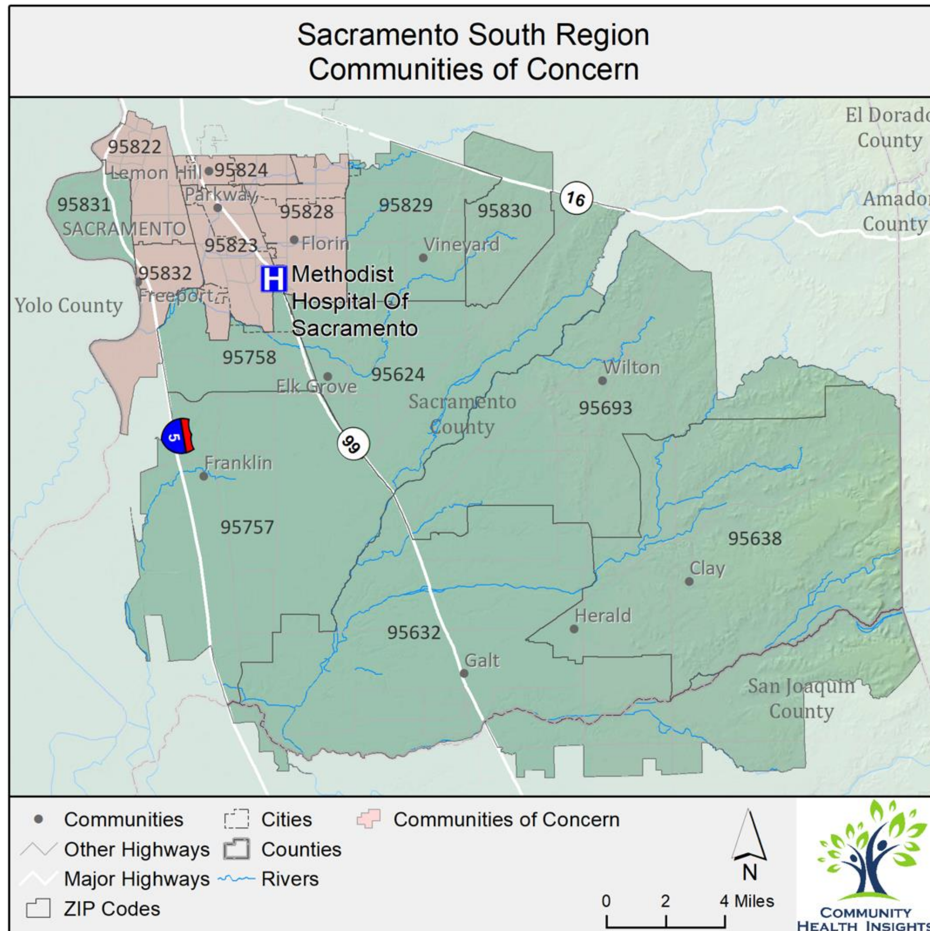

Figure 10: Communities of Concern for the South Region

Table 10: Identified Communities of Concern for the South Region

ZIP Code	*Community/Area*	*Population*
95822	South Sacramento	44,741
95823	South Sacramento	79,440
95824	South Sacramento	30,296
95828	South Oak Park, South Sacramento	58,717
95832	Meadowview, Freeport	12,114
Total Population in Communities of Concern		225,308
Total Population in Southern Region		520,960
Percentage of Southern Region Population in Communities of Concern		43.3%

Health Equity

The following section is a high-level summary of health equity in Sacramento County and is not intended to provide an extensive exploration of inequity in the service area. Quantifying and describing inequity in a community is challenging due to data limitations and the fact that inequity is a contributor to all health needs that exist in a community. The manner in which inequity manifests across Sacramento County is described in greater detail earlier in this report.

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

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

Inequities experienced early and throughout one's life, such as limited access to a quality education, have health consequences that appear later in life as health disparities. Health disparities are defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation."[15]

In the U.S. and many parts of the world, inequities are most apparent when comparing various racial and ethnic groups to one another. These comparisons clearly demonstrate that health inequities persist across communities, including Sacramento County.

This section of the report follows the organizing framework used throughout this assessment—the Robert Wood Johnson Foundation's County Health Rankings model.[16] The model shows that health outcomes are the result of health factors one experiences throughout life. Understanding where inequities appear helps in the planning of targeted interventions to reduce the ill-effects of inequity.

Health Outcomes - the Results of Inequity

Table 11 displays disparities among race and ethnic groups for the service area for life expectancy, mortality, and low birth weight.

Table 11: Health outcomes comparing race and ethnicity in the service area

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births	~	4.6	8.6	4.7	3.8	4.9
Life Expectancy	Average number of years a person can expect to live	74.8	84.9	75.1	82.8	78.9	79.6
Child Mortality	Number of deaths among children under age 18 per 100,000 population	~	35.9	62.3	39.8	37.9	41.5
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted)	479	217.8	523.2	258.5	338.7	325

[15] Center for Disease Control and Prevention. 2008. Health Disparities Among Racial/Ethnic Populations. Community Health and Program Services (CHAPS): Atlanta: U.S. Department of Health and Human Services.
[16] See: County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted)	10,827	4,368	10,712	5,352	6,430	6,381
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams)	7.9%	8.1%	11%	6.4%	5.4%	6.9%

~ Data Not Available; unless otherwise noted, data sources included in the technical section of the report.

When examining health outcomes across all race and ethnic groups disparities are apparent. For example, the infant mortality rate for Blacks is over twice the rate for Whites.

Health Factors - Inequities in the Service Area

Inequities can be seen in data that help describe health factors in the service area, such as education attainment and income. These health factors are displayed in Table 12 and are compared across race and ethnic groups. The indicators used in this table were selected based their ability to describe inequity across race and ethnic groups across Sacramento County. The inclusion of these particular equity-oriented indicators was guided by a review of previous research.[17]

Table 12: Health factors comparing race and ethnicity in the service area

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Some College[a]	Percentage of adults ages 25 and over with some post-secondary education	55.7%	65%	65.3%	46.7%	72.6%	65.3%
High School Completion[a]	Percentage of adults ages 25 and over with at least a high school diploma or equivalent	81.5%	82.2%	90.1%	74%	94.2%	87.7%
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	~	3.1	2.3	2.6	3.1	2.8
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	~	3	2.1	2.4	2.9	2.7
Children in Poverty	Percentage of people under age 18 in poverty	32.3%	18.7%	28.9%	23.7%	13.5%	16%
Median Household Income	The income where half of households in a county earn more and half of households earn less	$54,080	$74,804	$48,321	$57,031	$75,110	$71,891

[17] For example, see: Stillman, L. & Ridini, S. (May 2015). *Embracing Equity in Community Health Improvement*. Health Resources in Action Policy and Practice Report. Accessed: https://hria.org/wp-content/uploads/2016/02/Embracing-Equity-in-Community-Health-Improvement.pdf.

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Uninsured Population[b]	Percentage of the civilian non-institutionalized population without health insurance	7.5%	4.7%	4.2%	9.4%	4%	5.5%

~ Data Not Available; unless otherwise noted, data sources included in the technical section of the report
[a]From 2019 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.
[b]From 2019 American Community Survey 5-year estimates table S2701.

When comparing health factor data across race and ethnic groups, inequities are apparent. For example, median household income is notably lower for Black and Hispanic groups compared all others. Furthermore, the percent of Hispanics that were uninsured was significantly higher than most other groups.

Population Groups Experiencing Disparities

The following section describes populations in the service area identified through qualitative data analysis as experiencing health disparities. Interview participants were asked, "What specific groups of community members experience health issues the most?" Responses were analyzed by counting the total number of times all key informants and focus-group participants mentioned a particular group as one experiencing disparities. Figure 11 displays the results of this analysis. The groups are not mutually exclusive—one group may be a subset of another group. One of the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups.

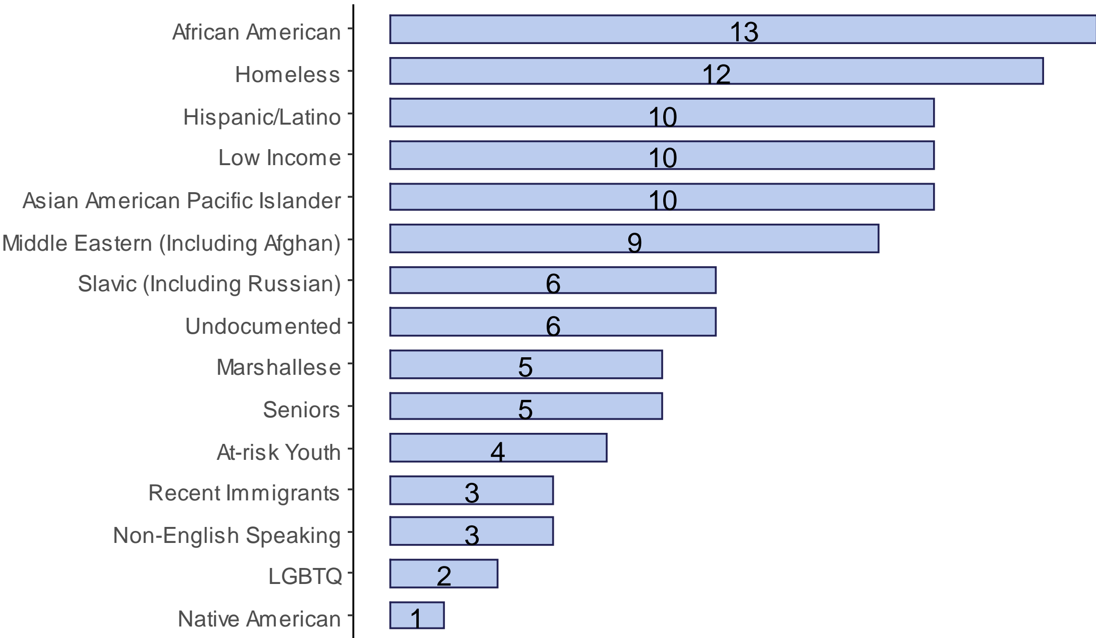

Figure 11: Populations experiencing disparities in the service area

The Impact of COVID on Health Needs

COVID-related health indicators for the service area are noted in Table 13.

Table 13: COVID-19-related rates for the service area

Indicators	Description	Sacramento	California	
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	150.8	185.1	Sacramento: 150.8 California: 185.1
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases.	1.4%	1.5%	Sacramento: 1.4% California: 1.5%
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	10,567	12,087	Sacramento: 10,567.2 California: 12,087.6
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	60,513	63,134	Sacramento: 60,513.9 California: 63,134.6

Source: COVID19.CA.GOV. Retrieved November 17, 2021.

Table 14 displays COVID-19 cases and testing percentages by race and ethnicity for Sacramento County.

Table 14: Cases/testing percentages and cases per 100K of population by race/ethnicity in Sacramento County

	% County Population	% Cases in Sacramento County	% Testing in Sacramento County	Cases per 100K of population
Black	10.6	13.3	11.9	1,751
Hispanic/Latino	22.9	25.6	21.6	1,558
Asian American	16.2	17.6	17.4	1,514
White	46.1	39.7	46.7	1,202
Multi-Race	2.6	1.1	0.6	620
American Indian or Alaskan Native	0.6	~	~	~
Native Hawaiian/other Pacific Islander	1.0	~	~	~

~ Data not shown because there were fewer than 20,000 people in this group.
Source: COVID19.CA.GOV. Retrieved January 12, 2022.

Key informants and focus group participants, as well as respondents to the Community Service Provider survey were asked how the COVID-19 pandemic had impacted health needs. A summary of their responses is described in Table 15.

Table 15: The impacts of COVID-19 on health need as identified in primary data sources

Primary Data Analysis	
Key Informant and Focus Group Data	Community Service Provider Survey Data
- The pandemic exacerbated existing challenges faced by many in the community. - There has been a marked increase in demand for mental, behavioral, and substance-use services due to the stress of the pandemic; especially in youth and seniors. - Violence, both in the home and community, has increased. - There has been a marked increase in violence and hate crimes against the AAPI community. - There has been an increase in evictions leading to homelessness during the pandemic. - Community members have been avoiding preventative care (e.g., immunizations, wellness visits, screenings) and chronic disease management (e.g., medications) due to fear of exposure to COVID. - Children not being in school led to a host of issues, such as the struggles of distance learning and the loss of services offered by schools. - Youth experienced a rise in domestic violence due to being home more; schools, which often detect this violence, were unable to intervene or report it. - The "digital divide" further exposed the challenges many face in distance learning and the shift to telehealth. - The trust between communities and government has been eroded. - COVID spread through essential workers that were unable to stay home; many live in multi-generational homes in close proximity to others, increasing the spread of COVID. - The pandemic exposed how vulnerable many of our social services and systems are.	- Some community service providers have lost funding during the pandemic, hampering their ability to deliver services. - There is a lot of misinformation spreading through the community regarding COVID. - Evictions have and will continue to increase as a result of the pandemic. Those behind on rent are falling further behind and will struggle to recover. - Many live in over-crowded housing due to affordability, and are at greater risk of infection. - The pandemic highlighted ongoing inequities in Black and Brown communities, including education and income inequities. - There has been a surge in domestic and neighborhood violence due to the pandemic. - Many parents have been struggling with multiple children learning at home; this exposed the lack of/poor quality internet access for many. - More community health workers are needed to combat misinformation and increase vaccination rates. - "I think it is important to acknowledge that the pandemic also showed the resiliency of the essential workers and support in this community. Our health systems rose to the challenge. Our essential non-profits stayed open and pivoted. This was a great crisis response and is not acknowledged enough!"

Resources Potentially Available to Meet the Significant Health Needs

In all, 877 resources were identified in the service area that were potentially available to meet the identified significant health needs. These resources were provided by a total of 321 social service, nonprofit, and governmental organizations, agencies, and programs identified in the CHNA. The identification method included starting with the list of resources from the 2019 Sacramento County CHNA, verifying that the resources still existed, and then adding newly identified resources to the 2022

CHNA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 16.

Table 16: Resources potentially available to meet significant health needs

Significant Health Needs (in Priority Order)	Number of Resources
Access to Mental/Behavioral Health and Substance-Use Services	110
Access to Basic Needs Such as Housing, Jobs, and Food	134
Access to Quality Primary Care Health Services	77
System Navigation	60
Injury and Disease Prevention and Management	90
Health Equity: Equal Access to Opportunities to be Healthy	*
Active Living and Healthy Eating	83
Safe and Violence-Free Environment	75
Increased Community Connections	170
Access to Specialty and Extended Care	44
Access to Functional Needs	11
Access to Dental Care and Preventive Services	14
Healthy Physical Environment	9
Total Resources	**877**

*Note: Most, if not all, resources noted work in some way to reduce or eliminate health inequity.

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

Impact of Actions Taken by Hospitals since 2019 CHNA

Regulations require that each hospital's CHNA report include: "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s)."[18]

Primary Health Need Addressed: Access to Quality Primary Care Health Services	
Mercy Family Health Center	
Program Description	A part of the Family Practice Residency Program, the hospital's Mercy Family Health Center provides care and treatment with over 15,000 clinical visits for underserved residents each year. The health center continues to increase capacity, and has expanded services at other locations in the community working collaboratively with various agencies and community clinics. Residency physicians are also actively involved in the Elk Grove School District's Adopt a School program and provide free sports physicals. Mercy Family Health Center continues to operate as a Human Trafficking Victim Medical Safe Haven and has partnered with several community organizations to bridge the gap between social and recovery support and medical services.
Active Hospitals	❑ Mercy Hospital of Folsom ❑ Mercy San Juan Medical Center ❑ Mercy General Hospital

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

	✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	✓ Access to Quality Primary Care Health Services ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment ❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	The clinic had 45,367 visits, most of which were provided to underinsured and uninsured individuals.
Dignity Health Contribution / Program Expense[2]	$3,253,692

Primary Health Need Addressed: Access to Mental, Behavioral and Substance Use Services	
Navigation to Wellness	
Program Description	This program engages nonprofit mental health provider, Turning Point, to improve the quality of care for patients in mental health crisis. A Peer Support Specialist works side by side hospital social workers to ensure patients are linked to appropriate public and community behavioral health services needed for wellness when they are discharged. The program provides ongoing support for up to 60 days post-discharge.
Active Hospitals	✓ Mercy Hospital of Folsom ❑ Mercy San Juan Medical Center ❑ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	✓ Access to Quality Primary Care Health Services ✓ Access to Mental, Behavioral and Substance Use Services ✓ Access to Basic Needs ❑ System Navigation ❑ Injury and Disease Prevention and Management ✓ Safe and Violence-Free Environment ❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	591 persons served. All patients were linked to community resources upon hospital discharge and followed up with for 30 days to ensure they connected to the resources. The collaborative includes: Turning Point Community Programs, Consumer Self Help, and NAMI.

Dignity Health Contribution / Program Expense[2]	$400,249
ReferNet Intensive Outpatient Mental Health Partnership	
Program Description	In collaboration with community-based nonprofit mental health provider, El Hogar, the program provides a seamless process for patients admitting to the emergency department with mental illness to receive immediate and ongoing treatment and other social services they need for a continuum of care when they leave the hospital.
Active Hospitals	✓ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center ✓ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	✓ Access to Quality Primary Care Health Services ✓ Access to Mental, Behavioral and Substance Use Services ✓ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ✓ Safe and Violence-Free Environment ❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	425 patients successfully received intensive outpatient treatment through the program. All patients were referred through hospital social workers and El Hogar referred to other social service resources as needed.
Dignity Health Contribution / Program Expense[2]	$345,811
Sacramento County Crisis Navigation Program	
Program Description	In partnership with Sacramento County Behavioral Health and Bay Area Community Services (BACS), the Crisis Navigation Program serves Sacramento County residents who are experiencing a mental health crisis resulting in functional impairment that interferes with primary activities of daily and independent living. Navigators respond to hospital emergency departments as well as the county jail and Loaves & Fishes to assist patients in accessing outpatient mental health services and other resources. Prior to April 2021, services were provided by Hope Cooperative. Services began with BACS in July 2021.
Active Hospitals	❑ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center ✓ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	✓ Access to Quality Primary Care Health Services ✓ Access to Mental, Behavioral and Substance Use Services ❑ Access to Basic Needs

	❑ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment ❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	822 persons served
Dignity Health Contribution / Program Expense[2]	Program funded by Sacramento County, however navigators work out of Dignity Health hospitals' emergency departments and are supervised by clinical staff. The Community Health and Outreach department managed the internal components of the program.

Primary Health Need Addressed: Access to Basic Needs	
Housing with Dignity	
Program Description	In partnership with Lutheran Social Services and Centene, the hospital aims to assist homeless individuals with severe chronic health and mental health issues obtain and retain housing, care and services designed to achieve stability in their lives. Hospital case managers work directly with Lutheran Social Services staff to identify participants who will be housed in supportive stabilization apartments and receive intensive case management and supportive services..
Active Hospitals	✓ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center ✓ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	✓ Access to Quality Primary Care Health Services ✓ Access to Mental, Behavioral and Substance Use Services ✓ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ✓ Safe and Violence-Free Environment ✓ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	68 persons served. In FY21, with additional partnership from Health Net, the program's capacity was increased from 12 to 24 units.
Dignity Health Contribution / Program Expense[2]	$650,000
Interim Care Program	
Program Description	The hospital is an active partner in the Interim Care Program (ICP). This collaborative engages other Dignity Health hospitals and health systems in the region, Sacramento County and Federally Qualified Health Center, WellSpace Health, and provides a respite care shelter for homeless patients with available

	physical and mental health, and substance abuse treatment. The program provides case management services to assist participants in connecting with outpatient services and community resources.
Active Hospitals	✓ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center ✓ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	✓ Access to Quality Primary Care Health Services ✓ Access to Mental, Behavioral and Substance Use Services ✓ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ✓ Safe and Violence-Free Environment ✓ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	235 persons served
Dignity Health Contribution / Program Expense[2]	$1,550,0000

Priority Health Need Addressed: System Navigation	
Patient Navigator Program	
Program Description	The Patient Navigator program focuses on assisting patients who rely on emergency departments for non-urgent needs. The navigators help patients by connecting them to a medical home in an appropriate setting and assisting them with scheduling a follow up appointment along with any other barriers that may create obstacles with accessing care. The Patient Navigator Program represents a unique collaboration between Dignity Health, Sacramento Covered, a community-based nonprofit organization, and community clinics in the region.
Active Hospitals	✓ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center ✓ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	✓ Access to Quality Primary Care Health Services ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment

	❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	32,047 persons served
Dignity Health Contribution / Program Expense[2]	$1,055,784

Primary Health Need Addressed: Injury and Disease Prevention and Management	
Healthier Living	
Program Description	The Healthier Living program allows participants to learn about and practice a wide variety of tools to help them become better self-managers of their ongoing health conditions. Workshops are open to anyone with a chronic health condition, as well as those who care for persons with chronic health conditions. They are offered at the community level in partnership with medical clinics, food banks, affordable housing developments and others to ensure the underserved have access to these peer led health education classes. Provided in both English and Spanish.
Active Hospitals	✓ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center ✓ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	❑ Access to Quality Primary Care Health Services ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment ✓ Access to Active Living and Healthy Eating ✓ Cultural Competency ❑ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	Reach of 509 community members and 393 participants completed the program through 44 workshops conducted. There are now 14 active leaders who can facilitate A Matter of Balance, Diabetes Empowerment Education Program, and/or Chronic Disease Self-Management Program.
Dignity Health Contribution / Program Expense[2]	$196,330
Congestive Heart Active Management Program (CHAMP)	
Program Description	CHAMP® establishes a relationship with patients who have heart failure after discharge from the hospital through regular phone interactions to support, educate and assist primary care physicians/cardiologists to manage this disease and monitoring of symptoms or complications.
Active Hospitals	✓ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center

	✓ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	✓ Access to Quality Primary Care Health Services ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment ❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ✓ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	34,597 patients served
Dignity Health Contribution / Program Expense[2]	$2,991,570

Primary Health Need Addressed: Safe and Violence-Free Environment	
WEAVE Patient Advocate	
Program Description	Mercy Family Health Center, Methodist Hospital and WEAVE developed and implemented the WEAVE Patient Advocate program to create a new model of comprehensive care for human trafficking. A Navigator is on-site at the Mercy Family Health Center several times a week to provide victims and survivors of human trafficking assistance with navigation and coordination of services and 'warm hand offs' to medical services and community-based resources and linkages.
Active Hospitals	❑ Mercy Hospital of Folsom ❑ Mercy San Juan Medical Center ❑ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	✓ Access to Quality Primary Care Health Services ✓ Access to Mental, Behavioral and Substance Use Services ✓ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ✓ Safe and Violence-Free Environment ❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care

Program Performance / Outcomes[1]	1,149 patient encounters were provided for identified victims and survivors of human trafficking. Services received at Mercy Family Health Center included primary care, and in some cases, many received a variety of health screenings, mental health and medication management. The embedded patient advocate was strategic to provide and referrals to resources and/or additional follow up care.
Dignity Health Contribution / Program Expense[2]	$130,946
Safe Kids Program	
Program Description	The Safe Kids Greater Sacramento coalition, lead by MSJMC, is comprised of individuals and organizations that are committed to reducing preventable childhood injuries. Projects focus on: Child Passenger Safety; Bicycle Safety; Pedestrian Safety; Safe Sleep; Fire/Burn Prevention; and Drowning Prevention. MSJMC also leads a no cost car seat education program targeting families with children living in poverty, and to families with children in immigrant communities. The program provides: car seat classes; car seat checkup appointments; car seat distribution to families in need; and program phone lines are currently offered in English, Spanish, and Hmong. Car seat checkups are offered to the general public at several hospital sites.
Active Hospitals	❑ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center ❑ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	❑ Access to Quality Primary Care Health Services ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment ❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	7,343 persons served which includes 1,196 car seat checks and distribution of 580 car seats.
Dignity Health Contribution / Program Expense[2]	$994,071 expensed from Mercy San Juan Medical Center.

Priority Health Need Addressed: Access to Active Living and Healthy Eating

Food Exploration and School Transformation (FEAST)	
Program Description	Supported through the Community Grants Program, a partnership between Food Literacy Center, Soil Born Farms and Health Education Council, FEAST's objective is to create a full circle connection for students in which they can grow their food, consume healthy produce at home, learn to cook or prepare this food, & practice healthy habits with their families.

Active Hospitals	✓ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center ✓ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	✓ Access to Quality Primary Care Health Services ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment ✓ Access to Active Living and Healthy Eating ❑ Cultural Competency ❑ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	In FY19 the Food Literacy Center delivered cooking and nutrition classes to over 2,500 students at 6 schools through the FEAST program. Health Education Council educated 41 parents on the importance of healthy lifestyles by focusing on nutrition education, fitness opportunities, and disease prevention. In FY20 and FY21, with school closures due to COVID-19. FEAST worked with schools through virtual afterschool classes providing mini lessons to keep children engaged during stay-at-home orders. Partnered with SCUSD Nutrition Services to create and provide recipe STEM kits to 660 students in FEAST schools complete with printed lesson materials, recipes and fresh produce for students to practice their cooking skills with our recipes at home.
Dignity Health Contribution / Program Expense[2]	$220,000

Primary Health Need Addressed: Cultural Competency	
Salud con Dignidad (Health with Dignity)	
Program Description	Supported through the Community Grants Program, a partnership between La Familia Counseling Center, Latino Coalition for Health California, Sacramento Native American Health Center and Dr. David Nylund, Salud con Dignidad connects and navigates low-income, under-insured/uninsured, predominantly Latino, Sacramento youth and residents with health education and social service resources. SCD will utilize a holistic, coordinated-care approach to well-being by providing behavioral health, COVID education and prevention, health education, youth engagement and leadership development services, but will also include access to primary, vision, and oral health services.
Active Hospitals	✓ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center ✓ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020

	✓ FY 2021
Secondary Health Need(s) Addressed	✓ Access to Behavioral Health Services ✓ Active Living and Health Eating ✓ Disease Prevention, Management and Treatment ✓ Access to High Quality Health Care and Services ✓ Safe, Crime, and Violence Free Communities
Program Performance / Outcomes[1]	In FY19, 178 community members received information on rights to access health care, social services and health education opportunities, and education on human trafficking.339 clients benefited from wellness classes; 831 enrolled into Medi-Cal and 68 individuals were provided legal support services. In FY20-FY21 during COVID, this program 1,079 persons Medi-Cal enrollment, 543 participants in health wellness workshops, 122 individuals served with short-term behavioral health counseling sessions, 1,177 families served during drive-thru food drives, 200-550 weekly for COVID testing, 1,932 individuals and families served during 8 PPE drives. Provided 2 building life skills/leadership workshops and trainings; and more than 5 volunteer opportunities to 22 youths.
Dignity Health Contribution / Program Expense[2]	$231,195

Primary Health Need Addressed: Access to Specialty and Extended Care	
Oncology Nurse Navigator	
Program Description	The Oncology Nurse Navigation program offers one-to-one support and guidance to patients diagnosed with cancer from the day of diagnosis onwards. The Oncology navigators provide interventions that address patient's immediate concerns and barriers to care such as difficulties with insurance, financial burden, lack of transportation and addressing the knowledge deficit of around their diagnosis and treatment options. The Navigation program also provide referrals for nutritional and psycho-social support as well hosting multiple cancer support groups across the region.
Active Hospitals	✓ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center ✓ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	❑ Access to Quality Primary Care Health Services ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Basic Needs ❑ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment ❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ✓ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	4,391 persons served.

Dignity Health Contribution / Program Expense[2]	$167,272
SPIRIT	
Program Description	Operated under the Sierra Sacramento Valley Medical Society, the program exists as a vehicle to involve physicians in the community. SPIRIT recruits and places physician volunteers in local clinics to provide free specialty medical care to the uninsured and coordinates and case manages surgical procedures donated at local hospitals and ambulatory surgery centers. Mercy General and Mercy San Juan play a leading role in this collaboration between the Sierra Sacramento Valley Medical Society, sister Dignity Health hospitals, Sacramento County and other health systems in the region.
Active Hospitals	✓ Mercy Hospital of Folsom ✓ Mercy San Juan Medical Center ✓ Mercy General Hospital ✓ Methodist Hospital
Fiscal Years Active	✓ FY 2019 ✓ FY 2020 ✓ FY 2021
Secondary Health Need(s) Addressed	❑ Access to Quality Primary Care Health Services ❑ Access to Mental, Behavioral and Substance Use Services ❑ Access to Basic Needs ✓ System Navigation ✓ Injury and Disease Prevention and Management ❑ Safe and Violence-Free Environment ❑ Access to Active Living and Healthy Eating ❑ Cultural Competency ✓ Access to Specialty and Extended Care
Program Performance / Outcomes[1]	91 persons served, services included a variety of in-office specialty consults, and cataract, hernia, and gall gallbladder surgeries.
Dignity Health Contribution / Program Expense[2]	$105,000

1. All program outcomes and expenses are reflective of the timeframe (fiscal years) indicated by the boxes checked in the 'Fiscal Years Active' section of the table for each program.
2. Outcomes and expenses are also shared between the Dignity Health hospitals indicated by the boxes checked in the 'Active Hospitals' section of the table for each program.

Collaboration

During FY19-FY21, Mercy General, Mercy San Juan, Methodist and Mercy Hospital Folsom utilized collaborative strategies to assess current strengths, weaknesses and gaps, and engaged non-traditional partners in community health programs to increase access to expanded services and increase the continuum of care beyond hospitals walls for its patients and communities they serve.

Collaborative programs and partnerships across these various initiatives include:

- Care for the Undocumented
- Human Trafficking Response Program
- Initiative to Reduce African American Child Deaths

- City of Sacramento Whole Person Care/ Pathways to Health + Housing
- WellSpace Health Capacity Building
- Mental Health Improvement Coalition
- Mack Road Partnership
- Mercy Clinic Loaves & Fishes
- Community Based Violence Prevention Program
- Mercy Faith and Health Partnership
- Mental Health Consultations and Conservatorship Services
- Prevent Alcohol and Risk-Related Trauma in Youth (PARTY)
- Financial assistance for uninsured/underinsured and low income residents
- Elk Grove Economic Development Corporation
- Green Team
- Sacramento County Health Authority Commission

Community Grants

The theme for Dignity Health's Community Grants program focuses on collaboration with an emphasis on responding to significant health needs identified in the 2019 CHNA. The goal of the program is to develop strategic partnerships between community-based organizations that link services directly to Dignity Health hospitals; leveraging resources that address priority health issues, and utilize creative strategies that have a direct, positive and lasting impact on the health of disadvantaged individuals and families in our community.

To be eligible for funding, organizations must work in collaboration with a minimum of 3 community partners. Program/Project responds to two or more of the following priority health needs:

1. Access to Behavioral Health Services: Includes access to mental health and substance abuse prevention and treatment services.
2. Active Living and Healthy Eating: Affects health behaviors (e.g., fruit and vegetable consumption), associated health outcomes (e.g., diabetes) and aspects of the physical environment/living conditions (e.g., food deserts).
3. Access to High Quality Health Care Services: Includes access to primary and specialty care, dental care and maternal and infant care. Additionally, this category includes health education and literacy, continuity of care, care coordination and patient navigation including linguistically and culturally competent services.
4. Disease Prevention, Management and Treatment: Includes disease prevention and/or management programs that improve health status.
5. Safe, Crime and Violence Free Communities: This encompasses programs that improve safety from violence and crime, including violent crime, property crimes, domestic violence and human trafficking.
6. Basic Needs: Includes food security, affordable housing, economic security (e.g., employment, benefits) and education (e.g., reading proficiency and graduation rates).

In FY 2019 through FY 2021, Sacramento County hospitals collectively awarded grants totaling $2,554,389. The table below highlights the grantees.

Community Grants					
Lead Grant Recipient	**Priority Health Need(s) Addressed**	**Project Name**	**Fiscal Years Funded**		
			FY19	FY20	FY21
Latino Coalition for a Healthy California	Access to Behavioral Health Services Active Living and Healthy Eating Access to High Quality Health Care Services	Salud con Dignidad / Health with Dignity	$90,000		
Wind Youth Services	Access to High Quality Health Care Services Safe, Crime and Violence Free Basic Needs	Wind Center Collaborative	$90,000		
Always Knocking	Active Living and Healthy Eating Disease Prevention, Management and Treatment	Recreate for Health	$50,000		
TLCS, Inc.	Access to Behavioral Health Services Access to High Quality Health Care Services Disease Prevention, Management and Treatment	Co-Occurring substance use Disorder Treatment Program	$90,000		
Big Brothers Big Sisters of the Greater Sacramento Area	Access to Behavioral Health Services Safe, Crime and Violence Free	The Bigs with Badges Mentoring Program	$45,000		
Wellspring Women's Center	Access to Behavioral Health Services Active Living and Healthy Eating Access to High Quality Health Care Services Basic Needs	Mercy Pedalers of Oak Park	$55,000		
		Coronavirus Pandemic Community Benefit Support Grant			$12,000
3 Strands Global Foundation	Safe, Crime and Violence Free Communities Basic Needs	The Employ + Empower Reintegration Program	$50,000	$80,000	

Alzheimer's Disease and Related Disorders Association	Access to Behavioral Health Services Disease Prevention, Management and Treatment. Basic Needs	Dementia Care and Support Navigation Program	$75,000	$75,000	
Harm Reduction Services	Access to Behavioral Health Services Disease Prevention, Management and Treatment	Education, Response, and Access (ERA)	$90,000	$80,000	$75,000
Food Literacy Center	Active Living and Healthy Eating Access to High Quality Health Care Services Disease Prevention, Management and Treatment.	FEAST- Food Exploration and School Transformation	$90,000	$80,000	$50,000
		Healthy Eating on Franklin Blvd.		$70,000	
Hmong Youth and Parents United	Active Living and Healthy Eating Access to High Quality Health Care Services Basic Needs	Empowering Healthy Living Project	$51,214		
		Proactive and Healthy Living Project		$75,000	
		Coronavirus Pandemic Community Benefit Support Grant			$10,000
Community Against Sexual Harm (CASH)	Access to High Quality Health Care Services Safe, Crime and Violence Free Basic Needs	Healthy Women and Families	$75,000		
		My Mom, My 1st Teacher		$75,000	$75,000
Mutual Assistance Network	Active Living and Healthy Eating Safe, Crime and Violence Free Basic Needs	Passport to Adulthood		$80,000	

Carrie's Touch	Access to Behavioral Health Services Active Living and Healthy Eating Access to High Quality Health Care Services Disease Prevention, Management and Treatment. Safe, Crime and Violence Free	Unveiling Breast, Cancer- Mind, Body, Soul, Serving the Whole Woman		$75,000	
Sacramento Life Center	Access to High Quality Health Care Services Basic Needs	Continuum of Care for Arden Area's Low Income Pregnant Women and Teens		$75,000	
Sacramento Covered	Access to Behavioral Health Services Active Living and Healthy Eating Access to High Quality Health Care Services Disease Prevention, Management and Treatment. Safe, Crime and Violence Free Basic Needs	Behavioral Health Recuperative Care		$100,000	$55,000
La Familia Counseling Center	Access to Behavioral Health Services Active Living and Healthy Eating Access to High Quality Health Care Services	Salud con Dignidad / Health with Dignity		$56,195	
		Salud Con Dignidad en Comunidad			$85,000
Hope Cooperative	Access to Behavioral Health Services Access to High Quality Health Care Services Disease Prevention, Management and Treatment. Safe, Crime and Violence Free	Innovative Pilot to Address Methamphetamine Use in the homeless Population			$100,000
The Race and Gender Equity Project	Access to Behavioral Health Services Active Living and Healthy Eating Safe, Crime and Violence Free	#RAGE Healing			$100,000

Boys & Girls Clubs of Greater Sacramento (BGC)	Access to Behavioral Health Services Safe, Crime and Violence Free	Keeping Communities Connected Together!			$22,240
Latino Leadership Council Inc.	Access to Behavioral Health Services Active Living and Healthy Eating Access to High Quality Health Care Services Safe, Crime and Violence Free Basic Needs	Creer En Tu Salud (Believe in your Health)			$94,326
Neighborhood Wellness Foundation	Access to Behavioral Health Services Access to High Quality Health Care Services Disease Prevention, Management and Treatment Safe, Crime and Violence Free	Truth Sets You Free: Healing Our Neighborhood of Generational Trauma, Stigma, and Shame			$68,414
Crime Victims Assistance Network I-CAN	Access to Behavioral Health Services Disease Prevention, Management and Treatment. Safe, Crime and Violence Free Basic Needs	Coronavirus Pandemic Community Benefit Support Grant			$5,000
Law Enforcement Chaplaincy	Access to High Quality Health Care Services Safe, Crime and Violence Free Basic Needs	Coronavirus Pandemic Community Benefit Support Grant			$10,000
NorCAL Resist	Access to Behavioral Health Services Safe, Crime and Violence Free	Coronavirus Pandemic Community Benefit Support Grant			$10,000

EveryONE Matters Ministries	Access to High Quality Health Care Services Disease Prevention, Management and Treatment. Safe, Crime and Violence Free Basic Needs	Coronavirus Pandemic Community Benefit Support Grant			$10,000
Grand Total			**$851,214**	**$846,195**	**$856,980**

Conclusion

This CHNA report details health needs of the Sacramento County community as a part of a successful collaborative partnership between Dignity Health, Sutter Health, and UC Davis Health. Community Health Assessments play an important role in helping community partners determine where to focus community benefit and health improvement efforts, including targeting efforts in geographic locations and on specific populations experiencing inequities leading to health disparities. Data in this report can help nonprofit hospitals, local health departments, and community service providers work in collaboration to engage in meaningful community health improvement efforts.