Sutter Health

SUTTER AUBURN FAITH HOSPITAL

2022 Community Health Needs Assessment

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

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

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

2022 Community Health Needs Assessment

Conducted on behalf of

Sutter Auburn Faith Hospital
11815 Education Street
Auburn, CA 95602

Conducted by

COMMUNITY HEALTH INSIGHTS

May 2022

Acknowledgments

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

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

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Report Summary

Purpose

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

Community Definition

The definition of the community served included the primary service area of the hospital, Sutter Auburn Faith Hospital with a population of 98,646. The primary service area of the hospital was defined by 10 ZIP Codes – 95602, 95603, 95631, 95658, 95703, 95713, 95717, 95722, 95736, and 95949. This is the designated service area because the majority of patients served by SAFH resided in these ZIP Codes. The service area is located in Placer County (with one ZIP Code extending into Nevada County) and includes the city of Auburn. This area of Placer county is often referred to as "the foothills" of the Sierra Nevada Mountain range.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[1] This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included 11 one-on-one and group interviews with 17 community health experts, social service providers, and medical personnel. Furthermore, 20 community residents or community service provider organizations participated in 2 focus groups across the service area. Finally, 41 community service providers responded to a Community Service Provider (CSP) survey asking about health need identification and prioritization.

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

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

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

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

Process and Criteria to Identify and Prioritize Significant Health Needs

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

List of Prioritized Significant Health Needs

The following SHNs identified for Sutter Auburn Faith Hospital are listed below in prioritized order.

1. Access to Basic Needs Such as Housing, Jobs, and Food
2. Access to Mental/Behavioral Health and Substance Use Services
3. Access to Quality Primary Care Health Services
4. Active Living and Healthy Eating
5. Access to Specialty and Extended Care
6. Healthy Physical Environment
7. Safe and Violence-Free Environment

Resources Potentially Available to Meet the Significant Health Needs

In all, 139 resources were identified in the service area that were potentially available to meet the identified SHNs. The identification method included starting with the list of resources from the 2019 CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report.

Conclusion

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

Introduction and Purpose

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

This report documents the processes, methods, and findings of a CHNA conducted on behalf of Sutter Auburn Faith Hospital (SAFH), located at 11815 Education Street, Auburn, CA 95602. SAFH's primary service area includes 10 ZIP codes across three counties. The total population of the service area was 98,646.

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

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

Findings

Prioritized Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize the SHNs in the SAFH service area. In all, 7 SHNs were identified. Primary data were then used to prioritize these SHNs.

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

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

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

Prioritized Health Needs	Percentage of Key Informants and Focus Groups Identifying Health Need	Percentage of Times Key Informants and Focus Groups Identified Health Need as a Top Priority	Percentage of Provider Survey Respondents that Identified Health Need as a Top Priority
Access to Basic Needs Such as Housing, Jobs, and Food	100%	22%	76%
Access to Mental/Behavioral Health and Substance Use Services	100%	19%	49%
Access to Quality Primary Care Health Services	85%	11%	20%
Active Living and Healthy Eating	69%	9%	2%
Access to Specialty and Extended Care	38%	5%	32%
Healthy Physical Environment	54%	8%	5%
Safe and Violence-Free Environment	31%	4%	12%

~ Health need not mentioned

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

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

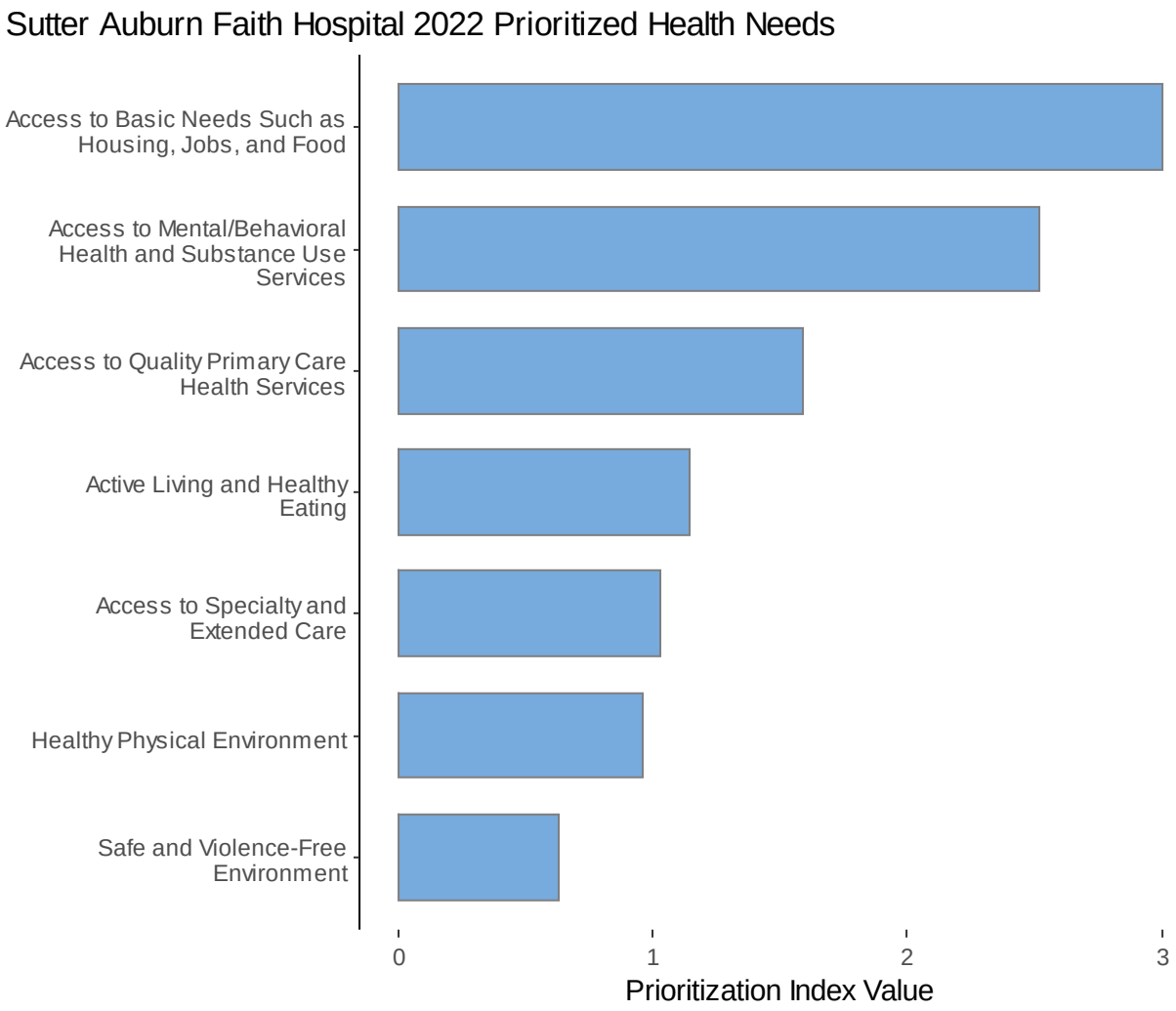


Figure 1: Prioritized significant health needs for SAFH service area.

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

The SHNs are described below. Those secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health ordered by their relationship to the conceptual model used to guide data collection for this report. Results from primary data analysis are also provided in the table. (A full listing of all quantitative indicators can be found in the technical section of this report).

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

Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs[4] suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.[5]

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:</td><td rowspan="2">The following indicators performed worse in the service area when compared to state averages:</td></tr>
<tr><td>Key Informant and Focus Group Responses</td><td>Community Service Provider Survey Responses</td></tr>
<tr><td>• Economic insecurity for many residents has worsened over the years.
• Food insecurity is a big concern for many.
• Increased access to technology and internet needed.
• Many in the area have a NIMBY (not in my back yard) mentality regarding homelessness.
• Need for more affordable, safe housing in the county.
• More shelters for those experiencing homelessness.
• Increased need for transitional housing.
• The cost of homes and rent prices in the county are high.
• Not enough well-paying jobs in the community to offset the excessive cost of living.
• A lot of people are on a fixed income and prices keep going up.
• Need for financial assistance for basic needs like food and diapers.</td><td>• The area needs additional low-income housing options.
• Lack of affordable housing is a significant issue in the area.
• It is difficult to find affordable childcare.
• Services for homeless residents in the area are insufficient.
• Many residents struggle with food insecurity.
• Many people in the area do not make a living wage.
• Services are inaccessible for Spanish-speaking and immigrant residents.
• Poverty in the county is high.
• Employment opportunities in the area are limited.
• Educational attainment in the area is low.</td><td>• Life Expectancy
• Premature Age-Adjusted Mortality
• Premature Death
• Hypertension Mortality
• Poor Mental Health Days
• Frequent Mental Distress
• Drug Induced Death
• Limited Access to Healthy Foods
• Food Environment Index
• Medically Underserved Area
• COVID-19 Cumulative Full Vaccination Rate
• Disconnected Youth
• Median Household Income</td></tr>
</table>

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

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Increase well-paying jobs in the county. Most jobs in the county pay extremely low wages. • The middle class is the fastest growing group in the community needing food assistance due to higher costs. • Increase need for more affordable childcare. • Translation needs for the Spanish speaking community. • Financial assistance to help pay bills and housing costs for the undocumented community.		

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

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Increased access to mental health services for Spanish Speaking community members. • Mental health stigma prevents people from seeking care. • Those of financial privilege have access to care, those without do not have access. • Suicide rates have increased in the younger populations.	• There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups). • Substance-abuse is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse). • Additional services for those who are homeless and experiencing mental/behavioral health issues	• Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Liver Disease Mortality • Suicide Mortality • Poor Mental Health Days • Frequent Mental Distress • Excessive Drinking • Drug Induced Death • Adult Smoking

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Increase in overdose deaths in the county, specifically fentanyl. • Local health systems need to increase outpatient mental health care access. • Need more behavioral health providers in the county. Hard to replace those that have left. • Number of mental health providers is way below the number of patients in need of care. • Alcohol use is a significant issue in the county, disproportionately affecting the Native American community members. • Lack of access to mental health resources and care for those un and underinsured. • Tobacco use is highly prevalent in the county. • Vaping among area youth and young adults is a concern. • Wait times to access mental health services is long. • Need for more behavioral health rehabilitation care in the county. • More resources for children, and their families, in a mental health crisis. • Increased access to mental health and behavioral health resources and care for those experiencing homelessness. • Access to early interventions	are needed. • Treatment options in the area for those with Medi-Cal are limited. • Substance-use treatment options for those with Medi-Cal are limited. • There aren't enough services here for those who are homeless and dealing with substance-abuse issues. • There are too few substance-abuse treatment services in the area (e.g., detox centers, rehabilitation centers). • Additional services specifically for youth are needed (e.g., child psychologists, counselors, and therapists in the schools). • It's difficult for people to navigate for mental/behavioral healthcare. • Substance-abuse is an issue among youth in particular. • The area lacks the infrastructure to support acute mental health crises. • The cost for mental/behavioral health treatment is too high. • The stigma around seeking mental health treatment keeps people out of care. • Awareness of mental health issues among community members is low. • The use of nicotine delivery products such as e-cigarettes and tobacco is a problem in the community. • There are substance-abuse treatment services available here, but people do not know about them.	• Primary Care Shortage Area • Mental Health Care Shortage Area • Medically Underserved Area • Mental Health Providers • Psychiatry Providers • Firearm Fatalities Rate • Juvenile Arrest Rate • Disconnected Youth

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
with a focus on social, emotional wellness. • Need for more medically supervised treatment programs. • Need for more prevention information on depression and anxiety for youth and adults.	• Mental/behavioral health services are available in the area, but people do not know about them.	

3. Access to Quality Primary Care Health Services

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Transportation is a barrier to primary care. • Hours of operation of primary care providers is a barrier for many. • Health literacy is a challenge for many. • Access to primary care in south Placer County is lacking for those under or uninsured. • Provider shortage is a major concern for north and northeastern portions of the Placer County. • Demand for primary health care outweighs the care available.	• There aren't enough primary care service providers in the area. • Wait-times for appointments are excessively long. • Patients seeking primary care overwhelm local emergency departments. • The quality of care is low (e.g., appointments are rushed, providers lack cultural competence). • Too few providers in the area accept Medi-Cal. • Patients have difficulty obtaining appointments	• Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Chronic Lower Respiratory Disease Mortality • Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Liver Disease Mortality • Kidney Disease Mortality • Alzheimer's Disease Mortality • Influenza and Pneumonia Mortality • Poor Mental Health Days

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• More providers needed for those uninsured, on Medi-Cal and Medi-Care. • Difficult to find a primary care doctor even if you have insurance. • Primary health care in the county is fragmented. • Long wait times to access primary care from the providers available. • Expand telehealth to account for provider shortages. • Increased need for more local community clinics or federally qualified health centers.	outside of regular business hours. • Primary care services are available but are difficult for many people to navigate. • Quality health insurance is unaffordable. • It is difficult to recruit and retain primary care providers in the region. • Out-of-pocket costs are too high. • Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine).	• Frequent Mental Distress • Colorectal Cancer Prevalence • Breast Cancer Prevalence • Lung Cancer Prevalence • Prostate Cancer Prevalence • Primary Care Shortage Area • Medically Underserved Area • Primary Care Providers • COVID-19 Cumulative Full Vaccination Rate

4. Active Living and Healthy Eating

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Increased access to healthy food at local food distribution centers. • Food insecurity is increasing due to the	• Food insecurity is an issue here. • Fresh, unprocessed foods are unaffordable. • Homelessness in parks or other public spaces deters their use.	• Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
inflated cost of living. • Increased need to healthy foods and opportunities to exercise. • More farmers markets in remote areas. • Need for cultural appropriate physical activities in the community (ballet folkloric dancing). • Need for an outdoor gym at parks for seniors to access at low cost.	• Recreational opportunities in the area are unaffordable (e.g., gym memberships, recreational activity programming). • The community needs nutrition education programs. • There are food deserts in the area where fresh, unprocessed foods are not available. • There aren't enough recreational opportunities in the area (e.g., organized activities, youth sports leagues).	• Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Kidney Disease Mortality • Poor Mental Health Days • Frequent Mental Distress • Colorectal Cancer Prevalence • Breast Cancer Prevalence • Prostate Cancer Prevalence • Limited Access to Healthy Foods • Food Environment Index • Access to Exercise Opportunities • Access to Public Transit

5. Access to Specialty and Extended Care

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Need for more psychiatrists in the county. • More heart, bone, and psych specialists needed in the county. • Minimal options for long	• People have to travel to reach specialists. • Too few specialty and extended care providers accept Medi-Cal. • Not all specialty care is covered by insurance. • It is difficult to recruit and	• Life Expectancy • Premature Age-Adjusted Mortality • Premature Death • Stroke Mortality • Chronic Lower Respiratory Disease Mortality

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
term care. • Increased need for expansion of home health care services for the rural areas. • Big need for women's and pediatric specialists in the county. • Patients have to travel out of the area to receive most specialty care. • Need more services in ophthalmology and chiropractic care in the area.	retain specialists in the area. • The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care). • Wait-times for specialist appointments are excessively long. • The area lacks a kind of specialist or extended care option not listed here. • There isn't enough OB/GYN care available. • Additional hospice and palliative care options are needed. • Out-of-pocket costs for specialty and extended care are too high.	• Heart Disease Mortality • Hypertension Mortality • Cancer Mortality • Liver Disease Mortality • Kidney Disease Mortality • Alzheimer's Disease Mortality • Poor Mental Health Days • Frequent Mental Distress • Lung Cancer Prevalence • Drug Induced Death • Psychiatry Providers • Specialty Care Providers

6. Healthy Physical Environment

Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one's living environment, including the physical (natural and built) and sociocultural environment, has more impact on individual health than one's lifestyle, heredity, or access to medical services.[6]

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Air pollution is a concern. • Many people working outside without the proper personal protective equipment (PPE).	• Heavy traffic in the area harms the air quality. • Low-income	• Life Expectancy • Premature Age-Adjusted Mortality • Premature Death

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Big concern with the frequency of wildfires. • Change the built environment to increase access to those living without adequate transportation and access to care. • High reliance on transportation in the county to access care. • Smoke pollution is a constant stress in the county. • Water scarcity is of concern given the rural nature of the area. • The challenge of people getting insurance for their homes given the increased risk of fires. • Few roads have sidewalks in the county.	housing is substandard. • Poor water quality is a concern in the area. • The air quality contributes to high rates of asthma. • Wildfires in the region harm the air quality.	• Chronic Lower Respiratory Disease Mortality • Hypertension Mortality • Cancer Mortality • Frequent Mental Distress • Colorectal Cancer Prevalence • Breast Cancer Prevalence • Lung Cancer Prevalence • Prostate Cancer Prevalence • Adult Smoking

7. Safe and Violence-Free Environment

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
• Increase intimate partner violence in the county. • Increased violence in the county driving an increase in	• There are not enough resources to address domestic violence and sexual assault.	• Life Expectancy • Premature Death • Hypertension Mortality • Poor Mental Health Days

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

Primary Data Analysis		Secondary Data Analysis
The manner in which the health need appeared or was expressed in the community was described as follows by key informants, focus group participants, and survey respondents:		The following indicators performed worse in the service area when compared to state averages:
Key Informant and Focus Group Responses	Community Service Provider Survey Responses	
homelessness. • Safety concerns due to increased frequency of wildfires. • Increased cases of sex trafficking in the county. • Need for more safe outdoor activities for seniors and youth, including improving lighting at local parks.	• Human trafficking is an issue in the area. • Specific groups in this community are targeted because of characteristics like race/ethnicity or age. • People feel unsafe because of crime. • The current political environment makes some concerned for their safety. • Youth need more safe places to go after school. • Gang activity is an issue in the area. • Isolated or poorly-lit streets make pedestrian travel unsafe. • Public parks seem unsafe because of illegal activity taking place.	• Frequent Mental Distress • Access to Exercise Opportunities • Firearm Fatalities Rate • Juvenile Arrest Rate • Motor Vehicle Crash Death • Disconnected Youth

Methods Overview

Conceptual and Process Models

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[8] 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. SAFH requested

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

written comments from the public on its 2019 CHNA and most recently adopted Implementation Strategy through SHCB@sutterhealth.org.

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

Data Used in the CHNA

Data collected and analyzed included both primary or qualitative data and secondary or quantitative data. Primary data included 11 interviews with 17 community health experts, 2 focus groups conducted with a total of 20 community residents or community-facing service providers, and 41 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 SHNs. Additionally, socioeconomic indicators were collected to help describe the overall social conditions within the service area. Health outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health factor indicators included measures of 1) health behaviors, such as diet, exercise, and tobacco, alcohol, and drug use; 2) clinical care, including access to quality care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, neighborhood safety, and similar; and 4) physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 86 different health-outcome and health factor indicators were collected for the CHNA.

Data Analysis

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

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

Description of Community Served

The definition of the community served was the primary service area of SAFH. This area was defined by 10 ZIP Codes—95602, 95603, 95631, 95658, 95703, 95713, 95717, 95722, 95736, and 95949. This is the designated service area because the majority of patients served by SAFH resided in these ZIP Codes. The service area is located in northern Placer County (with ZIP Code 95949 extending into Nevada County)

and includes the city of Auburn the seat of Placer County. Located at the base of the Sierra Nevada Mountains, this area provides countless recreational opportunities, as well as a relaxing natural environment and holds historical significance as an area of the Gold Rush. The total population of the service area was 98,646. The service area is shown in Figure 2.

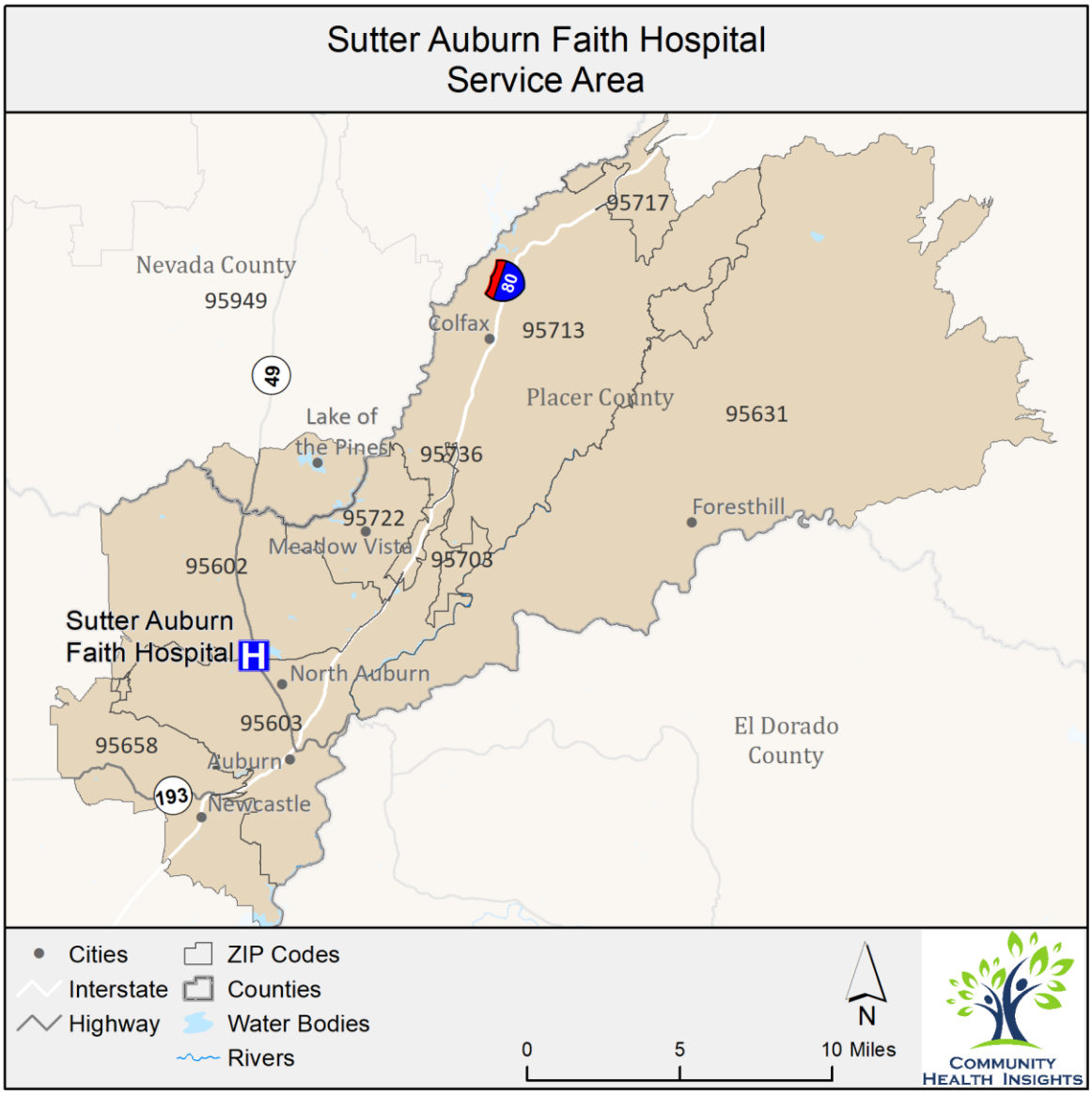


Figure 2: Community served by SAFH.

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

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

ZIP Code	Total Population	% Non-White or Hispanic\Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95602	17,557	16.7	54.7	$82,397	8.1	4.3	4.4	4.4	36.9	13.6
95603	29,474	17.9	47.7	$68,257	12.3	3.9	3.8	8.4	37.9	14.2
95631	6,851	14.3	51.5	$80,772	8.3	8.4	4.3	6.6	31.4	8.2
95658	6,837	17.3	48.5	$96,891	2.7	5.7	2.4	2.6	31.8	11.3
95703	831	12.3	55.6	$68,359	11.4	13.7	2.8	8.5	26.5	24.2
95713	10,472	19.4	46.5	$72,746	8.1	3.5	4.3	4.6	34.1	12.4
95717	176	17	59.5	$52,639	27.6	0	6.3	2.1	28.7	13.1
95722	5,123	12	52.1	$94,071	4.9	4	1.5	4.6	39.2	12.9
95736	289	21.1	24.9	$56,786	0	9.2	13.5	0	0	2.4
Placer	385,512	27.3	42	$89,691	7.7	4.2	4	5.5	34.5	10.6
95949	21,036	12.5	53.6	$71,059	8.3	4.4	4.7	6	38.7	14.3
Nevada	99,244	14.8	50.5	$66,096	11	4.6	6.5	5.6	40.3	14.3
California	39,283,497	62.8	36.5	$75,235	13.4	6.1	7.5	16.7	40.6	10.6

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

Health Equity

The Robert Wood Johnson Foundation's definition of health equity and social justice is used here to help establish a collective 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.*[9]

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

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

health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation."[10]

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

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

Health Outcomes - the Results of Inequity

The table below displays disparities among race and ethnic groups, where available, for the HSA for life expectancy, mortality, and low birthweight in both Placer and Nevada Counties.

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

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Placer							
Life Expectancy	Average number of years a person can expect to live.	~	86.1	~	84.5	81.2	81.3
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	~	~	~	191.3	281.5	276.5
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	~	~	~	4,616.3	6,094.8	6,068.4
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	~	9.5%	~	6.2%	5.7%	5.9%
Nevada							
Life Expectancy	Average number of years a person can expect to live.	81.7	89	80.1	85.6	81.8	82.4
Child Mortality	Number of deaths among children under age 18 per 100,000 population.	~	~	~	24.5	28.9	27.1
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	369.6	125.6	294.3	179.1	240.3	226.4

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

Health Outcomes	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	~	2,651.3	5,369.3	3,684.5	4,779.9	4,471.2
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	~	7.1%	10.5%	6.5%	5.1%	5.7%

~ Data Not Available
Data sources included in the technical section of the report.

Examination of health outcome data by race and ethnicity for Placer County, show that Asians have the highest life expectancy but also the highest percentage of low birthweight babies. Whites in Placer County have lower life expectancy than other race/ethnic groups, higher premature age-adjusted morality rates than Hispanic community members, and the lowest rate of low birthweight births. As the HSA extends into Nevada County, rates of health outcomes by race and ethnicity are also provided here. Data show Black community members with high premature age-adjusted mortality rate, the highest rate of premature deaths and higher percentage of low birthweight babies.

Health Factors - Inequities in the Service Area

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

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

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Placer							
Some College[a]	Percentage of adults ages 25 and over with some post-secondary education.	76%	71.4%	70.3%	60%	77.5%	76%
High School Completion[a]	Percentage of adults ages 25 and over with at least a high school diploma or equivalent.	93.6%	83.1%	81.2%	80.6%	95.9%	94.4%
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	~	~	~	2.6	3.1	3
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	~	~	~	2.6	2.9	2.8

Health Factors	Description	American Indian\ Alaska Native	Asian	Black	Hispanic	White	Overall
Children in Poverty	Percentage of people under age 18 in poverty.	~	~	~	17.5%	11.8%	13.5%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$48,750	$79,637	$77,898	$56,569	$66,268	$69,550
Uninsured Population[b]	Percentage of the civilian non-institutionalized population without health insurance.	9.3%	12.5%	9.8%	14.7%	5.5%	6.5%
Nevada							
Some College[a]	Percentage of adults ages 25 and over with some post-secondary education.	66.3%	83.1%	79.6%	59.5%	78.4%	76.6%
High School Completion[a]	Percentage of adults ages 25 and over with at least a high school diploma or equivalent.	89.6%	94.3%	96.7%	81.9%	96.4%	94.5%
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	~	3.7	2.7	2.8	3.3	3.2
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	~	3.6	2.6	2.6	3.1	3.1
Children in Poverty	Percentage of people under age 18 in poverty.	29.3%	7.4%	4.8%	15.3%	5.9%	7.5%
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$44,574	$121,425	$85,429	$72,709	$90,077	$97,688
Uninsured Population[b]	Percentage of the civilian non-institutionalized population without health insurance.	3.9%	3.5%	4.1%	6.9%	3.5%	4%

~ 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.

Health factor data for Placer County by race and ethnicity reveal that Hispanics have the lowest percent of some college attainment and high school completion, third grade reading and math levels, highest

percentage of children in poverty, the second lowest median income and highest percentage of uninsured population compared to other groups. In addition, American Indian/Alaska Native have the lowest median income or any group and the largest percentage of children living in poverty. Specific to Nevada County health factor data, Hispanics again have the lowest percent of some college attainment and high school completion, low third grade math and reading levels, and largest percentage of population uninsured.

Population Groups Experiencing Disparities

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

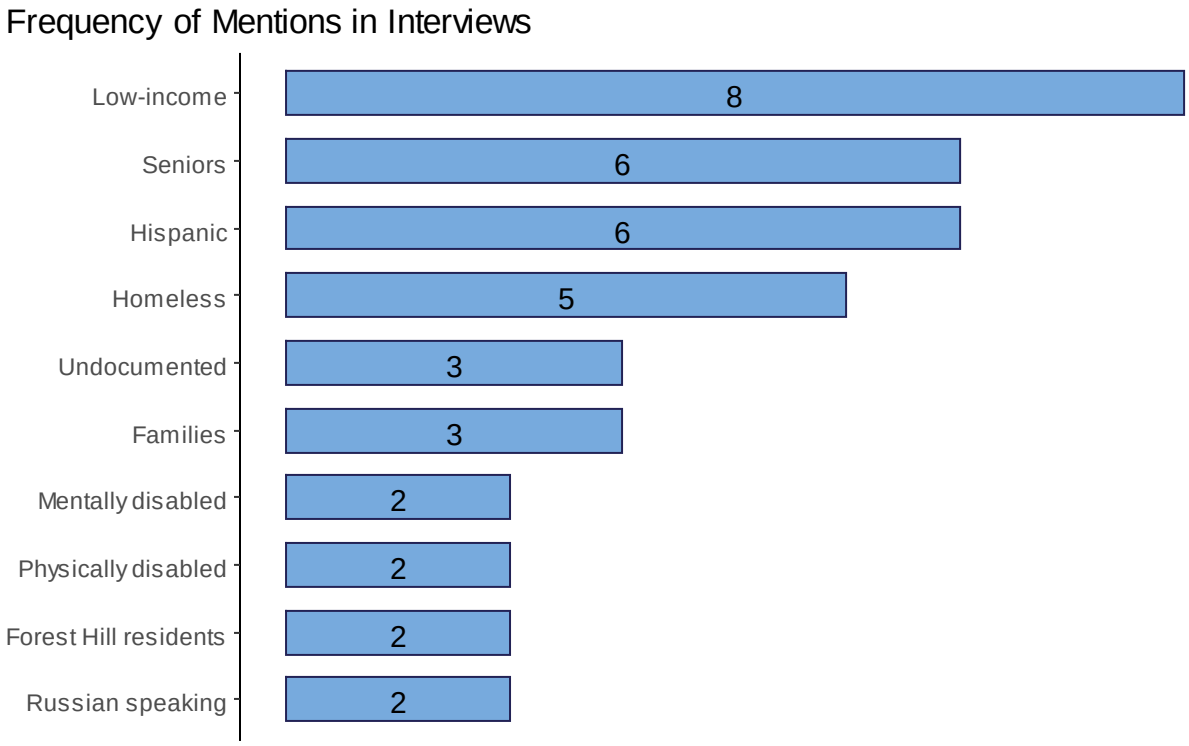


Figure 3: Populations experiencing disparities the SAFH service area.

California Healthy Places Index

Figure 4 displays the California Healthy Places Index (HPI)[11] values for the SAFH service area. The HPI is an index based on 25 health-related measures for communities across California. These measures included in the HPI were selected based on their known relationship to life expectancy and other health outcomes. These values are combined into a final score representing the overall health and well-being of the community which can then be used to compare the factors influencing health between communities. Higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present.

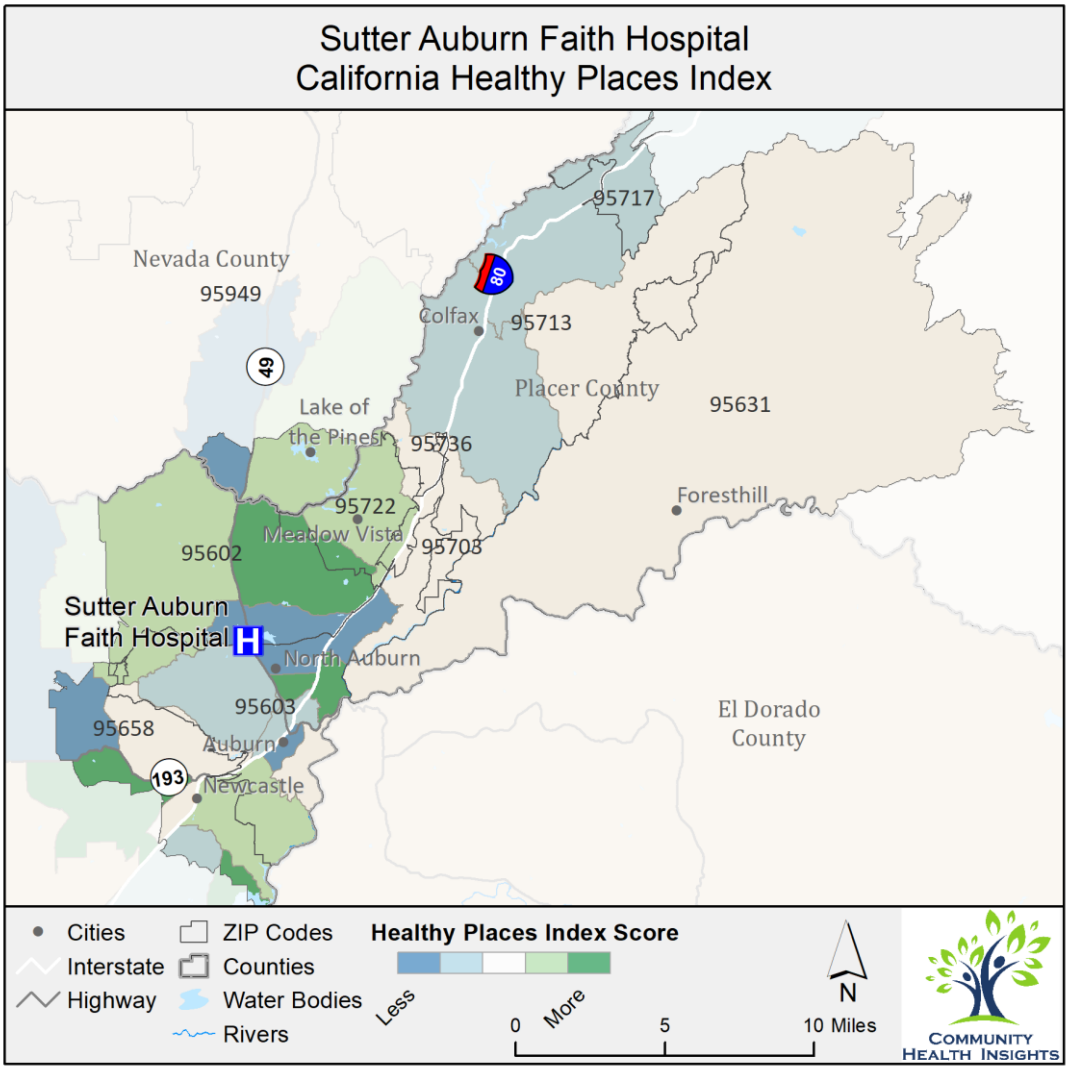


Figure 4: Healthy Places Index for SAFH.

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

Areas with the darkest blue shading in Figure 4 have the lowest overall HPI scores, indicating factors leading to less healthy neighborhoods. Areas immediately surrounding SAFH show low overall HPI scores. Specifically, areas of central Auburn, North Auburn, Virginatown (western portions of ZIP code 95658), the area of Boston Ravine (southern portion of ZIP code 95949 and Colfax are likely to have a higher concentration of residents experiencing health disparities.

Communities of Concern

Communities of Concern are geographic areas within the service area that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA methodology because, after the service area has been assessed more broadly, they allow for a focus on those portions of the region experiencing the greatest health disparities. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the technical section of this report for an in-depth description of how these are identified). Analysis of both primary and secondary data revealed 3 ZIP Codes that met the criteria to be classified as Communities of Concern. These are noted in Table 5, with the census population provided for each, and are displayed in Figure 5.

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

ZIP Code	Community\Area	Population
95602	Auburn	17,557
95603	Auburn (area of Lake of the Pines, Ophir, Clipper Gap, and Christian Valley)	29,474
95713	Colfax	10,472
Total Population in Communities of Concern		*57,503*
Total Population in Hospital Service Area		*98,646*
Percentage of Service Area Population in Community of Concern		*58.3%*
Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau.		

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

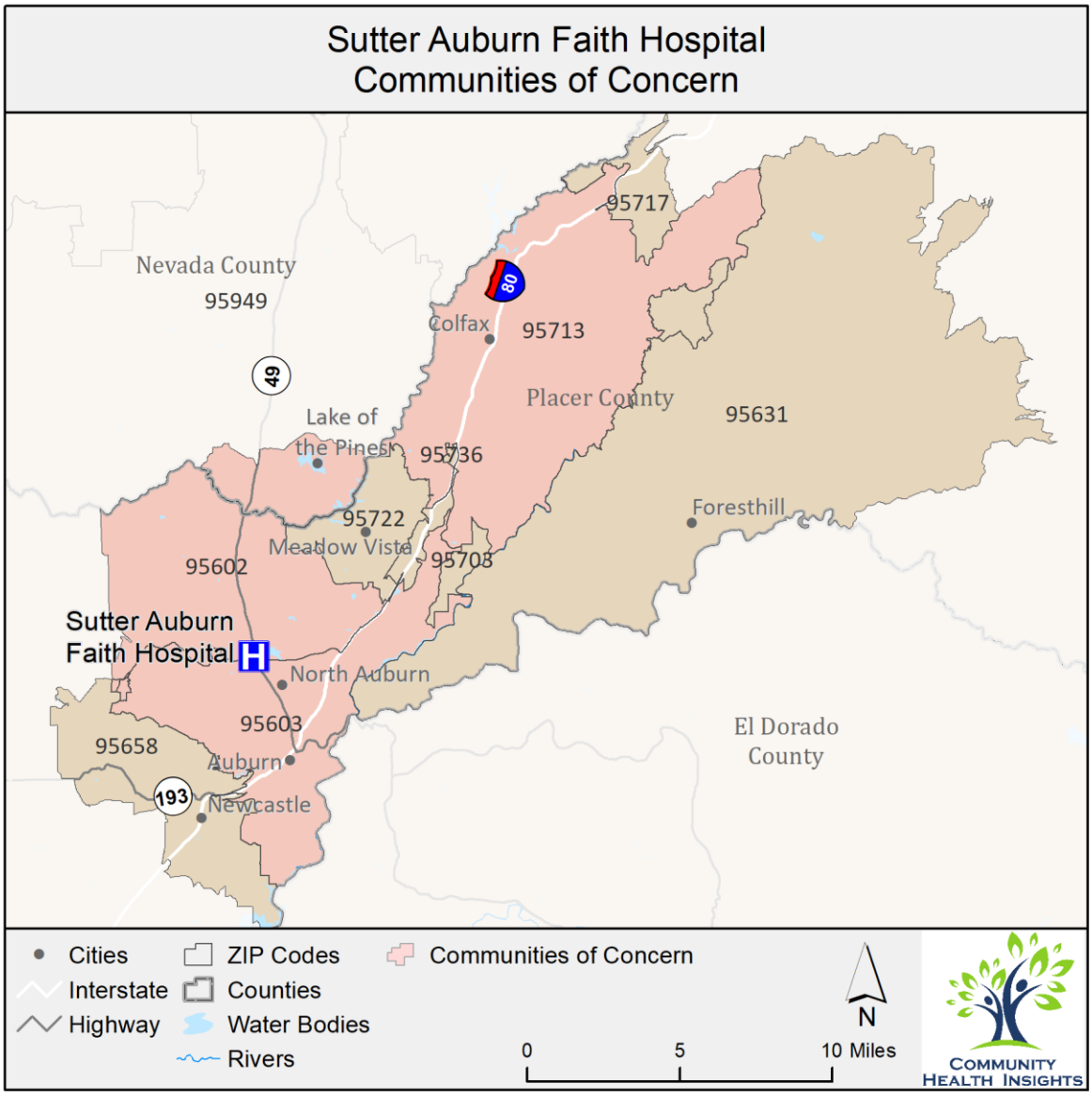
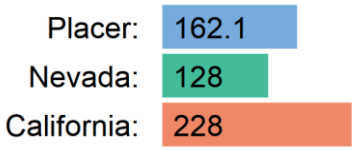
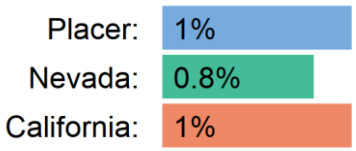
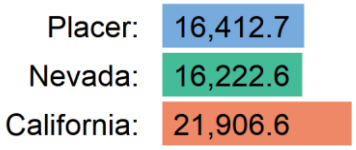
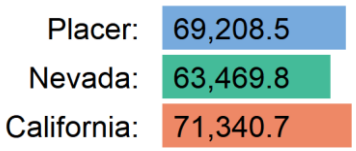


Figure 5: SAFH Communities of Concern.

The Impact of COVID-19 on Health Needs

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

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

Indicators	Description	Placer	Nevada	California	
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	162.1	128.0	228.0	
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases.	1.0%	0.8%	1.0%	
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	16,412.7	16,222.6	21,906.6	
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	69,208.5	63,469.8	71,340.7	

COVID-19 data collected on May 2 2022

COVID-19 data for Placer and Nevada Counties reveal that both counties have lower rates of COVID-19 mortality and cumulative incidence when compared to the California rate. The case-fatality rate for Placer County is equal to the state rate, while the Nevada County rate falls slightly below. Both Placer and Nevada Counties have lower COVID-19 full vaccination rates per 100,000 in comparison to the state rate.

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

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

Key Informant and Focus Group Responses	Community Service Provider Survey Responses
• Food insecurity worsened. • There was an increase in homelessness. • It was difficult for community organizations to keep up with changing rules and guidelines. • A lack of trust developed in the community between those that chose to be vaccinated and those that did not get vaccinated. • Public Health was underfunded to meet needs that came up during the pandemic. • The pandemic put stress on the health care delivery system. • Access to care was impacted in that people could not get in for routine care and screenings. • Mental health issues increased for youth feeling isolated when schools and other activities shut down. • Affordable housing has been an issue in the community and it got worse during the pandemic because options were so limited. • People who were isolated did not make the healthiest choices and became less healthy during the pandemic. • Many residents dealt with isolation issues that resulted in more mental health and behavioral health issues and needs. • People with chronic illness did not keep up with their care and their conditions got worse. • Dental care and other preventative services were put off. • Supplies typically used by a health care clinic like masks and gloves became more expensive – up to 5 times what was paid before the pandemic. • People lost their jobs and struggled with economic hardship. Many are still trying to catch up on bills. • Charitable donations to not for profit organizations went down. • There was an increase in alcohol use. • More people were showing up in the emergency department in a mental health crisis. • Seniors became fearful and afraid to go out and that added to their isolation. • People were experiencing more domestic violence and child abuse due to increased stress and being home. • Teens served by one community-based organization had a 40% increase in suicide ideation.	• Isolation is harming the mental health of community members. • Residents encounter economic hardships from lost or reduced employment. • Residents delay or forgo healthcare to limit their exposure to the virus. • Residents in the community are being evicted from their homes. • Youth no longer have ready access to the services they previously received at school (e.g., free/reduced lunch, mental and physical health services).

Key Informant and Focus Group Responses	Community Service Provider Survey Responses
• Accessing needed services and resources that switch to a virtual format was difficult for those with limited access to the internet and computers. • Stress and anxiety went up across the community. • Families struggled with online learning due to a lack of technology in the home. • Language barriers created challenges to the flow of information about the pandemic in the community. • Food distribution shifted from in person to "drive through pantries," which created hardship for those without a car. • People from the Bay Area moved to the community, which drove up housing costs, resulting in people losing their rentals because property owners wanted to sell their homes for a big profit. Service workers were especially impacted by this situation.	

Resources Potentially Available to Meet the Significant Health Needs

In all, 139 resources were identified in the SAFH service area that were potentially available to meet the identified SHNs. These resources were provided by a total of 66 social service, nonprofit, and governmental organizations, agencies, and programs identified in the CHNA. The identification method included starting with the list of resources from the 2019 Sutter Auburn Faith Hospital CHNA, verifying that the resources still existed, and then adding newly identified resources into the 2022 CHNA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 8.

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

Significant Health Needs (in Priority Order)	Number of Resources
Access to Basic Needs Such as Housing, Jobs, and Food	43
Access to Mental/Behavioral Health and Substance Use Services	32
Access to Quality Primary Care Health Services	27
Active Living and Healthy Eating	16
Access to Specialty and Extended Care	5
Healthy Physical Environment	1
Safe and Violence-Free Environment	15
Total Resources	**139**

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

Impact and Evaluation of Actions Taken by Hospital

Regulations require that each hospital's CHNA report include "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the SHNs identified in the hospital facility's prior CHNA(s) (p. 78969)."[12] SAFH invested efforts to address the SHNs identified in the prior CHNA. Appendix A includes details of those efforts.

Conclusion

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

Please send any feedback about this CHNA report to SHCB@sutterhealth.org with "CHNA Comments" in the subject line. Feedback received will be incorporate into the next CHNA.

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

2022 CHNA Technical Section

The following section presents a detailed account of data collection, analysis, and results for the Sutter Auburn Faith Hospital (SAFH) Hospital Service Area (HSA).

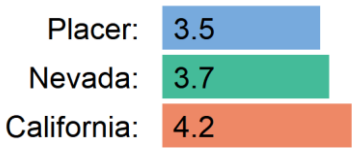
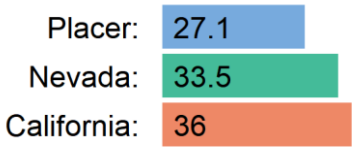
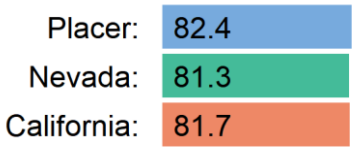
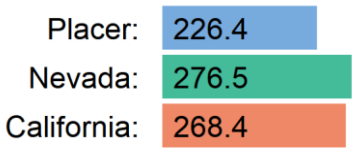
Results of Data Analysis

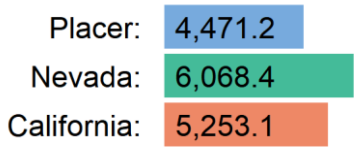
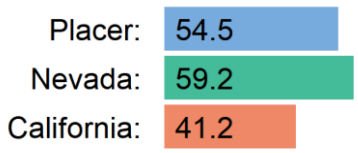
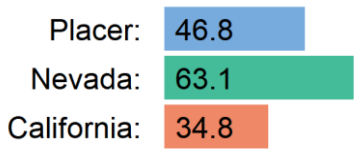
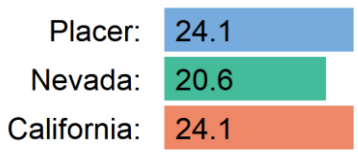
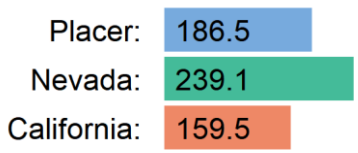
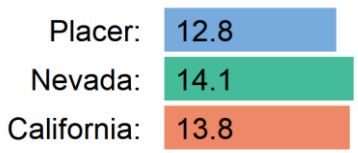
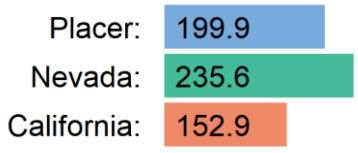
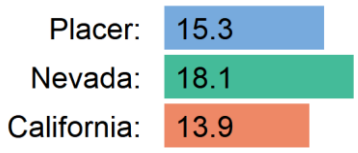
Compiled Secondary Data

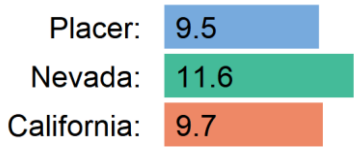
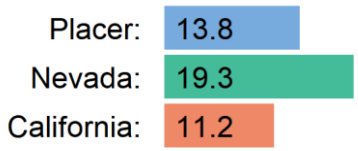
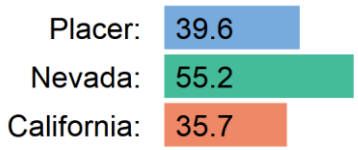
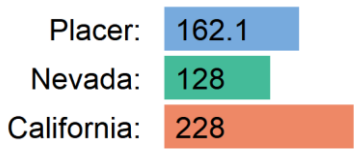
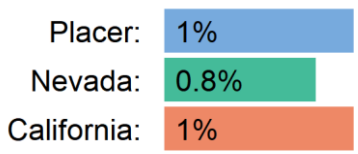
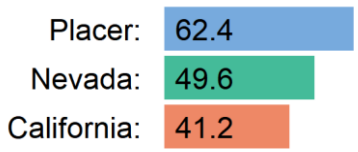
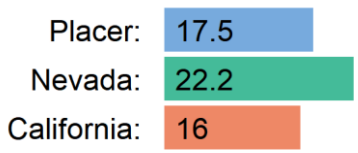
The tables and figures that follow show the specific values for the health need indicators used as part of the health need identification process. Indicator values for Placer and Nevada Counties were compared to the California state benchmark and are highlighted below when performance was worse in the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

Length of Life

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

Indicators	Description	Placer	Nevada	California	
Early Life					
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births.	3.5	3.7	4.2	
Child Mortality	Number of deaths among children under age 18 per 100,000 population.	27.1	33.5	36.0	
Life Expectancy	Average number of years a person can expect to live.	82.4	81.3	81.7	
Overall					
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted).	226.4	276.5	268.4	

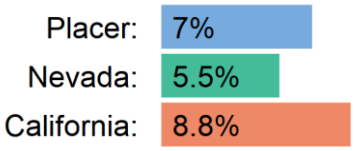
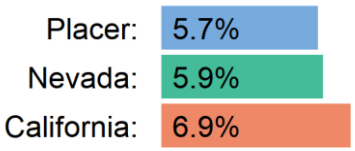
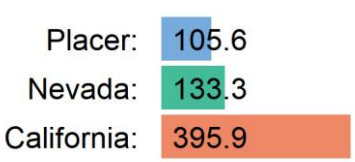
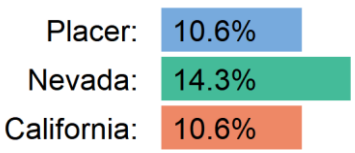
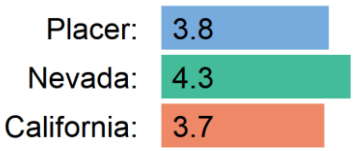
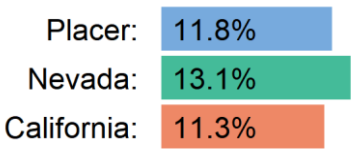
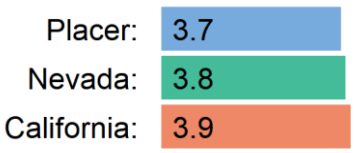
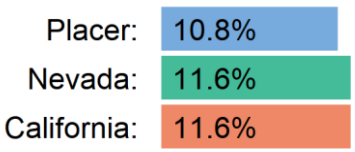
Indicators	Description	Placer	Nevada	California	
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted).	4,471.2	6,068.4	5,253.1	
Stroke Mortality	Number of deaths due to stroke per 100,000 population.	54.5	59.2	41.2	
Chronic Lower Respiratory Disease Mortality	Number of deaths due to chronic lower respiratory disease per 100,000 population.	46.8	63.1	34.8	
Diabetes Mortality	Number of deaths due to diabetes per 100,000 population.	24.1	20.6	24.1	
Heart Disease Mortality	Number of deaths due to heart disease per 100,000 population.	186.5	239.1	159.5	
Hypertension Mortality	Number of deaths due to hypertension per 100,000 population.	12.8	14.1	13.8	
Cancer, Liver, and Kidney Disease					
Cancer Mortality	Number of deaths due to cancer per 100,000 population.	199.9	235.6	152.9	
Liver Disease Mortality	Number of deaths due to liver disease per 100,000 population.	15.3	18.1	13.9	

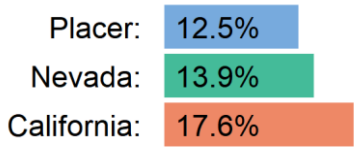
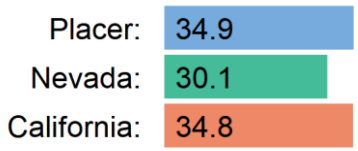
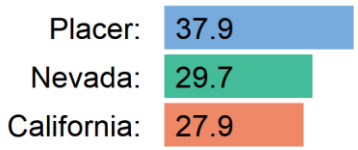
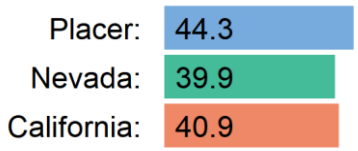
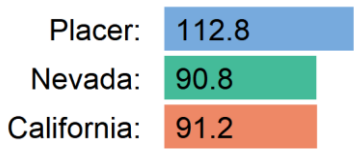
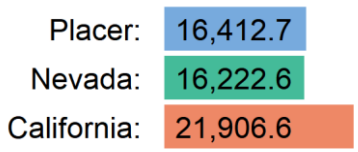
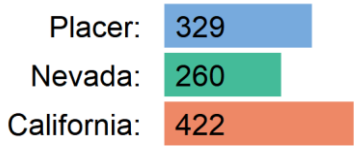
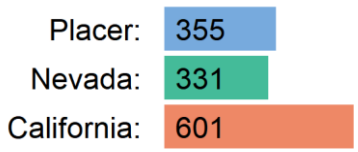
Indicators	Description	Placer	Nevada	California	
Kidney Disease Mortality	Number of deaths due to kidney disease per 100,000 population.	9.5	11.6	9.7	
Intentional and Unintentional Injuries					
Suicide Mortality	Number of deaths due to suicide per 100,000 population.	13.8	19.3	11.2	
Unintentional Injuries Mortality	Number of deaths due to unintentional injuries per 100,000 population.	39.6	55.2	35.7	
COVID-19					
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	162.1	128.0	228.0	
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases.	1.0%	0.8%	1.0%	
Other					
Alzheimer's Disease Mortality	Number of deaths due to Alzheimer's disease per 100,000 population.	62.4	49.6	41.2	
Influenza and Pneumonia Mortality	Number of deaths due to influenza and pneumonia per 100,000 population.	17.5	22.2	16.0	

Quality of Life

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

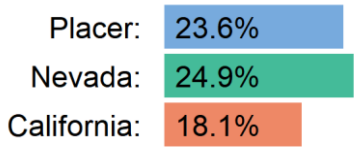
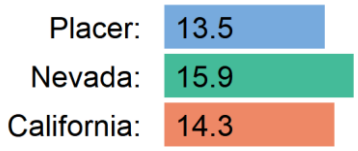
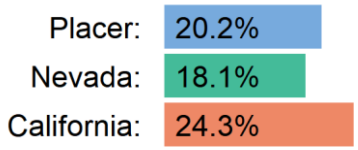
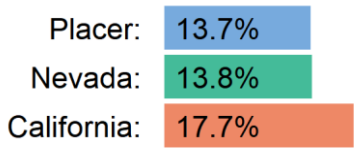
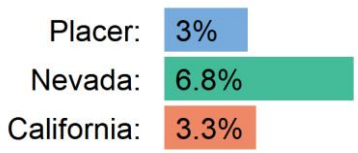
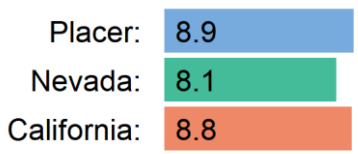
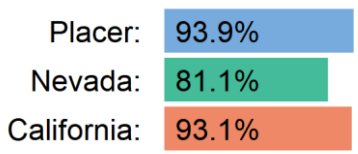
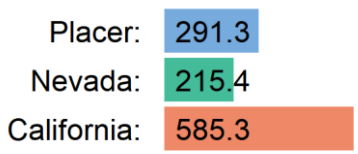
Indicators	Description	Placer	Nevada	California

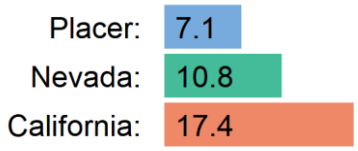
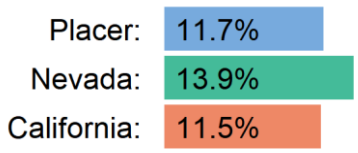
Indicators	Description	Placer	Nevada	California	
Chronic Disease					
Diabetes Prevalence	Percentage of adults ages 20 and above with diagnosed diabetes.	7.0%	5.5%	8.8%	
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams).	5.7%	5.9%	6.9%	
HIV Prevalence	Number of people ages 13 years and older living with a diagnosis of human immunodeficiency virus (HIV) infection per 100,000 population.	105.6	133.3	395.9	
Disability	Percentage of the total civilian noninstitutionalized population with a disability	10.6%	14.3%	10.6%	
Mental Health					
Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted).	3.8	4.3	3.7	
Frequent Mental Distress	Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).	11.8%	13.1%	11.3%	
Poor Physical Health Days	Average number of physically unhealthy days reported in past 30 days (age-adjusted).	3.7	3.8	3.9	
Frequent Physical Distress	Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).	10.8%	11.6%	11.6%	

Indicators	Description	Placer	Nevada	California	
Poor or Fair Health	Percentage of adults reporting fair or poor health (age-adjusted).	12.5%	13.9%	17.6%	
Cancer					
Colorectal Cancer Prevalence	Colon and rectum cancers per 100,000 population (age-adjusted).	34.9	30.1	34.8	
Breast Cancer Prevalence	Female in situ breast cancers per 100,000 female population (age-adjusted).	37.9	29.7	27.9	
Lung Cancer Prevalence	Lung and bronchus cancers per 100,000 population (age-adjusted).	44.3	39.9	40.9	
Prostate Cancer Prevalence	Prostate cancers per 100,000 male population (age-adjusted).	112.8	90.8	91.2	
COVID-19					
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	16,412.7	16,222.6	21,906.6	
Other					
Asthma ED Rates	Emergency department visits due to asthma per 10,000 (age-adjusted).	329.0	260.0	422.0	
Asthma ED Rates for Children	Emergency department visits due to asthma among ages 5-17 per 10,000 population ages 5-17 (age-adjusted).	355.0	331.0	601.0	

Health Behavior

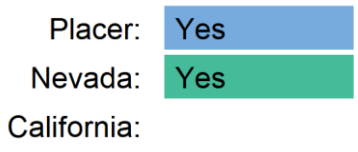
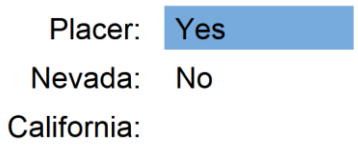
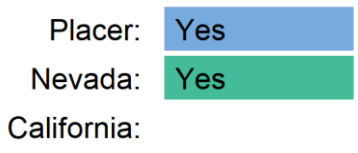
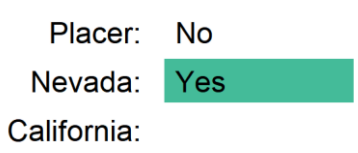
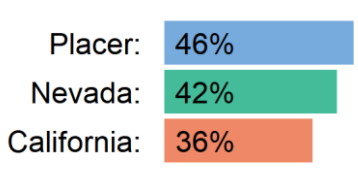
Table 11: County health behavior indicators compared to state benchmarks.

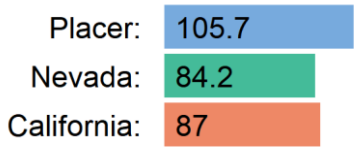
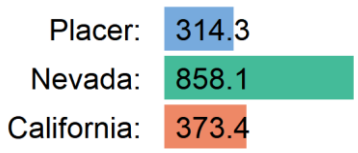
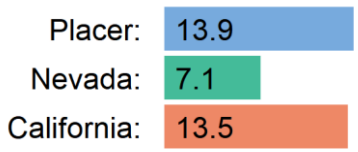
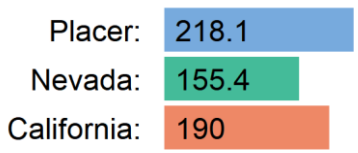
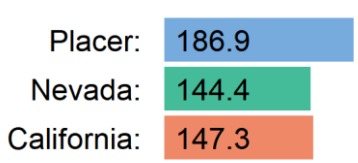
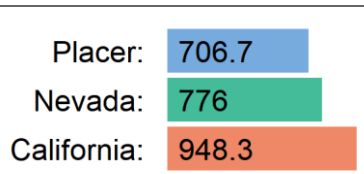
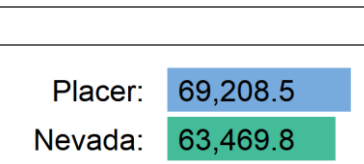
Indicators	Description	Placer	Nevada	California	
Excessive Drinking	Percentage of adults reporting binge or heavy drinking (age-adjusted).	23.6%	24.9%	18.1%	
Drug Induced Death	Drug induced deaths per 100,000 (age-adjusted).	13.5	15.9	14.3	
Adult Obesity	Percentage of the adult population (age 20 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m2.	20.2%	18.1%	24.3%	
Physical Inactivity	Percentage of adults ages 20 and over reporting no leisure-time physical activity.	13.7%	13.8%	17.7%	
Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	3.0%	6.8%	3.3%	
Food Environment Index	Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	8.9	8.1	8.8	
Access to Exercise Opportunities	Percentage of population with adequate access to locations for physical activity.	93.9%	81.1%	93.1%	
Chlamydia Incidence	Number of newly diagnosed chlamydia cases per 100,000 population.	291.3	215.4	585.3	

Indicators	Description	Placer	Nevada	California	
Teen Birth Rate	Number of births per 1,000 female population ages 15-19.	7.1	10.8	17.4	
Adult Smoking	Percentage of adults who are current smokers (age-adjusted).	11.7%	13.9%	11.5%	

Clinical Care

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

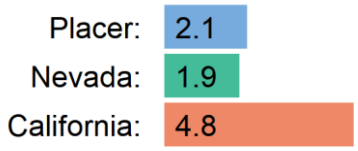
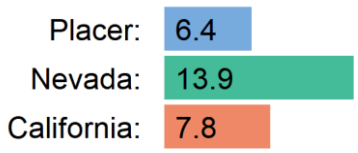
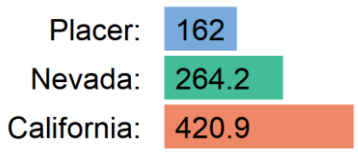
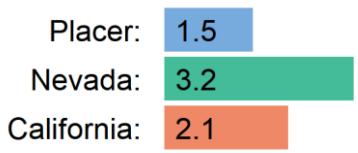
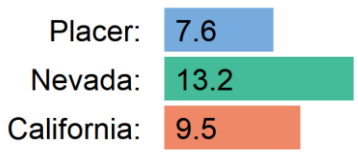
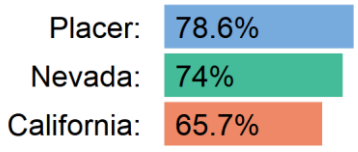
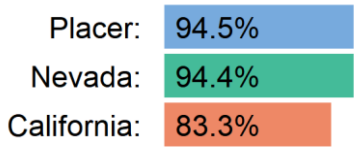
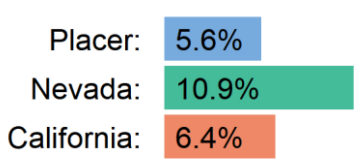
Indicators	Description	Placer	Nevada	California	
Primary Care Shortage Area	Presence of a primary care health professional shortage area within the county.	Yes	Yes		
Dental Care Shortage Area	Presence of a dental care health professional shortage area within the county.	Yes	No		
Mental Health Care Shortage Area	Presence of a mental health professional shortage area within the county.	Yes	Yes		
Medically Underserved Area	Presence of a medically underserved area within the county.	No	Yes		
Mammography Screening	Percentage of female Medicare enrollees ages 65-74 that received an annual mammography screening.	46.0%	42.0%	36.0%	

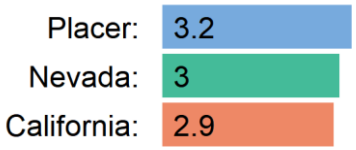
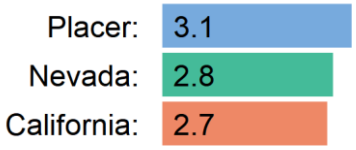
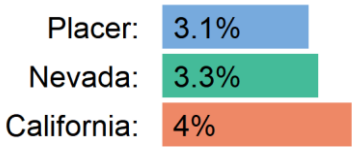
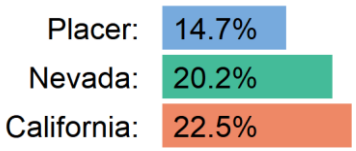
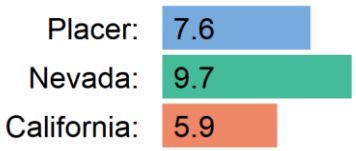
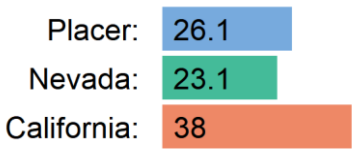
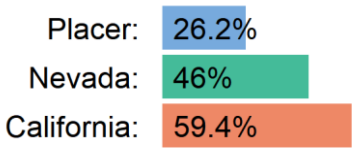
Indicators	Description	Placer	Nevada	California	
Dentists	Dentists per 100,000 population.	105.7	84.2	87.0	
Mental Health Providers	Mental health providers per 100,000 population.	314.3	858.1	373.4	
Psychiatry Providers	Psychiatry providers per 100,000 population.	13.9	7.1	13.5	
Specialty Care Providers	Specialty care providers (non-primary care physicians) per 100,000 population.	218.1	155.4	190.0	
Primary Care Providers	Primary care physicians per 100,000 population + other primary care providers per 100,000 population.	186.9	144.4	147.3	
Preventable Hospitalization	Preventable hospitalizations per 100,000 (age-sex-poverty adjusted)	706.7	776.0	948.3	
COVID-19					
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	69,208.5	63,469.8	71,340.7	

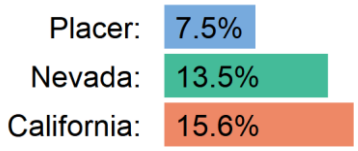
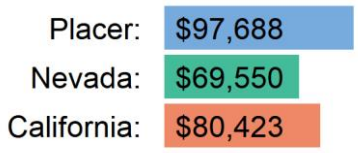
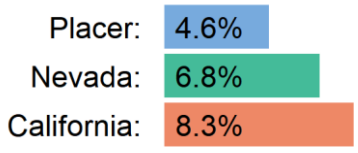
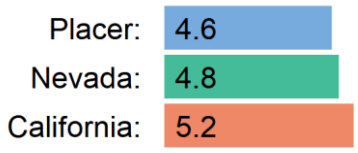
Socio-Economic and Demographic Factors

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

Indicators	Description	Placer	Nevada	California
Community Safety				

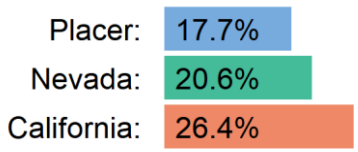
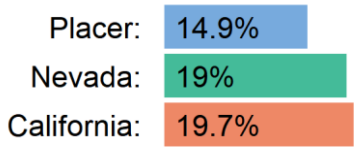
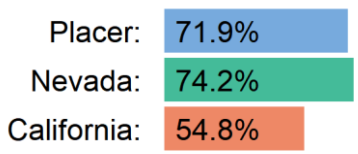
Indicators	Description	Placer	Nevada	California	
Homicide Rate	Number of deaths due to homicide per 100,000 population.	2.1	1.9	4.8	
Firearm Fatalities Rate	Number of deaths due to firearms per 100,000 population.	6.4	13.9	7.8	
Violent Crime Rate	Number of reported violent crime offenses per 100,000 population.	162.0	264.2	420.9	
Juvenile Arrest Rate	Felony juvenile arrests per 1,000 juveniles	1.5	3.2	2.1	
Motor Vehicle Crash Death	Number of motor vehicle crash deaths per 100,000 population.	7.6	13.2	9.5	
Education					
Some College	Percentage of adults ages 25-44 with some post-secondary education.	78.6%	74.0%	65.7%	
High School Completion	Percentage of adults ages 25 and over with a high school diploma or equivalent.	94.5%	94.4%	83.3%	
Disconnected Youth	Percentage of teens and young adults ages 16-19 who are neither working nor in school.	5.6%	10.9%	6.4%	

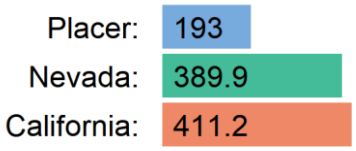
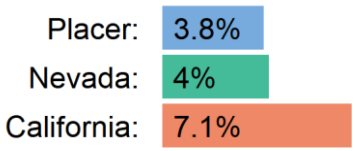
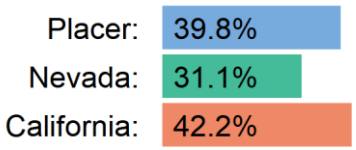
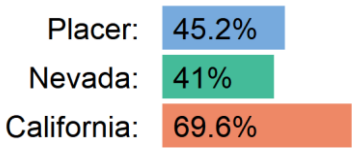
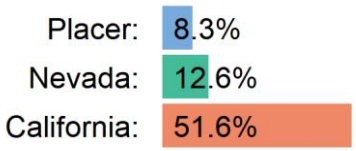
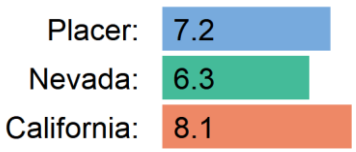
Indicators	Description	Placer	Nevada	California	
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	3.2	3.0	2.9	
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	3.1	2.8	2.7	
Employment					
Unemployment	Percentage of population ages 16 and older unemployed but seeking work.	3.1%	3.3%	4.0%	
Family and Social Support					
Children in Single-Parent Households	Percentage of children that live in a household headed by single parent.	14.7%	20.2%	22.5%	
Social Associations	Number of membership associations per 10,000 population.	7.6	9.7	5.9	
Residential Segregation (Non-White/White)	Index of dissimilarity where higher values indicate greater residential segregation between non-White and White county residents.	26.1	23.1	38.0	
Income					
Children Eligible for Free Lunch	Percentage of children enrolled in public schools that are eligible for free or reduced price lunch.	26.2%	46.0%	59.4%	

Indicators	Description	Placer	Nevada	California	
Children in Poverty	Percentage of people under age 18 in poverty.	7.5%	13.5%	15.6%	
Median Household Income	The income where half of households in a county earn more and half of households earn less.	$97,688.0	$69,550.0	$80,423.0	
Uninsured Population under 64	Percentage of population under age 65 without health insurance.	4.6%	6.8%	8.3%	
Income Inequality	Ratio of household income at the 80th percentile to income at the 20th percentile.	4.6	4.8	5.2	

Physical Environment

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

Indicators	Description	Placer	Nevada	California	
Housing					
Severe Housing Problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	17.7%	20.6%	26.4%	
Severe Housing Cost Burden	Percentage of households that spend 50% or more of their household income on housing.	14.9%	19.0%	19.7%	
Homeownership	Percentage of occupied housing units that are owned.	71.9%	74.2%	54.8%	

Indicators	Description	Placer	Nevada	California	
Homelessness Rate	Number of homeless individuals per 100,000 population.	193.0	389.9	411.2	
Transit					
Households with no Vehicle Available	Percentage of occupied housing units that have no vehicles available.	3.8%	4.0%	7.1%	
Long Commute - Driving Alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	39.8%	31.1%	42.2%	
Access to Public Transit	Percentage of population living near a fixed public transportation stop	45.2%	41.0%	69.6%	
Air and Water Quality					
Pollution Burden Percent	Percentage of population living in a census tract with a CalEnviroscreen 3.0 pollution burden score percentile of 50 or greater	8.3%	12.6%	51.6%	
Air Pollution - Particulate Matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5).	7.2	6.3	8.1	
Drinking Water Violations	Presence of health-related drinking water violations in the county.	No	No		Placer: No Nevada: No California:

Community Service Provider Survey Results

Table 15: Service provider survey results for Placer, Nevada Counties.

Service Provider Survey Snapshot | Placer County (N=22)	
Health Needs	**% Reporting**
Most Frequently Reported	
Access to Basic Needs Such as Housing, Jobs, and Food	86.4%
System Navigation	81.8%
Access to Mental/Behavioral Health and Substance-Abuse Services	72.7%
Access to Quality Primary Care Health Services	68.2%
Access to Specialty and Extended Care	59.1%
Top 3/ Priority *(Most Frequently Reported Characteristics)*	
Access to Basic Needs Such as Housing, Jobs, and Food	77.2%
Services for homeless residents in the area are insufficient.	
The area needs additional low-income housing options.	
Lack of affordable housing is a significant issue in the area.	
It is difficult to find affordable childcare.	
Many residents struggle with food insecurity.	
Access to Mental/Behavioral Health and Substance Abuse Services	54.5%
Substance-abuse is a problem in the area (e.g., use of opiates and methamphetamine, prescription misuse).	
There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).	
Treatment options (both mental health and substance-use) for those with Medi-Cal are limited.	
Additional services for those who are homeless and experiencing mental/behavioral health issues are needed.	
Access to Specialty and Extended Care	36.4%
People have to travel to reach specialists.	
Too few specialty and extended care providers accept Medi-Cal.	
Not all specialty care is covered by insurance.	
Wait-times for specialist appointments are excessively long.	

CHNA Methods and Processes

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

Conceptual Model

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

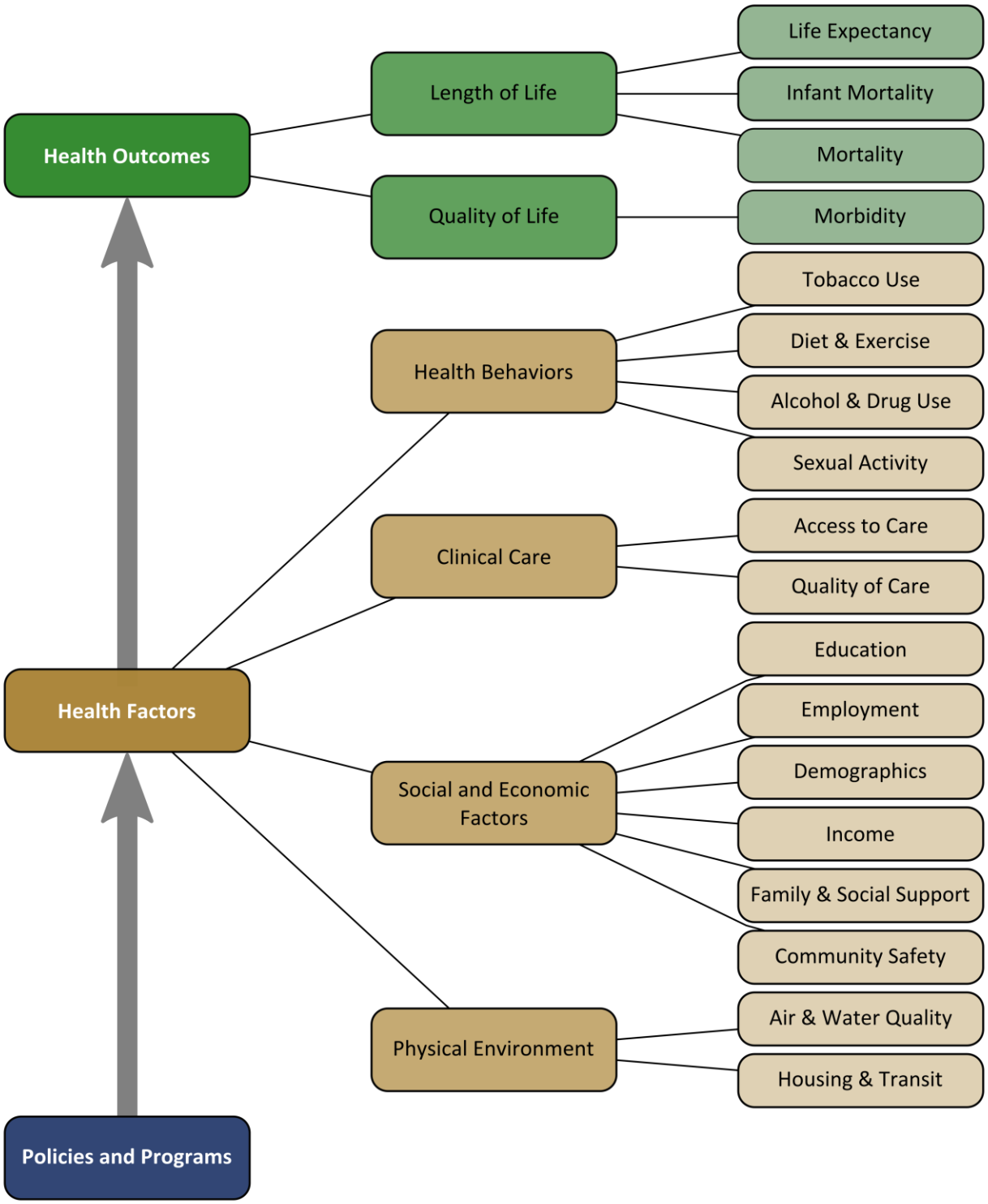


Figure 6: Community Health Assessment Conceptual Model as modified from the County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2015.

This model was used to guide the selection of secondary indicators in this analysis as well as to express in general how these upstream health factors lead to the downstream health outcomes. It also suggests

that poor health outcomes within the service area can be improved through policies and programs that address the health factors contributing to them. This conceptual model is a slightly modified version of the County Health Rankings Model used by the Robert Wood Johnson Foundation. It was primarily altered by adding a "Demographics" category to the "Social and Economic Factors" in recognition of the influence of demographic characteristics on health outcomes.

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

Process Model

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

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

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

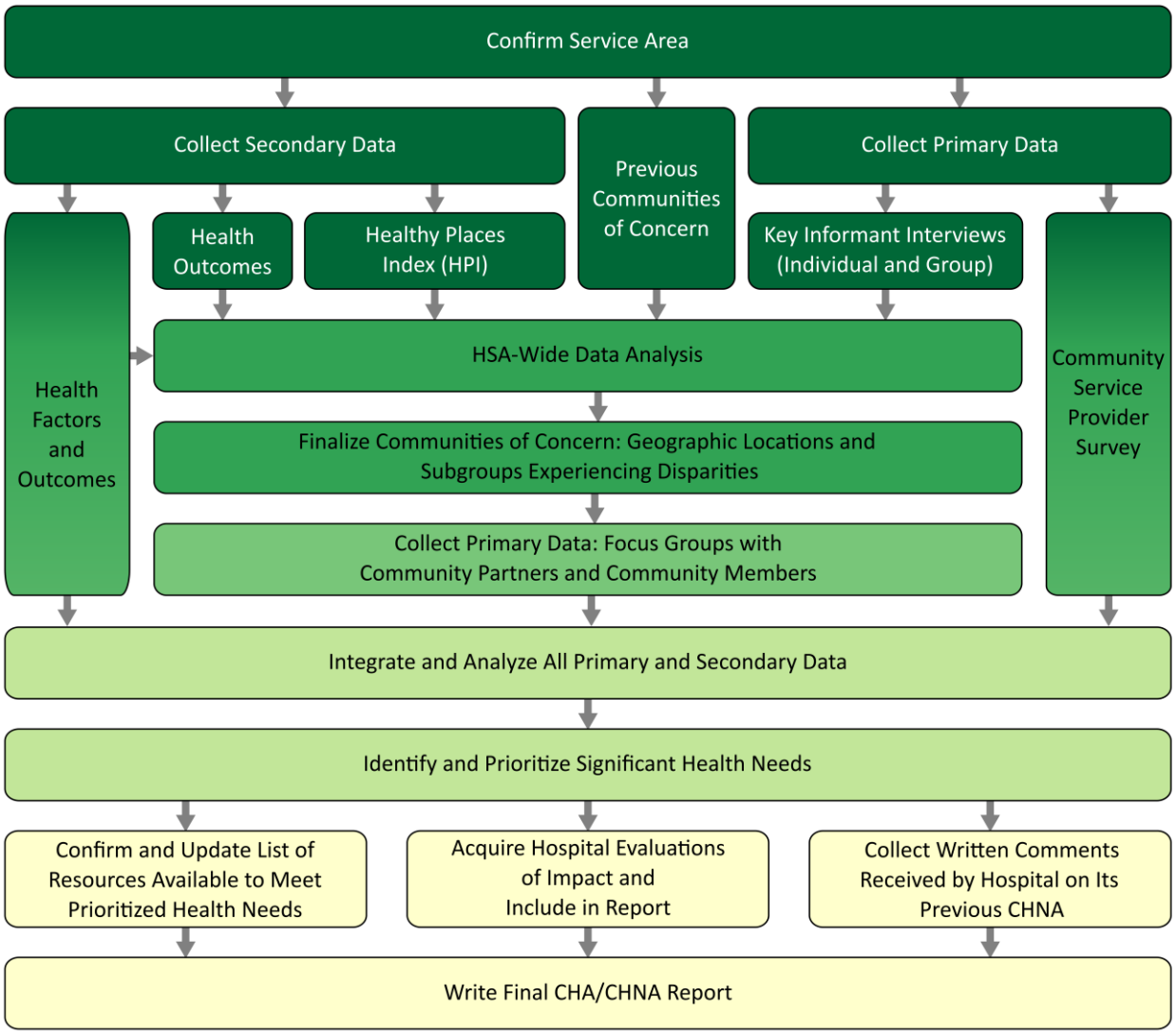


Figure 7: CHNA process model for SAFH.

Primary Data Collection and Processing

Primary Data Collection

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

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

Key Informant Results

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

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

Table 16 contains a listing of community health experts, or key informants, which contributed input to the CHNA. The table describes the name of the represented organization, the number of participants and area of expertise, the populations served by the organization, and the date of the interview.

Table 16: Key informant list.

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Placer County Public Health*	08/02/2021	1	Public Health	Placer County
Placer People of Faith Together*	08/04/2021	1	Faith based support and advocacy	Low income
Chapa-De Indian Health*	08/20/2021	1	Health care	Native American community
Seniors First Placer*	09/01/2021	1	Support services for independence	Seniors
Homeless Resource Council of the Sierras; Gathering Inn Placer; Roseville Housing Authority*	09/01/2021	3	Housing	Homeless
Auburn Renewal Center	03/02/2022	1	Free medical clinic	Uninsured, underinsured, undocumented, Spanish speaking, homeless
Sutter Auburn Faith Hospital Staff	03/03/2022	3	Acute care hospital; Healthcare services	Placer County
Lighthouse Counseling and Family Resource Center	03/03/2022	1	Counseling and social services	Low income families
Placer Food Bank	03/04/2022	1	Food insecurity	Low income; food insecure families; Spanish speaking; seniors

Organization	Date	Number of Participants	Area of Expertise	Populations Served
Wellspace Health	03/08/2022	3	FQHC; Healthcare services	Medi-Cal and underserved
Placer County Office of Education	03/15/2022	1	Education	Students and families

*interviews provided by Kaiser Permanente, via Harder and Co, for this CHNA as a part of a data sharing agreement.

Key Informant Interview Guide

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

2022 CHNA Group/Key Informant Interview Protocol

1. **BACKGROUND**
    a) **Please tell me about your current role and the organization you work for?**
        i. Probe for:
            1. Public health (division or unit)
            2. Hospital health system
            3. Local non-profit
            4. Community member
    b. **How would you define the community (ies) you or your organization serves?**
        i. Probe for:
            1. Specific geographic areas?
            2. Specific populations served?
            3. *Who? Where? Racial/ethnic make-up, physical environment (urban/ rural, large/small)*
2. **CHARACTERISTICS OF A HEALTHY COMMUNITY**
    a. **In your view, what does a healthy community look like?**
        i. Probe for:
            1. Social factors
            2. Economic factors
            3. Clinical care
            4. Physical/built environment (food environment, green spaces)
            5. Neighborhood safety
3. **HEALTH ISSUES**
    a. **What would you say are the biggest health needs in the community?**
        i. Probe for:
            1. How has the presence of COVID-19 impacted these health needs?
    b. **INSERT MAP exercise: Please use the map provided to help our team understand where communities that experience the greatest health disparities live?**
        i. Probe for:
            1. What specific geographic locations struggle with health issues the most?
            2. What specific groups of community members experience health issues the most?
4. **CHALLENGES/BARRIERS**

a. **Looking through the lens of equity, what are the challenges (barriers or drivers) to being healthy for the community as a whole?**
    i. **Do these inequities exist among certain population groups?**
    ii. Probe for:
        1. Health Behaviors (maladaptive, coping)
        2. Social factors (social connections, family connectedness, relationship with law enforcement)
        3. Economic factors (income, access to jobs, affordable housing, affordable food)
        4. Clinical Care factors (access to primary care, secondary care, quality of care)
        5. Physical (Built) environment (safe and healthy housing, walkable communities, safe parks)

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

Focus Group Results

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

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

Table 17: Focus group list.

Hosting Organization	Date	Number of Participants	Populations Represented
Lighthouse Counseling & Family Resource Center	03/25/2022	6	Low-income families and individuals; Spanish speaking
Latino Leadership Council	03/25/2022	14	Spanish speaking and Latino community in Placer and Sacramento Counties

Focus Group Interview Guide

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

2022 CHNA Focus Group Interview Protocol

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

Primary Data Processing

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

Community Service Provider Survey

A web-based survey was administered to community service providers (CSP) who delivered health and social services to community residents of the HSA. A list of CSPs affiliated with the nonprofit hospitals included in this report was used as an initial sampling frame. An email recruitment message was sent to these CSPs detailing the survey aims and inviting them to participate. Participants we also encouraged to forward the recruitment message to other CSPs in their networks. The survey was designed using Qualtrics, an online survey platform, and was available for approximately two weeks. 41 respondents completed the survey. Survey respondents were also given the opportunity to be acknowledged for their participation in the report and are listed as follows:

Ron Arneson, Louise Arquilla, Brandon Bettencourt, Darla Clark, Richard Crandall, Lisa Davies, Keith Diederich, Rebecca Dorcich-Fyfe, Elizabeth Duffy, Amy Eargle, Anthony Hill, June McKissick, Nicole McNeely, Mollie Murbach, Manena Ng'ambi, Carly Pacheco, Venus Paxton, Debra Plass, Alicia Rozum, Aimee Sagan, Robina Sana, Geoff Smith, Eileen Speaker, Alinea Stevens, and Sabrin Vella

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

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

Secondary Data Collection and Processing

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

Community of Concern Identification Datasets

Two main secondary data sources were used in the identification of Communities of Concern: California Healthy Places Index (HPI),[13] derived from health factor indicators available at the US Census tract level,

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

and mortality data from the California Department of Public Health (CDPH),[14] health outcome indicators available at the ZIP Code level. The CDPH mortality data reports the number of deaths that occurred in each ZIP Code from 2015-2019 due to each of the causes listed in Table 18.

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

Cause of Death	ICD 10 Codes
Alzheimer's disease	G30
Malignant neoplasms (cancers)	C00-C97
Chronic lower respiratory disease (CLRD)	J40-J47
Diabetes mellitus	E10-E14
Diseases of heart	I00-I09, I11, I13, I20-I51
Essential hypertension and hypertensive renal disease	I10, I12, I15
Accidents (unintentional injuries)	V01-X59, Y85-Y86
Chronic liver disease and cirrhosis	K70, K73-K74
Nephritis, nephrotic syndrome, and nephrosis	N00-N07, N17-N19, N25-N27
Pneumonia and influenza	J09-J18
Cerebrovascular disease (stroke)	I60-I69
Intentional self-harm (suicide)	*U03, X60-X84, Y87.0

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

ZIP Code Consolidation

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

First, ZCTAs are approximate representations of ZIP Codes rather than exact matches. While this is not ideal, it is nevertheless the nature of the data being analyzed. Second, not all ZIP Codes have corresponding ZCTAs. Some PO Box ZIP Codes or other unique ZIP Codes (such as a ZIP Code assigned to a single facility) may not have enough addressees residing in a given census block to ever result in the

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

creation of a corresponding ZCTA. But residents whose mailing addresses are associated with these ZIP Codes will still show up in reported health-outcome data. This means that rates cannot be calculated for these ZIP Codes individually because there are no matching ZCTA population figures.

To incorporate these patients into the analysis, the point location (latitude and longitude) of all ZIP Codes in California[15] were compared to ZCTA boundaries.[16] These unique ZIP Codes were then assigned to either the ZCTA in which they fell or, in the case of rural areas that are not completely covered by ZCTAs, the ZCTA closest to them. The CDPH information associated with these PO Boxes or unique ZIP Codes were then added to the ZCTAs to which they were assigned.

Rate Calculation and Smoothing

The next step in the analysis process was to calculate rates for each of these indicators. However, rather than calculating raw rates, empirical bayes smoothed rates (EBRs) were created for all indicators possible.[17] Smoothed rates are considered preferable to raw rates for two main reasons. First, the small population of many ZCTAs meant that the rates calculated for these areas would be unstable. This problem is sometimes referred to as the small-number problem. Empirical bayes smoothing seeks to address this issue by adjusting the calculated rate for areas with small populations so that they more closely resemble the mean rate for the entire study area. The amount of this adjustment is greater in areas with smaller populations, and less in areas with larger populations.

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

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

Significant Health Need Identification Dataset

The second main set of data used in the CHNA includes the health factor and health outcome indicators used to identify SHNs. The selection of these indicators was guided by the previously identified

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[15] Datasheer, L.L.C. 2018. ZIP Code Database Free. Retrieved 16 Jul 2018 from http://www.Zip-Codes.com.
[16] US Census Bureau. 2021. TIGER/Line Shapefile, 2019, 2010 nation, U.S., 2010 Census 5-Digit ZIP Code Tabulation Area (ZCTA5) National. Retrieved 9 Feb 2021 from https://www.census.gov/cgi-bin/geo/shapefiles/index.php.
[17] Anselin, Luc. 2003. Rate Maps and Smoothing. Retrieved 14 Jan 2018 from http://www.dpi.inpe.br/gilberto/tutorials/software/geoda/tutorials/w6_rates_slides.pdf

conceptual model. Table 19 lists these indicators, their sources, the years they were measured, and the health-related characteristics from the conceptual model they are primarily used to represent.

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

Conceptual Model Alignment			Indicator	Data Source	Time Period
Health Outcomes	Length of Life	Infant Mortality	Infant Mortality	County Health Rankings	2013 - 2019
		Life Expectancy	Child Mortality	County Health Rankings	2016 - 2019
			Life Expectancy	County Health Rankings	2017 - 2019
			Premature Age-Adjusted Mortality	County Health Rankings	2017 - 2019
			Premature Death	County Health Rankings	2017 - 2019
		Mortality	Stroke Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Chronic Lower Respiratory Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Diabetes Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Heart Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Hypertension Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Cancer Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Liver Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Kidney Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Suicide Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			Unintentional Injuries Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
			COVID-19 Mortality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2022-05-02
			COVID-19 Case Fatality	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2022-05-02
			Alzheimer's Disease Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Influenza and Pneumonia Mortality	CDPH California Vital Data (Cal-ViDa)	2015 - 2019
	Quality of Life	Morbidity	Diabetes Prevalence	County Health Rankings	2017
			Low Birthweight	County Health Rankings	2013 - 2019
			HIV Prevalence	County Health Rankings	2018
			Disability	2019 American Community Survey 5 year estimate variable S1810_C03_001E	2015 - 2019
			Poor Mental Health Days	County Health Rankings	2018
			Frequent Mental Distress	County Health Rankings	2018
			Poor Physical Health Days	County Health Rankings	2018
			Frequent Physical Distress	County Health Rankings	2018
			Poor or Fair Health	County Health Rankings	2018
			Colorectal Cancer Prevalence	California Cancer Registry	2013 - 2017
			Breast Cancer Prevalence	California Cancer Registry	2013 - 2017
			Lung Cancer Prevalence	California Cancer Registry	2013 - 2017
			Prostate Cancer Prevalence	California Cancer Registry	2013 - 2017
			COVID-19 Cumulative Incidence	CDPH COVID-19 Time-Series Metrics by County and State	Collected on 2022-05-02
			Asthma ED Rates	Tracking California	2018
			Asthma ED Rates for Children	Tracking California	2018
Health Factors	Health Behavior	Alcohol and Drug Use	Excessive Drinking	County Health Rankings	2018
			Drug Induced Death	CDPH 2021 County Health Status Profiles	2017 - 2019
		Diet and Exercise	Adult Obesity	County Health Rankings	2017
			Physical Inactivity	County Health Rankings	2017
			Limited Access to Healthy Foods	County Health Rankings	2015
			Food Environment Index	County Health Rankings	2015 & 2018

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Access to Exercise Opportunities	County Health Rankings	2010 & 2019
		Sexual Activity	Chlamydia Incidence	County Health Rankings	2018
			Teen Birth Rate	County Health Rankings	2013 - 2019
		Tobacco Use	Adult Smoking	County Health Rankings	2018
	Clinical Care	Access to Care	Primary Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Dental Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Mental Health Care Shortage Area	U.S. Heath Resources and Services Administration	2021
			Medically Underserved Area	U.S. Heath Resources and Services Administration	2021
			Mammography Screening	County Health Rankings	2018
			Dentists	County Health Rankings	2019
			Mental Health Providers	County Health Rankings	2020
			Psychiatry Providers	County Health Rankings	2020
			Specialty Care Providers	County Health Rankings	2020
			Primary Care Providers	County Health Rankings	2018; 2020
		Quality Care	Preventable Hospitalization	California Office of Statewide Health Planning and Development Prevention Quality Indicators for California	2019
			COVID-19 Cumulative Full Vaccination Rate	CDPH COVID-19 Vaccine Progress Dashboard Data	Collected on 2022-05-02
	Socio-Economic and Demographic Factors	Community Safety	Homicide Rate	County Health Rankings	2013 - 2019
			Firearm Fatalities Rate	County Health Rankings	2015 - 2019
			Violent Crime Rate	County Health Rankings	2014 & 2016

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Juvenile Arrest Rate	Criminal Justice Data: Arrests, OpenJustice, California Department of Justice	2015 - 2019
			Motor Vehicle Crash Death	County Health Rankings	2013 - 2019
		Education	Some College	County Health Rankings	2015 - 2019
			High School Completion	County Health Rankings	2015 - 2019
			Disconnected Youth	County Health Rankings	2015 - 2019
			Third Grade Reading Level	County Health Rankings	2018
			Third Grade Math Level	County Health Rankings	2018
		Employment	Unemployment	County Health Rankings	2019
		Family and Social Support	Children in Single-Parent Households	County Health Rankings	2015 - 2019
			Social Associations	County Health Rankings	2018
			Residential Segregation (Non-White/White)	County Health Rankings	2015 - 2019
		Income	Children Eligible for Free Lunch	County Health Rankings	2018 - 2019
			Children in Poverty	County Health Rankings	2019
			Median Household Income	County Health Rankings	2019
			Uninsured Population under 64	County Health Rankings	2018
			Income Inequality	County Health Rankings	2015 - 2019
	Physical Environment	Housing and Transit	Severe Housing Problems	County Health Rankings	2013 - 2017
			Severe Housing Cost Burden	County Health Rankings	2015 - 2019
			Homeownership	County Health Rankings	2015 - 2019
			Homelessness Rate	US Dept. of Housing and Urban Development 2020 Annual Homeless Assessment Report	2020

Conceptual Model Alignment			Indicator	Data Source	Time Period
			Households with no Vehicle Available	2019 American Community Survey 5-year estimate variable DP04_0058PE	2015 - 2019
			Long Commute - Driving Alone	County Health Rankings	2015 - 2019
			Access to Public Transit	OpenMobilityData, Transitland, TransitWiki.org, Santa Ynez Valley Transit; US Census Bureau	2021; 2020
		Air and Water Quality	Pollution Burden Percent	California Office of Environmental Health Hazard Assessment	2018
			Air Pollution - Particulate Matter	County Health Rankings	2016
			Drinking Water Violations	County Health Rankings	2019

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

County Health Rankings Data

All indicators listed with County Health Rankings (CHR) as their source were obtained from the 2021 County Health Rankings[18] dataset. This was the most common source of data, with 52 associated indicators included in the analysis. Indicators were collected at both the county and state levels. County-level indicators were used to represent the health factors and health outcomes in the service area. State-level indicators were collected to be used as benchmarks for comparison purposes. All variables included in the CHR dataset were obtained from other data providers. The original data providers for each CHR variable are given in Table 20.

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

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

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

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

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

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

California Department of Public Health

By-Cause Mortality Data

By-cause mortality data were obtained at the county and state level from the CDPH Cal-ViDa[19] online data query system for the years 2015-2019. Empirically bayes smoothed rates (EBRs) were calculated for

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

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

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

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

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

COVID-19 Data

Data on the cumulative number of cases and deaths[20] and completed vaccinations[21] for COVID-19 were used to calculate mortality, case-fatality, incidence, and vaccination rates. County mortality, incidence, and vaccination rates were calculated by dividing each of the respective values by the total population variable from the 2019 American Community Survey 5-year estimates table B01001, and then multiplying the resulting value by 100,000 to create rates per 100,000. Case-fatality rates were calculated by dividing COVID-19 mortality by the total number of cases, then multiplying by 100, representing the percentage of cases that ended in death.

[20] State of California, Department of Public Health. 2021. Statewide COVID-19 Cases Deaths Tests. Retrieved May 2, 2022, from https://data.chhs.ca.gov/dataset/f333528b-4d38-4814-bebb-12db1f10f535/resource/046cdd2b-31e5-4d34-9ed3-b48cdbc4be7a/download/covid19cases_test.csv.

[21] State of California, Department of Public Health. 2021. COVID-19 Vaccine Progress Dashboard Data . Retrieved May 2 2022 from https://data.chhs.ca.gov/dataset/e283ee5a-cf18-4f20-a92c-ee94a2866ccd/resource/130d7ba2-b6eb-438d-a412-741bde207e1c/download/covid19vaccinesbycounty.csv.

Drug-Induced Deaths Data

Drug-induced death rates were obtained from Table 19 of the 2021 County Health Status Profiles[22] and report age-adjusted deaths per 100,000.

U.S. Heath Resources and Services Administration

Indicators related to the availability of healthcare providers were obtained from the Health Resources and Services Administration[23] (HRSA). These included Dental, Mental Health, and Primary Care Health Professional Shortage Areas and Medically Underserved Areas/Populations. They also included the number of specialty care providers and psychiatrists per 100,000 residents, derived from the county-level Area Health Resource Files.

Health Professional Shortage Areas

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

Psychiatry and Specialty Care Providers

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

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

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

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

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

California Cancer Registry

Data obtained from the California Cancer Registry[24] includes age-adjusted incidence rates for colon and rectum, female breast, lung and bronchus, and prostate cancer sites for counties and the state. Reported rates were based on data from 2013 to 2017, and report cases per 100,000. For low-population counties, rates were calculated for a group of counties rather than for individual counties. That group rate was used in this report to represent incidence rates for each individual county in the group.

Tracking California

Data on emergency department visits rates for all ages as well as children aged 5 to 17 were obtained from Tracking California.[25] These data reported age-adjusted rates per 10,000. They were multiplied by 100 in this analysis to convert them to rates per 100,000 to make them more comparable to the standard used for other rate indicators.

US Census Bureau

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

California Office of Environmental Health Hazard Assessment

Data used to calculate the pollution burden percent indicator were obtained from the CalEnviroscreen 3.0[26] dataset produced by the California Office of Environmental Health Hazard Assessment. This indicator reports the percentage of the population within a given county, or within the state as a whole, that live in a US Census tract with a CalEnviroscreen 3.0 Pollution Burden score in the 50th percentile or higher. Data on total population came from Table B03002 from the 2019 American Community Survey 5-year Estimates dataset.

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[24] California Cancer Registry. 2021. Age-Adjusted Invasive Cancer Incidence Rates in California. Retrieved on 22 Jan 2021 from https://www.cancer-rates.info/ca/.
[25] Tracking California, Public Health Institute. 2021. Asthma Related Emergency Department & Hospitalization data. Retrieved on 24 Jun 2021 from www.trackingcalifornia.org/asthma/query.
[26] California Office of Environmental Health Hazard Assessment. 2018. CalEnviroScreen 3.0. Retrieved on 22 Jan 2021 from https://oehha.ca.gov/calenviroscreen/maps-data.

California Department of Health Care Access and Information

Data on preventable hospitalizations were obtained from the California Department of Health Care Access and Information (formerly Office of Statewide Health Planning and Development) Prevention Quality Indicators.[27] These data are reported as risk-adjusted rates per 100,000.

California Department of Justice

Data reporting the total number of juvenile felony arrests was obtained from the California Department of Justice.[28] This indicator reports the rate of felony arrests per 1,000 juveniles under the age of 18. It was calculated by dividing the total number of juvenile felony arrests for each county or state from 2015 - 2019 by the total population under 18 as reported in Table B01001 in the 2017 American Community Survey 5-year Estimates program. Population data from 2017 were used as this was the central year of the period over which juvenile felony arrest data were obtained. Population figures from 2017 were multiplied by 5 to match the years of arrest data used. Empirical bayes smoothed rates were calculated to increase the reliability of rates calculated for small counties. Finally, juvenile felony arrest rates were also calculated for Black, White, and Hispanic populations following the same manner, but using input population data from 2017 American Community Survey 5-year Estimates Tables B01001H, B01001B, and B01001I, respectively.

US Department of Housing and Urban Development

Data from the US Department of Housing and Urban Development's 2020 Annual Homeless Assessment Report[29] were used to calculate homelessness rates for the counties and state. This data reported point-in-time (PIT) homelessness estimates for individual Continuum of Care (CoC) organizations across the state. Each CoC works within a defined geographic area, which could be a group of counties, an individual county, or a portion of a county.

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

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

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

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

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

Proximity to Transit Stops

The proximity to transit stops variable reports the percent of county and state population that lives in a US Census block located within 1/4 mile of a fixed transit stop. Two sets of information were needed in order to calculate this indicator: total population at the Census block level, and the location of transit stops. Due to delays in data releases stemming from the COVID-19 pandemic, the most recent Census block population data available at the time of the analysis was from the 2010 Decennial Census,[30] so this was the data used to represent the distribution of population for this indicator.

Transit stop data were identified first by using tools in the TidyTransit[31] library for the R statistical programming language.[32] This was used to identify transit providers with stops located within 100 miles of the state boundaries. A search for transit stops for these agencies, as well as all other transit agencies in the state, was conducted by reviewing three main online sources: OpenMobilityData,[33] Transitland,[34] Transitwiki.org,[35] and Santa Ynez Valley Transit.[36] Each of these websites list public transit data that have been made public by transit agencies. Transit data from all providers that could be identified were downloaded, and fixed transit stop locations were extracted from them.

The sf[37] library in R was then used to calculate 1/4 mile (402.336 meter) buffers around each of these transit stops, and then to identify which Census blocks fell within these areas. The total population of all tracts within the buffer of the stops was then divided by the total population of each county or state to generate the final indicator value.

Detailed Analytical Methodology

The collected and processed primary and secondary data were integrated in three main analytical stages. First, secondary health outcome and health factor data were combined with area-wide key informant interviews help identify Communities of Concern. These Communities of Concern could potentially include geographic regions as well as specific sub-populations bearing disproportionate health burdens. This information was used to focus the remaining interview and focus-group collection

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[30] US Census Bureau. 2011. Census Blocks with Population and Housing Counts. Retrieved 7 Jun 2021 from https://www2.census.gov/geo/tiger/TIGER2010BLKPOPHU/.
[31] Flavio Poletti, Daniel Herszenhut, Mark Padgham, Tom Buckley, and Danton Noriega-Goodwin. 2021. tidytransit: Read, Validate, Analyze, and Map Files in the General Transit Feed Specification. R package version 1.0.0. Retreived 10 Sep 2021 from https://CRAN.R-project.org/package=tidytransit.
[32] R Core Team (2021). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL https://www.R-project.org/.
[33] OpenMobilityData. 2021. California, USA. Retrieved all feeds listed on 31 May to 1 June 2021 from https://openmobilitydata.org/l/67-california-usa.
[34] Transitland. 2021. Transitland Operators. Retrieved all operators with California locations on 31 May to 1 June 2021 from https://www.transit.land/operators.
[35] Transitwiki.org. 2021. List of publicly-accessible transportation data feeds: dynamic and others. Retrieved on 31 May to 1 June 2021 from https://www.transitwiki.org/TransitWiki/index.php/Publicly-accessible_public_transportation_data#List_of_publicly-accessible_public_transportation_data_feeds:_dynamic_data_and_others.
[36] Santa Ynez Valley Transit. GTFS Files. Retrieved 1 Jun 2021 from http://www.cityofsolvang.com/DocumentCenter/View/2756/syvt_gtfs_011921.
[37] Pebesma, E., 2018. Simple Features for R: Standardized Support for Spatial Vector Data. The R Journal 10 (1), 439-446, https://doi.org/10.32614/RJ-2018-009.

efforts on those areas and subpopulations. Next, the resulting data, along with the results from the service provider survey, were combined with secondary health need identification data to identify SHNs within the service area. Finally, primary data were used to prioritize those identified SHNs. The specific details for these analytical steps are given in the following three sections.

Community of Concern Identification

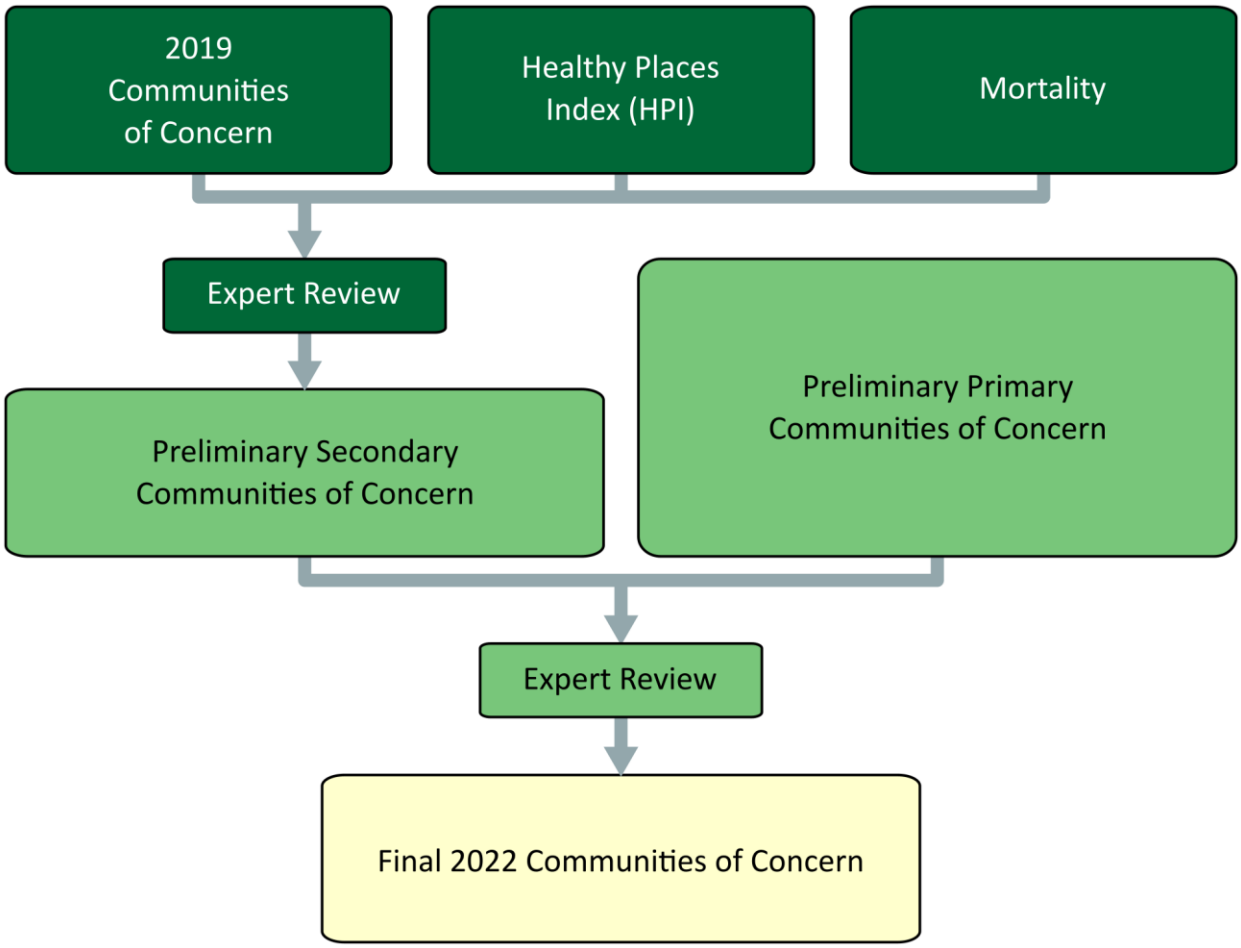

Figure 8: Community of Concern identification process.

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

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

2019 Community of Concern

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

Healthy Places Index (HPI)

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

CDPH Mortality Data

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

Integration of Secondary Criteria

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

Preliminary Primary Communities of Concern

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

Integration of Preliminary Primary and Secondary Communities of Concern

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

Significant Health Need Identification

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

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

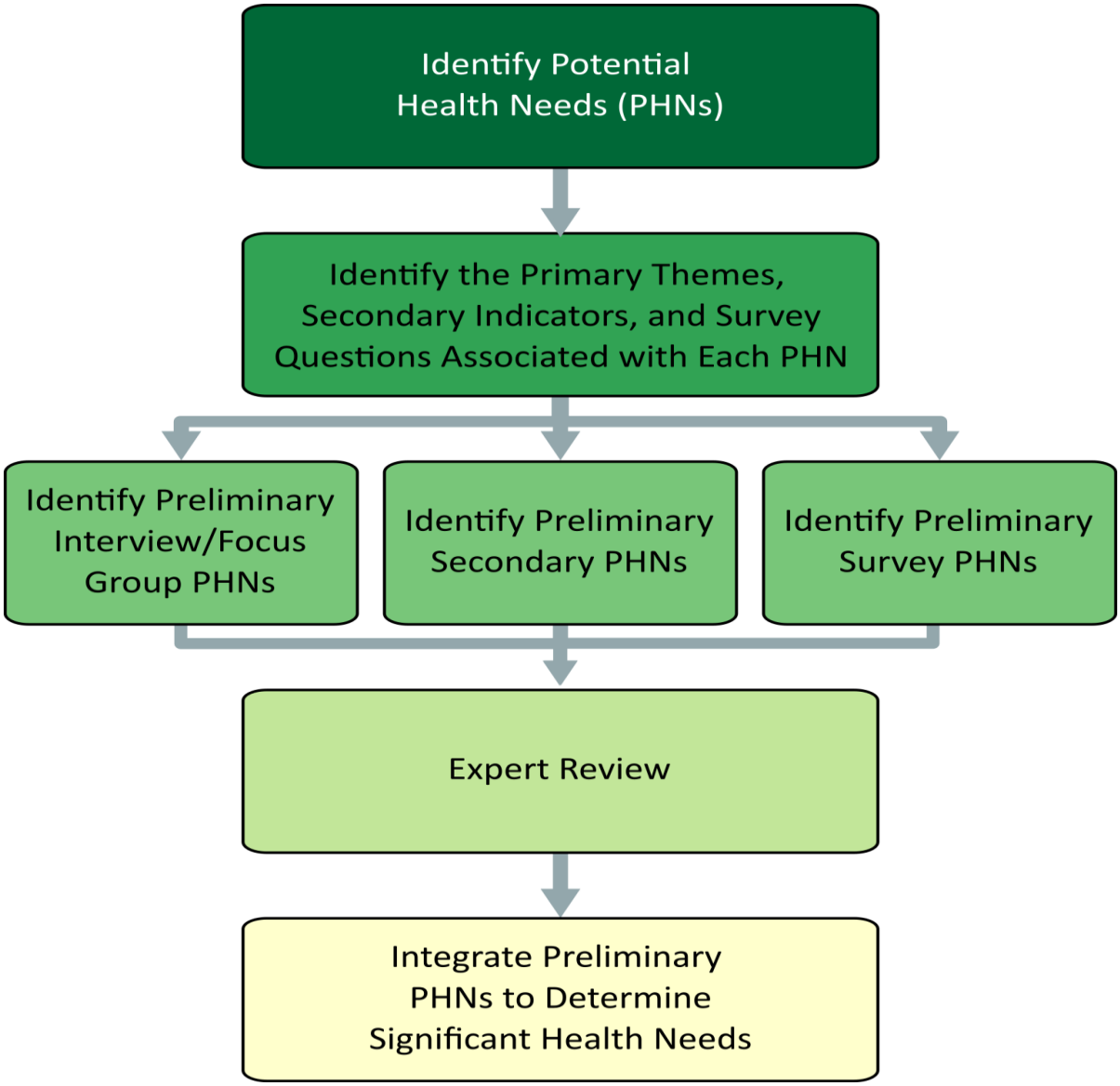

Figure 9: Significant health need identification process.

Table 21: 2022 Potential Health Needs.

Potential Health Needs (PHNs)	
PHN1	Access to Mental/Behavioral Health and Substance Use Services
PHN2	Access to Quality Primary Care Health Services
PHN3	Active Living and Healthy Eating
PHN4	Safe and Violence-Free Environment
PHN5	Access to Dental Care and Preventive Services
PHN6	Healthy Physical Environment

Potential Health Needs (PHNs)	
PHN7	Access to Basic Needs Such as Housing, Jobs, and Food
PHN8	Access to Functional Needs
PHN9	Access to Specialty and Extended Care
PHN10	Injury and Disease Prevention and Management
PHN11	Increased Community Connections
PHN12	System Navigation

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

Access to Mental/Behavioral Health and Substance Use Services

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

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

Access to Quality Primary Care Health Services

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

Primary Themes	Secondary Indicators
Insurance is unaffordable. Wait-times for appointments are excessively long. Out-of-pocket costs are too high. There aren't enough primary care service providers in the area. Patients have difficulty obtaining appointments outside of regular business hours. Too few providers in the area accept Medi-Cal. It is difficult to recruit and retain primary care providers in the region. Specific services are unavailable here (e.g., 24-hour pharmacies, urgent care, telemedicine). The quality of care is low (e.g., appointments are rushed, providers lack cultural competence). Patients seeking primary care overwhelm local emergency departments. Primary care services are available but are difficult for many people to navigate.	Infant Mortality Child Mortality Life Expectancy Premature Age-Adjusted Mortality Premature Death Stroke Mortality Chronic Lower Respiratory Disease Mortality Diabetes Mortality Heart Disease Mortality Hypertension Mortality Cancer Mortality Liver Disease Mortality Kidney Disease Mortality COVID-19 Mortality COVID-19 Case Fatality Alzheimer's Disease Mortality Influenza and Pneumonia Mortality Diabetes Prevalence Low Birthweight Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health Colorectal Cancer Prevalence Breast Cancer Prevalence Lung Cancer Prevalence Prostate Cancer Prevalence Asthma ED Rates Asthma ED Rates for Children Primary Care Shortage Area Medically Underserved Area Mammography Screening Primary Care Providers Preventable Hospitalization COVID-19 Cumulative Full Vaccination Rate Residential Segregation (Non-White/White) Uninsured Population under 64

Primary Themes	Secondary Indicators
	Income Inequality
	Homelessness Rate

Active Living and Healthy Eating

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

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

Primary Themes	Secondary Indicators
	Alone
	Access to Public Transit

Safe and Violence-Free Environment

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

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

Access to Dental Care and Preventive Services

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

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

Primary Themes	Secondary Indicators
	Income Inequality
	Homelessness Rate

Healthy Physical Environment

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

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

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

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

Primary Themes	Secondary Indicators
Lack of affordable housing is a significant issue in the area.	Infant Mortality
The area needs additional low-income housing options.	Child Mortality
Poverty in the county is high.	Life Expectancy
Many people in the area do not make a living wage.	Premature Age-Adjusted Mortality
Employment opportunities in the area are limited.	Premature Death

Primary Themes	Secondary Indicators
Services for homeless residents in the area are insufficient. Services are inaccessible for Spanish-speaking and immigrant residents. Many residents struggle with food insecurity. It is difficult to find affordable childcare. Educational attainment in the area is low.	Hypertension Mortality COVID-19 Mortality COVID-19 Case Fatality Diabetes Prevalence Low Birthweight Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days Frequent Physical Distress Poor or Fair Health COVID-19 Cumulative Incidence Asthma ED Rates Asthma ED Rates for Children Drug Induced Death Adult Obesity Limited Access to Healthy Foods Food Environment Index Medically Underserved Area COVID-19 Cumulative Full Vaccination Rate Some College High School Completion Disconnected Youth Third Grade Reading Level Third Grade Math Level Unemployment Children in Single-Parent Households Social Associations Residential Segregation (Non-White/White) Children Eligible for Free Lunch Children in Poverty Median Household Income Uninsured Population under 64 Income Inequality Severe Housing Problems Severe Housing Cost Burden Homeownership Homelessness Rate Households with no Vehicle Available Long Commute - Driving Alone

Access to Functional Needs

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

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

Access to Specialty and Extended Care

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

Primary Themes	Secondary Indicators
Wait-times for specialist appointments are excessively long. It is difficult to recruit and retain specialists in the area. Not all specialty care is covered by insurance. Out-of-pocket costs for specialty and extended care are too high. People have to travel to reach specialists. Too few specialty and extended care providers accept Medi-Cal. The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care) There isn't enough OB/GYN care available. Additional hospice and palliative care options are needed. The area lacks a kind of specialist or extended care option not listed here.	Infant Mortality Life Expectancy Premature Age-Adjusted Mortality Premature Death Stroke Mortality Chronic Lower Respiratory Disease Mortality Diabetes Mortality Heart Disease Mortality Hypertension Mortality Cancer Mortality Liver Disease Mortality Kidney Disease Mortality COVID-19 Mortality COVID-19 Case Fatality Alzheimer's Disease Mortality Diabetes Prevalence Poor Mental Health Days Frequent Mental Distress Poor Physical Health Days

Primary Themes	Secondary Indicators
	Frequent Physical Distress Poor or Fair Health Lung Cancer Prevalence Asthma ED Rates Asthma ED Rates for Children Drug Induced Death Psychiatry Providers Specialty Care Providers Preventable Hospitalization Residential Segregation (Non-White/White) Income Inequality Homelessness Rate

Injury and Disease Prevention and Management

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

Primary Themes	Secondary Indicators
There isn't really a focus on prevention around here. Preventive health services for women are needed (e.g., breast and cervical cancer screening). There should be a greater focus on chronic disease prevention (e.g., diabetes, heart disease). Vaccination rates are lower than they need to be. Health education in the schools needs to be improved. Additional HIV and STI prevention efforts are needed. The community needs nutrition education opportunities. Schools should offer better sexual health education. Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, the elderly, LGBTQ individuals, immigrants). 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 Liver Disease Mortality Kidney Disease Mortality Suicide Mortality Unintentional Injuries Mortality COVID-19 Mortality COVID-19 Case Fatality Alzheimer's Disease Mortality Diabetes Prevalence Low Birthweight HIV Prevalence Poor Mental Health Days Frequent Mental Distress Frequent Physical Distress Poor or Fair Health COVID-19 Cumulative Incidence

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

Increased Community Connections

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

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

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

System Navigation

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

Primary Themes	Secondary Indicators
People may not be aware of the services they are eligible for. It is difficult for people to navigate multiple, different health care systems. The area needs more navigators to help to get people connected to services. People have trouble understanding their insurance benefits.	

Primary Themes	Secondary Indicators
Automated phone systems can be difficult for those who are unfamiliar with the healthcare system	
Dealing with medical and insurance paperwork can be overwhelming.	
Medical terminology is confusing.	
Some people just don't know where to start in order to access care or benefits.	

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

Table 34: Benchmark comparisons to show indicator performance.

Indicator	Benchmark Comparison Indicating Poor Performance
Infant Mortality	Higher
Child Mortality	Higher
Life Expectancy	Lower
Premature Age-Adjusted Mortality	Higher
Premature Death	Higher
Stroke Mortality	Higher
Chronic Lower Respiratory Disease Mortality	Higher
Diabetes Mortality	Higher
Heart Disease Mortality	Higher
Hypertension Mortality	Higher
Cancer Mortality	Higher
Liver Disease Mortality	Higher
Kidney Disease Mortality	Higher
Suicide Mortality	Higher
Unintentional Injuries Mortality	Higher
COVID-19 Mortality	Higher
COVID-19 Case Fatality	Higher
Alzheimer's Disease Mortality	Higher
Influenza and Pneumonia Mortality	Higher
Diabetes Prevalence	Higher
Low Birthweight	Higher
HIV Prevalence	Higher
Disability	Higher
Poor Mental Health Days	Higher
Frequent Mental Distress	Higher
Poor Physical Health Days	Higher
Frequent Physical Distress	Higher
Poor or Fair Health	Higher

Indicator	Benchmark Comparison Indicating Poor Performance
Colorectal Cancer Prevalence	Higher
Breast Cancer Prevalence	Higher
Lung Cancer Prevalence	Higher
Prostate Cancer Prevalence	Higher
COVID-19 Cumulative Incidence	Higher
Asthma ED Rates	Higher
Asthma ED Rates for Children	Higher
Excessive Drinking	Higher
Drug Induced Death	Higher
Adult Obesity	Higher
Physical Inactivity	Higher
Limited Access to Healthy Foods	Higher
Food Environment Index	Lower
Access to Exercise Opportunities	Lower
Chlamydia Incidence	Higher
Teen Birth Rate	Higher
Adult Smoking	Higher
Primary Care Shortage Area	Present
Dental Care Shortage Area	Present
Mental Health Care Shortage Area	Present
Medically Underserved Area	Present
Mammography Screening	Lower
Dentists	Lower
Mental Health Providers	Lower
Psychiatry Providers	Lower
Specialty Care Providers	Lower
Primary Care Providers	Lower
Preventable Hospitalization	Higher
COVID-19 Cumulative Full Vaccination Rate	Lower
Homicide Rate	Higher
Firearm Fatalities Rate	Higher
Violent Crime Rate	Higher
Juvenile Arrest Rate	Higher
Motor Vehicle Crash Death	Higher
Some College	Lower
High School Completion	Lower
Disconnected Youth	Higher
Third Grade Reading Level	Lower
Third Grade Math Level	Lower
Unemployment	Higher
Children in Single-Parent Households	Higher
Social Associations	Lower
Residential Segregation (Non-White/White)	Higher
Children Eligible for Free Lunch	Higher
Children in Poverty	Higher
Median Household Income	Lower

Indicator	Benchmark Comparison Indicating Poor Performance
Uninsured Population under 64	Higher
Income Inequality	Higher
Severe Housing Problems	Higher
Severe Housing Cost Burden	Higher
Homeownership	Lower
Homelessness Rate	Higher
Households with no Vehicle Available	Higher
Long Commute - Driving Alone	Higher
Access to Public Transit	Lower
Pollution Burden Percent	Higher
Air Pollution - Particulate Matter	Higher
Drinking Water Violations	Present

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

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

For this report, a PHN was selected as a preliminary quantitative significant health need if 50% of the associated quantitative indicators were identified as performing poorly; as a preliminary qualitative significant health need if it was identified by 50% or more of the primary sources as performing poorly; and as a preliminary community survey provider survey significant health need if it was identified by at least 50% of survey respondents. Finally, a PHN was selected as a significant health need if it was included as a preliminary significant health need in two of three of these categories.

Health Need Prioritization

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

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

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

Detailed List of Resources to Address Health Needs

Table 35: Resources available to meet health needs.

Organization Information			Significant Health Needs							Other Health Needs				
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Mental/Behavioral Health and Substance Use Services	Access to Quality Primary Care Health Services	Active Living and Healthy Eating	Access to Specialty and Extended Care	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services	Access to Functional Needs	Injury and Disease Prevention and Management	Increased Community Connections	System Navigation
Acres of Hope	95603	www.acresofhopeonline.org	x						x					x
Advocates for the Mentally Ill Housing Inc.	95603	www.amihousing.org/home.html	x	x										
Agency on Aging- Area 4	95815	agencyonaging4.org/placer-county	x	x	x		x		x		x	x		x
Alta California Regional Center	95945	www.altaregional.org/post/roseville-1	x	x		x								
American Red Cross	95815	www.redcross.org/local/california/gold-country.html	x		x							x	x	
Auburn Interfaith Food Closet	95602	auburnfoodcloset.org	x											
Auburn Renewal Center	95602	www.auburnclinic.org		x	x					x		x	x	
Boys and Girls Clubs of Placer County	Placer County	bgcplacercounty.org	x	x		x			x				x	
Brookdale Senior Living	95602, 95661	www.brookdale.com/en.html			x	x	x		x				x	
Chapa-De Indian Health	95603	chapa-de.org		x	x		x			x		x		x
County of Placer- Whole Person Care	95603	www.placer.ca.gov/2972/Whole-Person-Care-WPC	x	x	x									x
Express Rides	95603	(530) 575-0001									x		x	
First 5 Placer	95603	www.first5placer.org	x	x	x	x			x	x		x	x	
Forgotten Soldier Program	95603	forgottensoldierprogram.com		x	x	x								
Granite Wellness Centers	95661	www.granitewellness.org	x	x	x	x						x		x
Keaton's Child Cancer Alliance	95661	childcancer.org		x								x		x

Organization Information			Significant Health Needs							Other Health Needs				
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Mental/Behavioral Health and Substance Use Services	Access to Quality Primary Care Health Services	Active Living and Healthy Eating	Access to Specialty and Extended Care	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services	Access to Functional Needs	Injury and Disease Prevention and Management	Increased Community Connections	System Navigation
KidsFirst	Placer County	www.kidsfirstnow.org	x	x		x			x			x	x	
Latino Leadership Council	95678, 95648	www.latinoleadershipcouncil.org	x		x								x	
Legal Services of Northern California-Health Rights	95603	lsnc.net	x											
Lighthouse Counseling & Family Resource Center	95648	lighthousefrc.org	x	x		x							x	
Lilliput Children's Services	95610	www.lilliput.org	x										x	
Lincoln Community Foundation	95648	lincolncommunityfoundation.org/contact-us											x	
Meals on Wheels	Placer County	seniorsfirst.org/2017/06/23/meals-on-wheels-placer-county	x										x	
Parent Project (Placer County)	95661	parentproject.com	x	x									x	
Placer Collaborative Network	95603	placercollaborativenetwork.org/index.html	x										x	
Placer Community Foundation	95603	placercf.org	x										x	
Placer County	95603	www.placer.ca.gov	x	x		x							x	
Placer County Adult System of Care	95678	www.placer.ca.gov/2158/Adult-System-of-Care	x	x	x				x					x
Placer County CalFresh	95765	www.placer.ca.gov/2103/CalFresh-Food-Stamps	x										x	
Placer County Children's System of Care	95765	www.placer.ca.gov/2050/Childrens-System-of-Care	x	x					x					x
Placer County- Dial-A-Ride	95603	www.placer.ca.gov/1793/Dial-A-Ride									x		x	

Organization Information			Significant Health Needs							Other Health Needs				
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Mental/Behavioral Health and Substance Use Services	Access to Quality Primary Care Health Services	Active Living and Healthy Eating	Access to Specialty and Extended Care	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services	Access to Functional Needs	Injury and Disease Prevention and Management	Increased Community Connections	System Navigation
Placer County- Health Education Council	95603	www.placer.ca.gov/3027/Community-Health-Education	x										x	
Placer County Human Services	95765	www.placer.ca.gov/2096/Human-Services	x											x
Placer County Mental Health Services	95678	www.placer.ca.gov/2166/Mental-Health-Services	x	x										x
Placer County Office of Education (PCOE)	95603	www.placercoe.org/Pages/PCOE/Home.aspx	x											x
Placer County Public Health	95603	www.placer.ca.gov/2863/Public-Health												
Placer County Public Health Nursing	95603	www.placer.ca.gov/2912/Public-Health-Nursing	x		x	x						x		
Placer County WIC	95765	www.placer.ca.gov/2918/Women-Infants-Children-WIC	x		x	x						x		x
Placer Food Bank	95678	placerfoodbank.org	x			x							x	
Placer Independent Resource Services (PIRS)	95603	www.pirs.org	x			x							x	
Roseville Joint Union High School District	95661	www.rjuhsd.us	x						x					x
Seniors First	95602	seniorsfirst.org	x	x					x		x			
Shady Creek Outdoor School and Event Center	95959	www.shadycreek.org												
Sierra College Foundation	95677	www.sierracollege.edu/about-us/sierra-college-foundation/index.php							x				x	
Sierra Community Medical Foundation	95677	www.scmfoundation.org		x	x									x
Sierra Community Medical Foundation	95677	www.scmfoundation.org		x	x									x
Sierra Foothills Outpatient Clinic	95603	www.va.gov/directory/guide/facility.asp?ID=986		x	x									x

Organization Information			Significant Health Needs							Other Health Needs				
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Mental/Behavioral Health and Substance Use Services	Access to Quality Primary Care Health Services	Active Living and Healthy Eating	Access to Specialty and Extended Care	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services	Access to Functional Needs	Injury and Disease Prevention and Management	Increased Community Connections	System Navigation
Sierra Health Foundation	95833	www.sierrahealth.org		x	x	x			x			x		x
Sierra Mental Wellness Group	95661	sierramentalwellness.org		x										x
Sierra Native Alliance	95603	sierranativealliance.org		x		x		x					x	
St. Vincent De Paul Society of Roseville	95678	www.placersvdp.com	x		x								x	
Stand Up Placer	95661	standupplacer.org	x	x					x				x	
Stanford Sierra Youth and Families *change web	95603	www.ssyaf.org		x					x				x	
Sutter Auburn Faith Hospital	95602	www.sutterhealth.org/auburn			x		x					x		x
Sutter Health- Auburn Urgent Care Clinic	95602	www.sutterhealth.org/find-location/facility/auburn-urgent-care			x									x
The Gathering Inn	95678	www.thegatheringinn.com	x	x	x									x
The Gathering Inn- Interim Care Program (ICP)	95603	www.thegatheringinn.com/auburn-interim-care-program	x		x						x			x
The Salvation Army	95603	auburn.salvationarmy.org/auburn	x										x	
The Salvation Army- Del Oro Division	95603	deloro.salvationarmy.org	x	x	x								x	
WarmLine Family Resource Center	95818	www.warmlinefrc.org	x	x	x								x	
WellSpace Health	95603	www.wellspacehealth.org		x	x					x		x		x
Western Sierra Medical Clinic	95603	wsmcmed.org		x	x		x			x		x		x
What Would Jesus Do, Inc.	95678	www.wwjdinc.org	x										x	

Organization Information			Significant Health Needs							Other Health Needs				
Name	Primary ZIP Code	Website	Access to Basic Needs Such as Housing, Jobs, and Food	Access to Mental/Behavioral Health and Substance Use Services	Access to Quality Primary Care Health Services	Active Living and Healthy Eating	Access to Specialty and Extended Care	Healthy Physical Environment	Safe and Violence-Free Environment	Access to Dental Care and Preventive Services	Access to Functional Needs	Injury and Disease Prevention and Management	Increased Community Connections	System Navigation
Women's Health Specialists	95945	www.womenshealthspecialists.org			x									
YMCA of Superior California	95945	www.ymcasuperiorcal.org	x			x			x				x	
Zafia's Family House	95678	zafiasfamilyhouse.org	x										x	

Limits and Information Gaps

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

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

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

Appendix A: Evaluation of the Impact of Actions Taken Since 2019 CHNA – Sutter Auburn Faith Hospital

ACCESS TO QUALITY PRIMARY HEALTHCARE SERVICES

Name of program/activity/initiative	Promotora Program – Latino Leadership Council
Description	The Promotora program is the only program regionally that uses Promotores to help uninsured and underinsured Latinos get access to health, dental, vision and mental health services and to teach them how to effectively navigate the health care system. Promotores conduct home visits during evenings and weekends to help participants learn how to properly and effectively engage the health care system, provide them with important health information and ensure that they find a medical home or other culturally and linguistically appropriate supports such as specialty care, mental health, or family wellness.
Goals	Provide access to health, dental, vision and mental health for Latino adults through Promotores.
Outcomes	• 2021: 991 total adults, youth and families served; 3,569 total services provided; 3,891 referrals made; 436 obtained basic needs. • 2020: 652 total adults, youth and families served; 2,324 total services provided; 1,830 referrals made; 517 obtained basic needs. • 2019: 446 total adults, youth and families served; 177 total services provided; 648 referrals made; 39 obtained basic needs.

Name of program/activity/initiative	ED Navigator/Triage, Treat, Transport (T3) Program
Description	The WellSpace Health ED Navigator/ T3 Case Manager program provides case management services for people who frequent the emergency departments for non-urgent needs. The case manager works both in the hospital and in the community providing support to enrolled individuals. The Case Manager, receives referrals from hospital staff for patients who frequently utilize the emergency department for care that can be provider at a lower level of care and social needs. Once enrolled, the case manager provides wraparound services including but not limited to establishing a primary health care home, housing assistance, insurance enrollment, substance abuse treatment, life skills, income (SSA and GA), medical and behavioral health services, transportation, and other key community resources.
Goals	1. Reduce the frequency of individuals utilizing high cost systems of care 2. Coordinate and link clients to a medical and behavioral health home 3. Provide wraparound case management services to the under-served 4. Educate and assist clients with additional community resources

Outcomes	• 2021: Served 147 total clients; provided 523 direct services; made 3,604 referrals to other support services. • 2020: Served 55 total clients; provided 486 direct services; made 4,103 referrals to other support services. • 2019: Served 315 total clients; provided 336 direct services; made 2,103 referrals to other support services.

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

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

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

Name of	The Gathering Inn – Interim Care Program

program/activity/initiative	
Description	The Gathering Inn's Interim Care Program provides homeless individuals a safe place to rest and recover following hospital discharge. Its housing first model, and low barrier approach, make it a viable option to being discharged to the street and have a positive effect on health and housing outcomes. Guests of the program reside in a 5 bedroom fully furnished home and have access to showers, computers, cable television, laundry services, food, and clothes. In addition to meeting the basic needs of guests, the program provides intensive case management. Case management works with guests daily, helping to connect them to health care providers, income assistance programs, housing opportunities, and more. Since its inception in 2009, the Interim Care Program has served over 600 individuals.
Goals	1. To improve the health outcomes of homeless individuals. 2. To break the costly cycle of emergency room as first-line medical care. 3. To reduce recidivism and facilitate healing, recovery, and hope 4. To reduce health inequity by providing appropriate accommodation for recovery. 5. To transition patients to permanent supportive housing after their stay.
Outcomes	• 2021: Served 81 adults; provided 8,149 direct services; made 405 referrals to support services. • 2020: Served 61 adults; provided 4,557 direct services; made 430 referrals to support services. • 2019: Served 54 adults; provided 235 direct services; made 353 referrals to support services.

ACCESS TO MENTAL/BEHAVIORAL/SUBSTANCE ABUSE SERVICES

Name of program/activity/initiative	Area Wide Mental Health Strategy
Description	The need for mental health services and resources, especially for the underserved, has reached a breaking point across the Sutter Health Valley Operating Unit. This is why we are focused on building a comprehensive mental health strategy that integrates key elements such as policy and advocacy, county specific investments, stigma reduction, increased awareness, and education, with tangible outreach such as expanded mental health resources to professionals in the workplace and tele psych options to the underserved.
Goals	By linking these various strategies and efforts through engaging in statewide partnerships, replicating best practices, and securing innovation grants and award opportunities, we have the ability to create a seamless network of mental health care resources so desperately needed in the communities we serve.
Outcomes	In 2020, the mental health strategy helped with the following initiatives: • Advance legislation that expands the California Mental Health Parity Act and ensures that medical necessity coverage determinations are consistent with generally accepted standards of care. This legislation -- Senate Bill 855 – passed in

	June 2020. • Additionally, based on parity advocacy, the Governor publicly touted parity enforcement as a priority on a number of occasions and the enacted budget for California includes over $2.7 million in additional resources for the Department of Managed Health Care (DMHC) to enforce parity this year with $4.7 million annually thereafter. In 2021, the mental health strategy helped with the following initiatives: • Launch the 988 crisis line going live on July 26, 2022 • Pass SB803 for peer certification. • Secure funding for SB71/Bring CA Home in amount of $2 billion over two years and an unspecified amount future funding. • Advocate for funding for board and care with the County Behavioral Health Directors Association and other organizations serving people living with severe mental illness and/or substance use disorder. Resulting in securing $803 million, with program details still to be fleshed out. • Propose Children and Youth Initiative and assist Secretary Ghaly to develop what became one of the Governor's signature budget achievements: $4.5 billion over five years to meet the behavioral health needs of children.

Name of program/activity/initiative	Lighthouse Counseling and Family Resource Center Family Wellness Program
Description	Our Family Wellness Initiative provides comprehensive counseling services and a wide variety of family wellness classes for children and families who are negatively affected by trauma, anxiety and depression, family attachment issues, domestic violence, child abuse and neglect, crime, poor mental health, and other forms of familial distress. Our goals are to help families heal by establishing long-term safety, self-sufficiency, and positive health outcomes. We accomplish this through an inclusive approach that incorporates case management and referral services, counseling and parental support, and a variety of educational classes.
Goals	Programs goals include the following: 1) Improve the quality of life for Placer County families and the community as a whole by providing quality evidence-based mental health counseling services (individual and/or group therapy) and educational classes for up to 150 individuals. 2) Reduce the incidences of familial violence, and child abuse and neglect in Placer County. 3) Provide intensive case management for Placer County families we serve by connecting them to critical resources such as Medi-Cal, Cal-Fresh, rent and utility assistance, diapers, bus passes, back-to-school supplies, seasonal assistance, Christmas toys, reconditioned bicycles, and gift cards for food, gas, and clothing. 4) Our primary goal is to build strong families and in turn strong

	communities.
Outcomes	• 2021: Served 675 adults, 491 children/youth and 872 families; provided 1,609 counseling sessions; made referrals to 1,121 support services. • 2020: Served 1,981 adults, 1,732 children/youth and 1,325 families; provided 2,676 counseling sessions; made referrals to 1,670 support services.

INJURY AND DISEASE PREVENTION AND MANAGEMENT

Name of program/activity/initiative	Telehealth Diabetes Prevention Program – Chapa De Indian Health
Description	Chapa-De's Diabetes Prevention Program (DPP) is a year-long program that helps Chapa-De patients to avoid the onset of diabetes and to live healthier. Using CDC teaching materials proven to promote weight loss and lifestyle change, Chapa-De lifestyle coaches teach participants about eating healthy, being physically active and managing stress. Participants attend weekly classes for10 weeks, then 6 bi-weekly classes, followed by optional monthly sessions to help maintain weight loss and healthy lifestyles.
Goals	Utilize a video telehealth platform to engage 40 individuals who have been identified as at-risk for type II diabetes to participate in our Diabetes Prevention Program to receive virtual instruction, support, and assistance along with all necessary equipment and supplies to empower them to live healthier lives, lose weight, prevent diabetes, and heart disease.
Outcomes	• 2021: 113 total adults served; 486 total services provided.

ACCESS AND FUNCTIONAL NEEDS

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

HEALTHY EATING AND ACTIVE LIVING

Name of program/activity/initiative	Shady Creek Outdoor Education Foundation: FitQuest
Description	The three tenets of Fit Quest are nutrition, physical activity, and mental wellness and the students' overall health. The Fit Quest program serves students in the 5th and 6th grades (ages 9-13 years old in their respective communities) either in the classroom or, if the school permits, by interactive virtual assemblies (at least 2 site visits, if approved by the school) to accommodate current health concerns. In addition, Fit Quest hosts Family Camp once a year allowing the program to share its objectives, tenets, and encouraging families to eat healthier, engage in physical fitness and instill behaviors to improve their overall mental health as a family unit.
Goals	• Reduce the number of children at risk or, by definition, obese with long term effect of reducing community health care costs. • Increase mindfulness, individual uniqueness, awareness of emotional triggers and responses, tools, and resources for navigating stressors. • Empower students to effect change with inclusion of family in process. • Increase overall number of students meeting physical fitness standards; encourage physical activity. • Reach as many students as possible and their families to educate them of the tenets of Fit Quest in the counties served.
Outcomes	• 2021: 426 total adults and youth served. • 2020: 349 total adults and youth served. • 2019: 711 total adults and youth served; including 24 families.